STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075271	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of nine (9) sampled residents (Resident #2) who were admitted to the facility over the prior ninety (90) days, the facility failed to conduct a thorough investigation following an elopement incident involving a resident with known wandering and exit-seeking behaviors, when the facility did not interview all potential staff witnesses to determine how Resident #2 exited the building unattended through the rear exit door. Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of nine (9) sampled residents (Resident #2) who were admitted to the facility over the prior ninety (90) days, the facility failed to conduct a thorough investigation following an elopement incident involving a resident with known wandering and exit-seeking behaviors, when the facility did not interview all potential staff witnesses to determine how Resident #2 exited the building unattended through the rear exit door.Resident #2's diagnoses included Alzheimer's Disease, traumatic subdural hemorrhage, cerebral infarction, depression, and generalized anxiety disorder.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 1), required maximum assistance with oral hygiene, toileting, showers, and bathing and self-propelled in a wheelchair.The Resident Care Plan dated 3/6/26 identified Resident #2 was at risk of wandering and elopement. Interventions directed to ensure Resident #2's picture was in the elopement risk binder at the reception desk, exercise and walk with resident to prevent restlessness, wanderguard (a wander management system designed to protect memory care residents against elopement) to left ankle, assist resident to find own room as appropriate, and provide diversional activities.The nurse's note dated 4/9/26 at 4:08 PM by the Director of Nurses (DON) identified on 4/9/26 at approximately 3:10 PM RN #1 entered her office which was across the hall from Resident #2's room and identified she saw Resident #2 seated in his/her wheelchair inside the room. Shortly thereafter, another resident yelled, He/She's outside. Recreation Assistant (RA) #1 identified that while walking on the unit, she observed Resident #2 outside through another resident's window. RA #1 immediately exited the unit through the therapy doors and was the first staff member to reach Resident #2. RN #1 approached Resident #2 from an alternate direction, and he/she was immediately assisted and escorted back into the building by staff. Resident #2's condition was assessed following the incident and no injuries were observed or reported at the time of return. The physician and a family member were notified. A psychiatric consult was ordered for Resident #2, and 72-hour monitoring was initiated as directed by the facility protocol.Interview and observation with the DON on 5/5/26 at 12:15 PM identified Resident #2 was unsafe to ambulate independently and had a wheelchair which he/she self-propelled, however Resident #2 often would get up and self-ambulate. Prior to 4/7/26 re-admission to the facility, Resident #2 had been identified as an elopement risk and had a wanderguard bracelet for safety due to exit seeking behaviors. Upon return from the hospital LPN #1 failed to complete an elopement assessment and obtain a new order for a wanderguard. On 4/9/26 at approximately 3:10 PM, RN #1 saw Resident #2 last in his/her room and then was alerted by another resident that Resident #2 was outside. Resident #2's wheelchair was found by the rear exit door of the building. The rear exit door (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was used by staff who parked behind the building and for vendors. Upon observation, after entering the key code to exit the first door, approximately three (3) seconds lapsed prior to the door re-locking. The DON identified the investigation concluded Resident #2 exited the back door after a staff member exited, prior to the door re-locking. The DON identified staff did not see Resident #2 exit when they used the rear exit door. The DON further identified she did not interview all staff that worked during the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts on 4/9/26 to determine who entered and exited through the rear exit door that could have potentially seen Resident #2 by the door or left the door open. The DON identified she did not conduct a thorough investigation at the time of the event.The facility Reporting/Investigating Resident Accident/Incidents Policy identified, in part, that all accidents and incidents would be thoroughly investigated by management.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for three (3) of nine (9) sampled residents (Residents #2, #5, and #6) reviewed for elopement, he facility failed to conduct required wandering/elopement risk assessments upon admission and re-admission in accordance with facility policy and the admission process, resulting in delayed identification and implementation of elopement interventions, including Resident #2 who subsequently exited the facility unattended The findings include:1. Resident #2's diagnoses included Alzheimer's Disease, traumatic subdural hemorrhage, cerebral infarction, depression, and generalized anxiety disorder.