

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Pendleton Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Maritime Drive Mystic, CT 06355	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to revise to complete neurological checks as per facility standard. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to ensure neurological checks were completed after an unwitnessed fall, in accordance with facility policy. The findings include: Resident #1 was admitted with diagnoses that included non-traumatic subdural hematoma, atrial fibrillation (irregular heartbeat) right leg below the knee amputation. The Resident Care Plan (RCP) dated 5/13/2025 identified Resident #1 was at risk for falls due to confusion, disorientation and was on anticoagulation (blood thinner). Interventions directed Resident #1 was independent with transfers, and to remind resident to ask for help. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 (had moderate cognitive impairment) and was independent for bed mobility, personal care and required supervision with transfer. A facility incident report dated 7/5/2025 at 1:00 PM identified Resident #1 was found sitting on the floor next to the bed and stated he/she had slid off the bed. The report indicated Resident #1 was alert and pleasant, and an RN assessment was completed with no injuries identified. The physician was notified and vital signs monitored. A nursing note dated 7/5/2025 at 6:15 PM by RN #1/supervisor, identified MD #1 was notified of the fall and instructed to continue neurological vital sign protocol as per policy. A facility incident report dated 7/5/2025 at 4:10 PM identified Resident #1 was found on the floor next to the bed, denied hitting his/her head, denied pain, and was alert and oriented. Two (2) abrasions that measured three (3) and five (5) centimeters (cm) were noted on the left lower extremity. MD #1 was contacted with actions taken that included neurological vitals (neuro checks), RN assessment and labs (blood work). A facility reportable event form dated 7/5/2025 at 6:15 PM identified Resident #1 had an unwitnessed fall; Resident #1 was found on his/her buttocks at the bedside with his/her head against the dresser and denied hitting his/her head. Resident #1 was alert and oriented, had no apparent injury, but a decline in mental status was noted on assessment; decreased interaction and ability to articulate words, neurological vital signs were initiated. The physician was notified and ordered transfer to the hospital for evaluation. The report indicated a CT scan with results acute on chronic subdural (brain) hematoma (localized collection of blood outside of blood vessels due to injury or trauma) with mass effect and midline shift, and Resident #1 was admitted to the hospital. Facility documentation review identified Resident #1's medical record included a neurological check sheet dated 7/5/2025 that directed to evaluate blood pressure, pulse, temperature, level of consciousness, pupil reaction and eye-motor-verbal response every 1/2 hour times four (4), then every hour times 4 hours times twenty-four (24) hours, then every 8 hours for the remaining 72 hours or as ordered by physician. Record review identified neurological assessments were initiated on 7/5/2025 after the fall at 1:00 PM; they were completed at 1:10, 1:40, 2:10, 2:40 PM, and 3:40 PM (completed 4 half hour checks and 1 hourly check). Further review identified although a second unwitnessed fall occurred at 4:10 PM, the next neurological assessment was completed at 4:40 (half an hour after the fall, and one (1) hour after the prior assessment was performed at 4:10 PM). The next assessment was completed one (1) hour later, at 5:45 PM. Resident #1 then had a third fall at 6:15 PM. Review identified that the neurological assessments were not completed every half hour after an unwitnessed fall occurred per the facility policy. Interview with LPN #2 on 8/6/2025 at 10:45 AM identified Resident #1 was his resident on 7/5/2025 during the 3:00 to 11:00 PM shift. LPN #2 stated neurological checks are to be completed as directed by the neurological record form: evaluate blood pressure, pulse, temperature, level of consciousness, pupil reaction and eye-motor-verbal response every 1/2 hour times four (4), then every hour times 4 hours times twenty-four (24) hours, then every 8 hours for the remaining 72 hours or as ordered by physician after an unwitnessed fall. LPN #2 stated he completed the neurological checks as directed on the form, but stated he did not recall if he initiated new neurological checks after the unwitnessed 4:10 PM fall. LPN #2 stated he completed the neurological checks as directed on the form, but stated he did not recall if he initiated new neurological checks after the unwitnessed 4:10 PM fall. Interview with LPN #1 on 8/6/2025 at 11:30 AM identified she was Resident #1's nurse on 7/5/2025 from 7:00 AM to 3:00 PM. LPN #1 stated she initiated the neurological record to document the required checks after Resident #1's unwitnessed fall at 1:00 PM. LPN #1 further stated she was going off duty when Resident</p>		