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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on tour of the Dietary Department, review of facility policy and staff interview, the facility failed to ensure perishable food items were dated upon opening and dishwasher temperatures were consistently monitored. The findings include:1. Tour of the Dietary Department on 9/4/25 at 9:40 AM with the Director of Food Services identified the following:a. The dry storage area was observed to contain the following items which were not labeled/dated when opened: a 10 pound (lb.) bag of acini pasta that was 9/10 full, a 10 lb. bag of penne pasta that was 1/3 full, a 10 lb. bag of ziti pasta that was 3/4 full, a 20 lb. bag of split peas that was 1/3 full, and a 2 lb. bag of bread crumbs that was 3/4 full.b. The walk-in cooler was observed to contain the following items which were not labeled/dated when opened: 1/4 of a 6 lb. roll of genoa salami, 1/8 of a 15 lb. section of virginia ham, and 1/8 of a 6 lb. roast beef (cooked rare).c. The walk-in freezer was observed to contain the following items which were not labeled/dated when opened: a 4 lb. bag of corn that was 1/4 full, a 5 lb. bag of sliced pepperoni that was 1/8 full, a 5 lb. bag of clams (not in shells) that was 1/8 full. Additionally, the following items were not dated when opened and had no expiration date because the items were removed from the original packages: 13 fish cakes wrapped with clear plastic wrap and a clear plastic bag with 6 seasoned white fish fillets.Interview with Director of Food Services at that time identified that food items were to be labeled with the date opened at the time of use/opening, and she was unable to identify the reason the items had not been labeled when opened.Subsequent to surveyor inquiry on 9/8/25 identified staff was inserviced on the food storage policy.Review of the Dietary Food & Drink Storage Policy directed, in part, dietary staff will date all perishable food items upon opening and monitor for expiration dates upon stocking. The policy further identified any food found unlabeled or out of date will be discarded immediately.2. Observation of the dishwashing process on 9/9/25 at 11:10 AM identified the stationary rack dual temperature machine performed the wash cycle at 160 F and then rinsed the dishes at 192 F which was within the appropriate temperature range.Review of the Dishwashing Temps Daily Log 2024 (wrong year within document title) on 9/9/25 at 11:15 AM identified columns for logging dishwasher temperatures (temps) for wash and rinse for all 3 meals (breakfast, lunch, and dinner) with additional columns for the date and staff initials. The first row of documentation on the log was dated 8/24/25 and failed to contain documentation of dishwasher temps for all 3 meals. The next 5 rows of documentation on the log dated 8/25/25-8/29/25 included documentation of dishwasher temps for breakfast and lunch but failed to include documentation for dinner. The next 2 rows of documentation on the log dated 8/30/25 and 8/31/25 failed to include documentation of dishwasher temps for all 3 meals. The next 9 rows of documentation on the log dated 9/1/25-9/9/25 included documentation of dishwasher temps for breakfast and lunch but failed to include documentation for dinner. Interview with Food Service Director on 9/10/25 at 2:15 PM identified she was aware of missing temperature documentation on the log sheet and that she had verbally spoken to the staff members involved. The Food Service Director identified there should not be any missing entries on the temp log. She further identified, she had not written the education down nor had the staff sign that they had been educated about their failure to document dishwasher temps on the log sheet. The Food Service Director identified she (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would initiate an inservice with written instructions, identified that the cooks were responsible for oversite of the kitchen and they should have ensured the dishwasher temps were documented as required. The Food Service Director was unable to identify the reason there were missing dishwasher temps nor why the cooks had not directed the dishwashers to document the temps.Subsequent to surveyor inquiry on 9/10/25, education was provided to the dietary staff on observing the dish machine temperatures and logging them properly according to facility policy.Review of the Dish Machine Wash/Rinse Policy directed, in part, kitchen personnel will check and log the temperature of the dishwasher at least once per meal period or shift. The policy directed the machine used high heat to sanitize and must reach the following temperatures: wash cycle 150 F to 165 F and final sanitizing rinse cycle 165 F to 180 F and any variations should be reported to the Food Service Director.