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 1), required maximum assistance with oral hygiene, toileting, showers, and bathing and self-propelled in a wheelchair.The Resident Care Plan dated 3/6/26 identified Resident #2 was at risk of wandering and elopement. Interventions directed to ensure Resident #2's picture was in the elopement risk binder at the reception desk, exercise and walk with resident to prevent restlessness, wanderguard (a wander management system designed to protect memory care residents against elopement) to left ankle, assist resident to find own room as appropriate, and provide diversional activities.The nursing admission assessment for dated 4/7/26 by LPN #1 failed to identify that a Wandering or Elopement assessment was conducted.Review of the clinical record identified the Elopement assessment was conducted on 4/9/26 and identified Resident #2 was at risk of elopement.The nurse's note dated 4/9/26 at 4:08 PM by the Director of Nurses (DON) identified on 4/9/26 at approximately 3:10 PM RN #1 entered her office which was across the hall from Resident #2's room and identified she saw Resident #2 seated in his/her wheelchair inside the room. Shortly thereafter, another resident yelled, He/She's outside. Recreation Assistant (RA) #1 identified that while walking on the unit, she observed Resident #2 outside through another resident's window. RA #1 immediately exited the unit through the therapy doors and was the first staff member to reach Resident #2. RN #1 approached Resident #2 from an alternate direction, and he/she was immediately assisted and escorted back into the building by staff. Resident #2's condition was assessed following the incident and no injuries were observed or reported at the time of return. The physician and a family member were notified. A psychiatric consult was ordered for Resident #2, and 72-hour monitoring was initiated as directed by the facility protocol.Interview and observation with the DON on 5/5/26 at 12:15 PM identified Resident #2 was unsafe to ambulate independently and had a wheelchair which he/she self-propelled, however Resident #2 often would get up and self-ambulate. Prior to the 4/7/26 re-admission to the facility, Resident #2 had been identified as an elopement risk and had a wanderguard bracelet for safety due to exit seeking behaviors. Upon return from the hospital, LPN #1 failed to complete an Elopement assessment and obtain a new order for a wanderguard. The DON identified an Elopement assessment should have been completed upon re-admission to the facility as directed by the admission Checklist and LPN #1 failed to follow the facility admission process.Interview with LPN #1 on 5/6/26 at 1:50 PM identified she worked with Resident #2 prior to the hospital admission and was aware Resident #2 was at risk for elopement. LPN #1 identified Resident #2 wore a wanderguard prior to the hospitalization. LPN #1 identified an Elopement assessment should have been performed immediately upon re-admission due to Resident #2's history of wandering and elopement risk. She further identified she forgot to complete the Elopement assessment and to obtain the wanderguard order.2.The Nursing admission assessment for Resident #5 dated 2/9/26 by LPN #1 failed to identify that a Wandering or Elopement assessment was conducted. Resident #5's Elopement assessment was conducted two (2) days after admission on [DATE].3.The Nursing admission assessment for Resident #6 dated 2/11/26 by LPN #1 failed to identify that a Wandering or Elopement assessment was conducted. Resident #6's Elopement (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment was conducted five (5) days after admission on [DATE].Interview with the DON on 5/5/26 at 12:15 PM identified all residents should have an Elopement assessment performed on admission and readmission to the facility according to the facility policy and admission Checklist. The facility Elopement Policy identified, in part, that residents will be assessed for risk of elopement and unsafe wandering upon admission to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of nine (9) sampled residents (Resident #2) reviewed for elopement, the facility failed to implement existing elopement interventions for a severely cognitively impaired resident with known wandering and exit-seeking behaviors, resulting in Resident #2 exiting the facility unattended through a secured rear exit door without staff knowledge. The findings included:Resident #2's diagnoses included Alzheimer's Disease, traumatic subdural hemorrhage, cerebral infarction, depression, and generalized anxiety disorder.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 1), required maximum assistance with oral hygiene, toileting, showers, and bathing and self-propelled in a wheelchair.The Resident Care Plan dated 3/6/26 identified Resident #2 was at risk of wandering and elopement. Interventions directed to ensure Resident #2's picture was in the elopement risk binder at the reception desk, exercise and walk with resident to prevent restlessness, wanderguard (a wander management system designed to protect memory care residents against elopement) to left ankle, assist resident to find own room as appropriate, and provide diversional activities.The nurse's note dated 4/7/26 at 11:15 PM identified Resident #2 was re- admitted from the Behavioral Health hospital on 4/7/26. Resident #2 was interacting appropriately with nursing staff and was adjusting well.The Social Service Note dated 4/9/26 at 11:47 AM identified a readmission Interdisciplinary Team Meeting (IDT) was held and Resident #2's family member attended by phone. The team discussed a plan to increase Resident #2's ability to walk with staff safely to assist in expelling some energy. They discussed a long-term plan of transferring Resident #2 to a secure dementia unit due to wandering and agitation.The nurse's note dated 4/9/26 at 4:08 PM by the Director of Nurses (DON) identified on 4/9/26 at approximately 3:10 PM RN #1 entered her office which was across the hall from Resident #2's room and identified she saw Resident #2 