STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075341	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Rehabilitation and Nursing Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Residents #1 and #2) who were reviewed for an allegation of abuse, the facility failed to ensure a nursing assessment was completed and documented in the clinical record at the time the allegation and assessment was reported. The findings include:1.Resident #1's diagnoses included altered mental status, adjustment disorder with depressed mood and cerebral edema (swelling in the brain caused by an accumulation of excess fluid in the brain tissues). The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a staff assessment for mental status completed identifying both short and long-term memory problems, required supervision assistance with toileting and was independent with bed mobility, transfers and ambulation. The Resident Care Plan dated 10/9/25 identified Resident #1 could be non-compliant with medication administration, Activities of Daily Living (ADL) care due to cognitive impairment and knowledge deficit. Interventions included offering as many alternatives as possible to choose from, discussing the resident's objections, reasons, fears and ideas, notifying the provider if resident refuses medications and/or treatments and psychiatric/psychological consultations as needed. The Facility Reported Incident form dated 11/2/25 identified that at 3:50 PM, Resident #1's family member reported to the Nursing Supervisor, Resident #1 had reported to the family member he/she had sustained both right and left upper forearm bruising due to a nurse aide who pulled Resident #1 out of bed by the arms and threw Resident #1 into the shower at night time on 10/30/25. The report identified a nursing assessment was completed noting a 1.5 centimeter (cm) circular bruise to the left upper forearm and a 2 cm circular bruise to the right upper forearm. The report indicated the provider and the police were notified of the allegation, the nurse aide was suspended, and an investigation was initiated per protocol. Review of the clinical record dated 11/2/25 failed to identify a nurse's note regarding the allegation or that a nursing assessment was completed following the allegation of physical abuse. A late entry Situation, Background, Assessment and Recommendation (SBAR) dated 11/3/25 at 6:53 PM was noted to be created by the Director of Nursing (DON) on 11/16/25 at 3:04 PM (14-days after the allegation). Interview with the Nursing Supervisor, Registered Nurse (RN) #1, on 11/18/25 at 12:28 PM identified that although she assessed Resident #1 following the allegation of abuse on 11/2/25, she was unable to explain why she did document the allegation or her assessment, stating she must have forgotten but she should have prior to leaving for her shift that evening. 2. Resident #2's diagnoses included generalized anxiety disorder, major depressive disorder and Attention-Deficit Hyperactivity Disorder (ADHD). The admission Evaluation dated 9/6/25 identified Resident #2 was oriented to person, place, time and situation and required assistance for mobility. The Resident Care Plan dated 9/7/25 identified Resident #2 had major depressive disorder and utilized an antidepressant medication. Interventions included monitoring/documenting/reporting to the provider any ongoing signs and (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms of depression, administering antidepressant medications per physician's orders and monitoring/documenting the side effects and effectiveness and psychiatry and/or psychology consultations as needed. The Facility Reported Incident form dated 9/12/25 identified at 2:40 PM an allegation was made by Resident #2 to the social worker. Resident #2 reported during the 3-11PM shift on 9/11/25, a nurse aide barged into his/her room, ripped the dentures out of his/her mouth, abruptly got Resident #2 off the toilet and called him/her a cunt. The report identified Resident #2 had no injuries, the family, the provider and the police were notified of the allegation, the nurse aide was suspended, and an investigation was initiated. Review of the clinical record from 9/12/25 through 11/18/25 failed to identify a nurse's note was written regarding the allegation or that a nursing assessment was completed following the allegation of both physical and verbal abuse. Interview with the Director of Nursing (DON) on 11/18/25 at 2:40 PM identified for Resident #2, she realized when finalizing the 11/2/25 investigation on 11/16/25 a note nor an assessment were documented on the allegation in the clinical record by RN #1, so she opened the SBAR on 11/16/25 and backdated it 11/3/25 mistakenly instead of 11/2/25. The DON identified RN #1 should have documented her encounter and her assessment of Resident #1 on 11/2/25 following the abuse allegation before the end of her shift. The DON identified for Resident #2 she was present in the facility at the time of the allegation on 9/12/25, and although she personally assessed Resident #2 and completed all the paperwork, she never documented the allegation or her assessment of the resident in the clinical record. Review of the Documentation in the Medical Record policy (undated) directed, in part, that each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Documentation shall be timely and in chronological order.