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	04/29/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **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 two (2) sampled residents (Resident #1) reviewed for abuse, the facility failed to ensure the victim of a resident-to-resident altercation was afforded the choice to remain in his/her original room before staff initiated a room change following an incident in which Resident #2 threatened Resident #1 with a plastic knife. The facility further failed to ensure the room relocation promoted Resident #1's sense of safety and access within the facility when Resident #1 was moved four (4) rooms away from Resident #2 to a room located at the end of a corridor with no alternate route of exit/access, requiring Resident #1 to routinely pass Resident #2's room to access common areas of the facility. The findings include:1. Resident #1's diagnoses included muscle weakness, type II diabetes mellitus and absolute glaucoma (end stage glaucoma characterized by total irreversible blindness and eye pain).The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required substantial assistance for transfers and was dependent on staff for bed mobility.The Resident Care Plan (RCP) dated 2/16/26 identified Resident #1 had impaired Activities of Daily Living (ADLs) and mobility related to being newly admitted , weakness post hospitalization, a diagnosis of rhabdomyolysis (rare muscle injury that causes muscles to break down) and was at risk for impaired visual function related to glaucoma and a diagnosis of diabetes. Interventions included a partial assist of one (1) for bed mobility, transferred independently with a rolling walker and ambulated independently in the room and throughout the facility with a rolling walker.2. Resident #2?s diagnoses included Alzheimer's disease, major depressive disorder with psychotic symptoms (when hallucinations or delusions occur alongside depressive symptoms) and generalized anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation.The RCP dated 3/26/26 identified Resident #2 lacked safety awareness and had the potential to demonstrate manipulative behaviors related to poor impulse control, dementia, mental illness, ineffective coping skills and a history of substance use and had a history of making accusatory statements. Interventions included Resident #2 was to utilize plastic utensils for all meals, assessing and anticipating needs, assisting in developing more appropriate methods of coping and interacting, and if reasonable, staff discussing behavior and explaining/reinforcing why noted behavior is inappropriate and/or unacceptable.The facility Reportable Event (RE) dated 4/3/26 identified at 5:45 PM Resident #1 reported the dinner cart was outside of his/her room so he/she started yelling hello looking for help when Resident #2 walked over to Resident #1's side of the room and asked Resident #1 why he/she kept saying hello and told Resident #1 to use the call bell. Resident #2 then placed a plastic knife to Resident #1's neck and moved it across. The RE identified Resident #1 went into the hall and reported the alleged altercation to NA #1 who immediately removed Resident #1 from the area, notified the charge nurse (LPN #1) and Resident #2 was placed on one-to-one observation. No injury was noted to Resident #1, the APRN and the police were notified and Resident #2 was sent to (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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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Emergency Department (ED) for evaluation.A late entry nurse's note by RN #1 dated 4/3/26 at 5:45 PM (created 4/6/26 at 8:45 PM) identified Resident #1 reported to staff that his/her roommate (Resident #2) approached him/her with a plastic knife and lightly ran the plastic knife across his/her throat and reported Resident #2 stated he/she was annoyed that Resident #1 was calling out for assistance as a staff member walked by the room. RN #1 identified Resident #1 was immediately removed from the room to the hallway and denied acute pain or other discomfort and no acute skin changes were noted to the throat area at that time. She reported Resident #1's affect was calm and Resident #1 remained in the hallway with staff in attendance.A late entry nurse's note by LPN #1 dated 4/3/26 at 9:30 PM (created 4/4/26 at 11:26 AM) identified Resident #1 was alert and oriented at baseline and at 5:45 PM, NA #1 identified Resident #1 reported Resident #2 placed a plastic knife to Resident #1's neck. No injuries were noted, Resident #1 was removed from the room by another staff member and the DON, APRN and police were notified of the altercation. Emotional support was provided to Resident #1 throughout the evening and a room change was offered to Resident #1, and he/she accepted and was subsequently moved at 7:00 PM and offered no complaints regarding the new room.A psychiatric APRN note dated 4/4/26 identified she was asked to see Resident #1 following the 4/3/26 altercation. Resident #1 was alert but slightly anxious and stated he/she was upset and worried about the other resident (Resident #2) returning from the Emergency Department (ED). The APRN offered antianxiety medication, but Resident #1 refused.Review of the facility census on 4/29/26 identified although Resident #2 was the aggressor, Resident #1's room remained the same since 6/13/24 and was not moved following the 4/3/26 altercation.Observation of Resident #1's room in proximity to Resident #2's room on 4/29/26 at 11:12 AM identified