seated in his/her wheelchair inside the room. Shortly thereafter, another resident yelled, He/She's outside. Recreation Assistant (RA) #1 identified that while walking on the unit, she observed Resident #2 outside through another resident's window. RA #1 immediately exited the unit through the therapy doors and was the first staff member to reach Resident #2. RN #1 approached Resident #2 from an alternate direction, and he/she was immediately assisted and escorted back into the building by staff. Resident #2's condition was assessed following the incident and no injuries were observed or reported at the time of return. The physician and a family member were notified. A psychiatric consult was ordered for Resident #2, and 72-hour monitoring was initiated as directed by the facility protocol.The untimed psychotherapy note dated 4/9/26 identified Resident #2 had been struggling with increased anxiety and agitation and returned from hospitalization two days prior, at which point Resident #2 had been calm and fatigued, but on 4/9/26 Resident #2 was struggling with confusion, anger and agitation. Resident #2 was observed outside by another resident and was brought back inside. The provider met with the DON and administrator and communicated concerns that a more appropriate setting for Resident #2 would be a locked memory care unit. The facility has been seeking a bed for Resident #2. The wanderguard on his/her ankle was placed.Interview and observation with the DON on 5/5/26 at 12:15 PM identified Resident #2 was unsafe to ambulate independently and had a wheelchair which he/she self-propelled, however Resident #2 often would get up and self-ambulate. Prior to the 4/7/26 re-admission to the facility, Resident #2 had been identified as an elopement risk and had a wanderguard bracelet for safety due to exit seeking behaviors. Upon return from the hospital, LPN #1 failed to complete an elopement assessment and obtain a new order for a wanderguard. On 4/9/26 at approximately 3:10 PM, RN #1 saw Resident #2 last in his/her room and then was alerted by another resident that Resident #2 was outside. Resident #2's wheelchair was found by the rear exit door of the building. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The rear exit door was used by staff who parked behind the building and for vendors. Upon observation, after entering the key code to exit the first door, approximately three (3) seconds lapsed prior to the door re-locking. The DON identified the investigation concluded Resident #2 exited the back door after a staff member exited, prior to the door re-locking. The DON further identified staff did not see Resident #2 exit behind them when they used the back door.Interview with NA #5 on 5/6/26 at 1:08 PM identified prior to Resident #2 being hospitalized he was aware Resident #2 was an elopement risk and had worn a wanderguard at the facility. On 4/9/26 NA #5 clocked out of work at 3:03 PM and prior to exiting the back door, saw Resident #2 self-propelling down the hallway from his/her room towards the exit door. NA #5 redirected Resident #2 into the recreation room and prior to leaving ensured he/she was settled. NA #5 proceeded to put the code in to exit the back door, exited the building and went to the car. NA #5 did not see Resident #2 exit the building.Interview with NA #3 on 5/6/26 at 1:23 PM identified she was aware Resident #2 had a wanderguard prior to going to the hospital and redirected Resident #2 when Resident #2 attempted to follow a staff member out of the building. NA #3 identified on 4/9/26, she clocked out a few minutes after 3:00 PM and passed NA #5 in the hall when he was on the way to the time clock to punch out. NA #3 then exited to the car through the back door. NA #3 was giving NA #5 a ride home, so she turned around in the car to see if he was coming and saw him through the windows in the recreation room bringing Resident #2 into the room. At around 3:05 PM, she saw NA #5 wheel Resident #2 to a table with other residents and then exit the building to the car. NA #3 and NA #5 began to exit the parking lot when NA #3 received a call from the DON asking if she saw Resident #2 exit the building.The facility Elopement Policy identified, in part, that residents who exhibited wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #1), who required the assistance of two staff for transfers, the facility failed to transfer the resident according to the plan of care resulting in a fall with major injury (left hip fracture) requiring surgical intervention. The findings include:Resident #1's diagnoses included hemiplegia and hemiparesis following a cerebral infarct affecting left side, abnormality of gait, muscle weakness, and bradycardia.The physician's order dated 2/9/26 directed an assist of two (2) using the ETAC [NAME] (turn aid with a functional design that offers safe patient turning with standing support during transfers).The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14) and was dependent on staff for transfers in and out of bed and chair and required maximum assistance with the wheelchair.The Resident Care Plan dated 3/5/26 identified Resident #1 had a self-care deficit and was at risk for falls due to flaccidity on the left non-dominant side. Interventions directed assistance of two (2) with transfers in and out of bed and chair using the ETAC [NAME], provide two (2) staff for care at all times, keep call bell in reach, apply proper footwear, wheelchair for mobility, assist with bathing, dressing, and hygiene, and therapy services as needed.Review of the Resident Care Card (RCC) dated 4/22/26 identified Resident #1 required the assistance of two (2) staff with ETAC [NAME] for transfers.The nurse's note dated 4/22/26 at 11:49 AM identified Resident #1 was observed on the floor. NA #1 stated she was transferring Resident #1 to the wheelchair and had to assist Resident #1 to the floor. Resident #1 did not hit his/her head and reported left hip pain. The Director of Nursing (DON) and physician were contacted, and a left hip x-ray was ordered. Resident #1's family member was notified, and Resident #1 was assisted back to bed with the mechanical lift.The nurse's note dated 4/22/26 at 1:49 PM by the DON identified the left hip x-ray results identified an acute oblique nondisplaced intertrochanteric fracture on the left and diffuse osteopenia. The Advanced Practice Registered Nurse (APRN) was updated and directed to send Resident #1 to the Emergency Department (ED) for evaluation and treatment.The hospital Discharge summary dated [DATE] identified Resident #1 underwent a repair of the left intertrochanteric hip fracture and directed the facility to hold aspirin for two weeks and resume Eliquis.The nurse's note dated 4/26/26 at 4:40 PM identified Resident #1 returned to the facility after surgical repair of the left hip fracture. Orders were given to perform left hip x-rays on 5/24/26 and forward to the orthopedic specialist for review. Lab work was scheduled for the next day. Resident #1 reported a pain level of seven (7) out of ten (10) at the left hip and oxycodone five (5) milligrams (mg) was administered as directed by the physician's orders. Physical and Occupational Therapy were ordered. Physician's orders directed transfer status as a mechanical lift with the assistance of two (2).A written statement dated 4/22/26 by NA #1 identified she transferred Resident #1 using the stand-pivot method. NA #1 identified she engaged the wheelchair brakes and as Resident #1 was sitting down the wheelchair began to roll and Resident #1 began to go down so NA #1 pulled Resident #1 against her body and slid him/her down her leg until Resident #1 landed on the floor on his/her bottom. NA #1 then laid Resident #1 down and called for assistance.An interview with the DON on 5/5/26 at 12:00 PM identified she conducted the investigation into Resident #1's fall. The DON identified NA #1 worked at the facility for approximately one (1) month but worked at the facility several times prior as an agency staff member. NA #1 was oriented in proper transfer techniques upon hire. The facility requirement was for NA's to review the RCC for direction on transfer status and if the NA was uncertain, they should check with the nurse. After Resident #1 fell, the DON questioned NA #1 as to why she transferred the resident alone and did not use the ETAC [NAME] and NA #1 was unable to provide an answer. The DON interviewed Resident #1 who identified NA #1 did not use the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	equipment during the transfer. The DON further identified the facility terminated NA #1 for not following the facility policy or physician's order for transfers.An interview with COTA #1 (Certified Occupational Therapy Assistant) on 5/6/26 at 9:10 AM identified it was the facility policy for any resident that required assistance with transfers with equipment to have two (2) staff provide assistance for safety of the resident and if NA #1 had followed the policy and physician orders, Resident #1's fall could have been prevented. COTA #1 further identified she was working with Resident #1 to return to his/her prior baseline of transfers using the ETAC [NAME] and Resident #1 was fearful and nervous when attempting the transfers.An interview with NA #1 on 5/6/26 at 9:45 AM identified she worked with Resident #1 several times prior to 4/22/26. NA #1 identified she did not review the RCC for transfer orders and transferred Resident #1 based on what she recollected the transfer status was from previously working with Resident #1. NA #1 identified that while in the process of completing a stand-pivot transfer without the use of the ETAC [NAME] the wheelchair began to move and Resident #1 began to go down so NA #1 pulled the resident close to her and slid him/her down to the floor along NA #1's leg. Resident #1 landed on his/her bottom. The nurse then took over care.An interview with Resident #1 on 5/6/26 at 11:15 AM, in the presence of COTA #1 per Resident #1's request, identified in the past year, two (2) people assisted him/her with transfers except for the day of the fall.Review of the facility Safe Resident Handling/Transfer Policy identified while manual lifting techniques may be utilized, mechanical lifts are a safer alternative and should be used. Resident lifting and transferring will be performed according to the resident's individual plan of care, and two (2) staff members must be present when transferring a resident with a mechanical lift. Failure to maintain compliance with the policy may lead to disciplinary action up to and including termination. Review of facility documentation identified that a Plan of Correction was initiated immediately:Staff training was completed and included review of the facility Safe Resident Handling/Transfer Policy, including proper transfer techniques, use of mechanical lifts, and the correct place to find the residents' transfer status.Random audits to be completed weekly for four (4) weeks, then monthly for three (3) months to ensure staff compliance with appropriate transfers for residents.Audits to be reviewed at the monthly QAPI meetings.The Administrator and Director of Nursing are responsible for the plan.Facility was in compliance as of 4/27/26 The plan of correction was reviewed on 5/6/26 and the facility met all components for past non-compliance.