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 2 sampled residents (Resident #1) reviewed for accidents, the facility failed to ensure the care plan was revised when Resident #1 was removing the wanderguard bracelet (sensor used to assist in preventing exiting through doorways outside). The findings include:Resident #1 was admitted to the facility in December 2023 with diagnoses that included Alzheimer's dementia, history of viral hepatitis and seizure disorder. Physician's orders dated 6/12/25 directed to check function of wanderguard every night and check placement of wanderguard once a shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and was independent with activities of daily living (ADLs).The Resident Care Plan dated 6/24/25 identified elopement as an area of concern including having a history of removing the wanderguard bracelet. Interventions included to check wanderguard function daily, check placement once a shift, offer diversional activities, place in wanderguard book, psychiatric consults as needed, approach in non-threatening manner, and medicate for anxiety as needed. Nursing notes dated 6/25/25 at 6:36 AM identified that Resident #1's wanderguard was not in place and that the resident had stated that he/she had to take it off because his/her ankle swells. The nursing note indicated that a new bracelet with same sensor was applied to Resident #1's right ankle but failed to identify how Resident #1 was able to remove the wanderguard bracelet. An elopement assessment dated [DATE] identified Resident #1 was an elopement risk. The 6/28/25 elopement assessment did not differ from previous elopement assessments completed on 3/23/25 and 4/3/25 that identified Resident #1 was an elopement risk. Nursing notes dated 7/21/25 at 6:13 AM identified that Resident #1 continued to refuse wanderguard replacement after multiple attempts as resident stated he/she does not need it anymore. The nursing note failed to identify when the wanderguard was removed and how Resident #1 removed the wanderguard bracelet. A follow up nursing note by the Assistant Director of Nurse's (ADNS) on 7/21/25 at 7:04 AM identified that Resident #1 allowed the wanderguard to be reapplied to left ankle after Resident #1 was educated on the rationale for the need of the wanderguard bracelet. An interview with the ADNS on 9/12/25 at 9:30 AM identified that he was unaware how Resident #1 removed the wanderguard on 6/25/25 and 7/21/25 and was unsure if it was investigated on how it was removed. Furthermore, the ADNS stated that the care plan was not revised to include the removals of the wanderguard on 6/25/25 and 7/21/25 and it is nursing and the Care Plan Coordinator's responsibility to ensure the care plan was updated with new interventions. The ADNS was unaware of the reason the care plan was not revised to reflect the wanderguard removals and new interventions to prevent the removals attempted.An interview with Registered Nurse (RN) #2 on 9/12/25 at 9:45 AM indicated that she was responsible along with nursing to update the care plans with new interventions. RN #2 indicated that Resident #1's care plan should have been revised with new interventions when he/she removed the wanderguard on 2 occasions. RN #2 stated that she was unsure why it was not updated as it was an oversight, but she may have been on vacation when the 7/21/25 incident occurred. Additionally, RN #2 stated she was unaware how Resident #1 was removing his/her wanderguard. An interview with Resident #1 on 9/12/25 at 10:10 AM indicated that he/she had removed the wanderguard on more than one occasion. Resident #1 stated that he/she removed the wanderguard using nail clippers because he/she just did not want to wear it. Review of the Resident Care Plan Policy dated December 1998 directed, in part, that the Resident Care Coordinator shall be responsible for conducting spot check reviews of written care plan to correct any deficiencies in documentation or lack of updating by any discipline.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of the clinical record and facility policy for 1 of 1 sampled resident (Resident #54) reviewed for death, the facility failed to ensure a comprehensive assessment was completed at the time of death. The findings include: Resident #54's diagnoses included hemophagocytic lymph histiocytosis, chronic obstructive pulmonary disease, unspecified atrial fibrillation and, diastolic (congestive) heart failure, and anemia.An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #54 was cognitively intact and was dependent on staff for all transfers and personal care activities. Additionally, the MDS identified that Resident #54 required set-up assistance for eating.A Resident Care Plan dated 7/1/25 noted Resident #54 had altered respiratory status and difficulty breathing related to a right lower infiltrate from 6/30/25. Interventions included administering medications (specifically bronchodilation inhaled agents) as ordered and monitoring for effectiveness and side effects.A physician's order dated 7/4/25 directed Do Not Resuscitate (DNR), Do Not Intubate (DNI), Do