Resident #1 was moved to the end of a hallway that was 4 rooms down from Resident #2.Interview with Resident #1 on 4/29/26 at 11:16 AM identified prior to the 4/3/26 altercation Resident #2 had never been aggressive towards him/her but when he/she (Resident #1) started yelling that evening, Resident #1 immediately rushed over cursing, calling him/her names and then ran the plastic knife over his/her throat in a threatening manner and stated, If you don't shut up it will be worse next time. Resident #1 reported the behavior shocked and frightened him/her. Resident #1 identified following the altercation, staff approached him/her and reported they would be moving his/her room, and he/she agreed because he/she felt they had no choice but to move to feel safe and get away from Resident #2. Resident #1 reported he/she was angry that he/she did not get the choice to stay in the room and Resident #2 got his/her way and got the room to his/herself after threatening Resident #1, making him/her feel as if they were the issue and not Resident #2. Resident #1 identified he/she enjoyed ambulating out of the room, socializing with friends and going to the dining room for meals and reported since the room change, he/she had to walk past Resident #2's room to do any of those things which he/she continued to do, but felt nervous because Resident #2 was independent and could come out at any time. Resident #1 reported the Director of Social Services reapproached him/her numerous times since the altercation and offered room changes farther away from Resident #2, but he/she declined because he/she had no issue with the current roommate and was afraid of what kind of roommate he/she would be placed with if he/she were to move.Interview with Resident #2 on 4/29/26 at 12:16 PM identified on 4/3/26, Resident #1 was continuously yelling, hello which aggravated Resident #2, and he/she told Resident #1 to use the call bell and Resident #1 ignored him/her (Resident #2) so he/she went over to Resident #1 with a plastic knife, called Resident #1 names and then pushed the knife up against Resident #1's throat. Resident #2 reported he/she should have used the call bell and not touched Resident #1 but was just trying to, shut up Resident #1.Interview with LPN #1 on 4/29/26 at 12:00 PM identified following the altercation she spoke with the DON, and the DON directed her to move Resident #1 to a new room, so she asked Resident #1 if he/she was agreeable to the move and Resident #1 agreed. LPN #1 reported she did not give Resident #1 the option of staying in the room he/she was in at the time of the altercation LPN #1 identified that since the altercation, Resident #1 verbalized he/she was concerned and upset that Resident #2 had a private room and Resident #2 got (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what he/she wanted.Interview with the DON on 4/29/26 at 12:28 PM identified LPN #1 called her following the 4/3/26 altercation and although Resident #2 was the aggressor, she only had vacant private rooms on the short term unit available, so she contacted the Administrator and it was decided to keep Resident #2 in the room he/she was in, and she directed LPN #1 to move Resident #1 into a new room. Resident #1 agreed so she thought it was fine. The DON identified it did not occur to her that Resident #1's new room was at the end of a hallway and Resident #1 would be required to walk by Resident #2's room to access the remainder of the facility.Interview with the Director of Social Services on 4/29/26 at 1:27 PM identified Resident #1 should have remained in his/her room after the 4/3/26 altercation and the aggressor (Resident #2) should have been moved to a different room. She reported she understood why Resident #1 was frustrated with the room change.Re-interview with the DON on 4/29/26 at 1:45 PM identified Resident #1 should have been offered to remain in his/her original room and Resident #2 should have had the room change since the facility had two (2) private rooms on a different unit available at the time. Additionally, she reported she should have ensured the residents rooms were located on separate units.Review of the facility census dated 4/3/26 identified there were three (3) private rooms available on the East (short-term) unit that Resident #2 could have been moved to, which would have allowed Resident #1 to remain in his/her original room following the altercation.Review of the Abuse, Definitions and Procedure for Suspected Abuse policy dated 11/2021 directed, in part, the procedure for incidents of resident-to-resident abuse includes: the charge nurse and supervisor assess the victim of abuse for injury/harm, initiate proper treatment and investigate the incident to determine etiology and precipitating factors. Using this information, interventions are put into place to prevent further incidents and mitigate any negative consequences for the victim of such abuse. The plan of care for both the victim and the abuser is updated to reflect these interventions and a nurse's note is written.Review of the Residents' [NAME] of Rights policy (undated) directed, in part, you have the right to notice before your roommate is changed, you have the right to be treated equally with other residents in receiving care and services and regarding transfer and discharge regardless of the source of payment for your care and you have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment or involuntary seclusion.Although requested, a facility policy for room transfer following a resident-to-resident altercation was not available.