STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075349	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cook Willow Health & Rehabilitation Center, Inc.	81 Hillside Avenue Plymouth, CT 06782

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 #56) reviewed for abuse, the facility failed to ensure staff reported an allegation of mistreatment timely, and failed to ensure the State Agency was notified timely of an allegation of mistreatment. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #56) reviewed for abuse, the facility failed to ensure staff reported an allegation of mistreatment timely, and failed to ensure the State Agency was notified timely of an allegation of mistreatment. The findings include: Resident #56's diagnoses included cerebral infarction, dementia, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen (14/15), indicating alert and oriented, and required moderate assistance for showers. The Resident Care Plan (RCP) dated 7/9/2025 identified Resident #56 had impaired ADLs (activities of daily living) and mobility related to acute right side cerebral infarction. Interventions directed to provide assistance with ADLs. Interview with Person #1 on 9/4/2025 at 10:15 AM identified on 8/1/2025, Resident #56 reported to Person #1 that during his/her shower, he/she was inappropriately touched by the staff member on the groin. Person #1 stated he/she reported the allegations to the ADON. Interview with ADON on 9/4/2025 at 10:25 AM identified on an unknown date, Person #1 had reported that Resident #56 alleged he/she was inappropriately touched during the shower. The ADON stated that Person #1 did not report any specific type of touching, such as foundling, roughness, or pain. The ADON stated Resident #56 was confused during that timeframe, and although Person #1 reported the allegation, Person #1 verbally indicated he/she did not believe the event had occurred. The ADON stated he did not report or investigate the allegation of abuse, due to Person #1 had requested staff not speak with Resident #56 about the allegation because Resident #56 would think Person #1 had told on him/her and Person #1 did not believe the allegation. Review of CT's Department of Health's FLIS Events Report Tracking System identified the facility failed to submit a reportable event for the allegation made on 8/1/2025. Interview with the DON on 9/4/2025 at 2:30 PM identified she was not aware of the allegation of mistreatment. The DON stated all abuse allegations must be reported immediately, investigated promptly, and reported to the State Agency within two hours of discovery. The DON stated the ADON should have notified her of the allegation, and Resident #56's allegation of inappropriate touching during a shower should have been investigated in a timely manner, and the State Agency should have been notified. Review of the Abuse Policy dated 11/2021 directed in part, any complaint of, observation of, or suspicion of resident abuse, mistreatment, or neglect is to be thoroughly investigated and reported. The facility will follow State Health Department guidelines and other regulatory agencies for reporting requirements. Facility investigations will be completed with seventy-two (72) hours. All incident reports must be completed immediately after the incident has occurred (all abuse, alleged or confirmed), and the facility will follow State Health Department guidelines and other regulatory agencies for reporting requirements.

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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 review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #56) reviewed for abuse, the facility failed to ensure timely investigation of an allegation of mistreatment. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #56) reviewed for abuse, the facility failed to ensure timely investigation of an allegation of mistreatment. The findings include: Resident #56's diagnoses included cerebral infarction, dementia, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen (14/15), indicating alert and oriented, and required moderate assistance for showers. The Resident Care Plan (RCP) dated 7/9/2025 identified Resident #56 had impaired ADLs (activities of daily living) and mobility related to acute right side cerebral infarction. Interventions directed to provide assistance with ADLs. Interview with Person #1 on 9/4/2025 at 10:15 AM identified on 8/1/2025, Resident #56 reported to Person #1 that during his/her shower, he/she was inappropriately touched by the staff member on the groin. Person #1 stated he/she reported the allegations to the ADON. Although requested, the facility was unable to provide documentation regarding an investigation conducted regarding the allegation of mistreatment. Interview with ADON on 9/4/2025 at 10:25 AM identified on an unknown date, Person #1 had reported that Resident #56 alleged he/she was inappropriately touched during the shower. The ADON stated that Person #1 did not report any specific type of touching, such as foundling, roughness, or pain. The ADON stated Resident #56 was confused during that timeframe, and although Person #1 reported the allegation, Person #1 verbally indicated he/she did not believe the event had occurred. The ADON stated he did not report or investigate the allegation of abuse, due to Person #1 had requested staff not speak with Resident #56 about the allegation because Resident #56 would think Person #1 had told on him/her and Person #1 did not believe the allegation. Although requested, the facility was unable to provide documentation regarding an investigation was performed for the allegation made on 8/1/2025. Interview with the DON on 9/4/2025 at 2:30 PM identified she was not aware of the allegation of mistreatment. The DON stated all allegations of abuse must be investigated properly, and this allegation should have been reported by the ADON and then investigated in a timely manner. Review of the Abuse Policy dated 11/2021 directed in part, any complaint of, observation of, or suspicion of resident abuse, mistreatment, or neglect is to be thoroughly investigated. The investigation will include an accident report, obtaining statements from potential witnesses, completion of necessary evaluations (i.e., skin/body checks, pain evaluation), and maintaining a timeline of events. Facility investigations will be completed with seventy-two (72) hours.