Not Hospitalize (DNH), Register Nurse Pronouncement (RNP), and comfort measures only (CMO).Nursing notes dated 7/7/25 at 6:08 AM and written by Registered Nurse (RN) #5 identified that Resident #54 was observed not to be breathing, without a heartbeat and RN #5 pronounced death at 5:47 AM (the assessment failed to include a lack of blood pressure and pupillary response). The next of kin and the funeral home were notified of Resident #54's death, however the assessment at the time of death failed to include a lack of blood pressure.In an interview and clinical record review with the Director of Nursing Services on 9/12/25 at 8:25 AM, it was identified that the RNP assessment completed by RN #5 was not comprehensive to include a lack of blood pressure.In an interview, clinical record, and facility policy review with the Assistant Director of Nursing Services (ADNS) on 9/12/25 at 9:40 AM, the ADNS indicated that the RNP assessment needed to include the absence of a heartbeat or breath sounds, both verified for a full minute, and a lack of blood pressure. The ADNS indicated that the RNP assessment policy was overseen by the interdisciplinary team and that nursing staff have access to review this policy, with no known reason for not following the policy as written.Interview and clinical record review on 9/12/25 at 10:41 AM with Registered Nurse #5 identified that he was aware of the facility policy and believed he had followed this. He identified that he verified that Resident #54 was not breathing, had no pulse, and that Resident #54's pupils were fixed and dilated. RN #5 identified his note from 7/7/25 failed to include blood pressure, stating this was taken earlier in the evening, and that he believed he had included all necessary additional information in this note. RN #5 further identified he had become concerned about his inability to immediately access the state portal to report the death, potentially leading to the missing details in his note, and that he was responsible for performing a complete assessment upon death.The facility policy for Registered Nurse pronouncement of death directs that the RN record the clinical findings and notify the physician, as well as that the assessment findings at the time of pronouncement include the following: absence of pulse, respirations, blood pressure, heart sounds, pupillary response (fixed and dilated), and the time the assessment was conducted.

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F 0689 Level of Harm - Minimal harm or potential for 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 policy and staff interviews for 1 of 4 residents reviewed for accidents (Resident #28), the facility failed to provide transfer assistance per the physician's order which resulted in a fall with an injury. The findings include: Resident #28's diagnoses included non-traumatic subarachnoid hemorrhage (bleeding in the brain), muscle weakness, difficulty in walking, unsteadiness on feet and repeated falls. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 was cognitively intact and required partial/moderate assistance with transfers, and substantial/maximal assistance with toileting and bed mobility. The MDS indicated Resident #28 had not had any falls since admission/entry, reentry or on the prior assessment.A plan of care progress note (a note written after a resident care plan conference was held) dated 5/15/25 at 12:37 PM identified Resident #28 had a resident care conference held with the interdisciplinary team (IDT) and the responsible party was in attendance. The progress note indicated Resident #28 was at risk for falls related to a history of a fall with injury, had decreased mobility and was a transfer assist of 2 with a rolling walker (RW). Additionally, the progress note identified Resident #28 was on a skilled Physical Therapy (PT) maintenance program and that the care plan and kardex updates had been completed. Review of the Resident Care Conference form dated 5/15/25 identified Resident #28 was a fall risk and an assist of 2 with a rolling walker (RW) for transfers.The Resident Care Plan (RCP) dated 5/16/25 identified Resident #72 had impaired mobility due to weakness and was at risk for falls related to gait and balance problems. Interventions included assistance of 2 with a RW for transfers and ambulation and to anticipate and meet the resident's needs. A physician's order dated 5/19/25 directed Resident #28 was to be transferred with an assist of 2 with a RW and a pivot assist device may be used to transfer the resident off the toilet. A therapy progress note dated 8/5/25 at 9:43 AM identified Resident #28 was seen for a quarterly screen and required extensive assistance for toileting, bed mobility and an assist of two staff for transfers. The progress note indicated Resident #28 was participating in a PT maintenance program. A nursing progress note dated 8/15/25 at 10:45 AM and written by the DNS identified Resident #28 was found on the floor at his/her bedside with a large, raised hematoma to the left forehead area. The Advanced Practice Registered Nurse (APRN) was notified, and Resident #28 was transferred by ambulance to the hospital emergency department for a trauma evaluation. A facility Reportable Event form (RE) completed by Licensed Practical Nurse (LPN) #1 on 8/15/25 (no time noted) identified Resident #28 had a witnessed fall during a transfer on 8/15/25 at 10:45 AM, sustained a hematoma to the left side of his/her head and had complaints of pain after the fall. The RE indicated the Resident #28 was sent by ambulance to the hospital emergency department for further evaluation. Review of hospital documentation dated 8/15/25 identified Resident #28 was evaluated in the emergency department after a fall and had sustained a traumatic hematoma to the forehead. The documentation noted Resident #28 was to have ice applied to the area of swelling and receive pain relievers as needed. Nursing notes dated 8/16/25 through 8/17/25 identified Resident #28 received Acetaminophen once, Tramadol twice and an ice pack once for discomfort. Review of the kardex/Nurse Aide (NA) care card dated as printed on 8/20/25 indicated that Resident #28 was an assist of 2 for transfers with a RW. (The DNS and Physical Therapist indicated although the Nurse Aide care card was printed on 8/20/25, it was in effect on 8/15/25). Interview, review of the clinical record and facility documents with the DNS on 9/9/25 at 1:05 PM identified Resident #28 had a witnessed fall during a transfer with injuries (hematoma, facial swelling, and bruising) on 8/15/25. The DNS indicated although the Resident #28 was an assist of 2 with a RW for transfers, NA #4 did not follow the plan of care and transferred the resident alone, which caused the resident to fall and sustain injuries. The DNS was unsure why NA #4 had transferred the resident with an assist of 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(despite a 5/19/25 physician's order for transfers with an assist of 2 with a RW) and identified after the incident NA #4 was terminated and education was conducted with the facility's NA staff regarding completing all transfers per the resident's plan of care. Interview with NA #4 on 9/9/25 and 1:55 PM identified she had made a mistake and transferred Resident #28 by herself on 8/15/25 and the resident subsequently fell and was injured. NA #4 indicated prior to transferring the resident from the bed to the wheelchair she failed to reference Resident #28's kardex/NA care card and thought the resident was a stand pivot assist of 1 for transfers. NA #4 identified she should have referenced Resident #28's kardex/NA care card, obtained help from another nursing staff and followed the resident's plan of care before transferring the resident. NA #4 further indicated she did not utilize a gait belt because she didn't have a gait belt with her to use or the RW when transferring Resident #28 on 8/15/25 and during the transfer she was unable to stop the resident from falling, witnessed the resident fall and hit his/her head on the floor. Interview with the physical therapist (PT) #1 on 9/10/25 at 10:10 AM identified due to weakness in Resident #28's legs, the risks of transferring the resident with an assist of 1 were that he/she would lose balance or strength during the transfer and fall. PT #1 indicated NA # 4 should have followed Resident #28's plan of care and physician's orders and had another staff to assist her with transferring the resident. PT #1 indicated by not transferring Resident #28 with 2 staff, she caused the resident to fall and sustain injuries on 8/15/25. PT #1 identified she was familiar with Resident #28 because the resident was on a PT maintenance program at the time of the fall. In addition, PT #1 identified Resident #28 had no changes in his/her functional abilities prior to the fall and was a transfer assist of 2 with a RW for a long period of time. Interview with Resident #28 on 9/10/25 at 10:19 AM identified he/she still had a painful bump under his/her hairline on the left side of his/her head and it bothered him/her that the lump was still there. Resident #28 indicated although the large amount of bruising to his/her head and face had resolved, she was unhappy a bruised area remained under her left eye. Resident #28 identified since the fall on 8/15/25, he/she also had episodes of dizziness when turning his/her head to the left and he/she was seen by the APRN for it. Although Resident #28 was unable to recall the details of his/her fall on 8/15/25, he/she indicated he/she insists there are 2 staff with a RW to transfer him/her at all times. Interview with LPN #1 on 9/10/25 at 11:42 AM identified she was the charge nurse when Resident #28 fell on 8/15/25 and when she was called to the resident's room, she found Resident #28 on the floor with only NA #4 in the room. LPN #1 indicated NA #4 had transferred Resident #28 by herself and should not have. LPN #1 identified NA #4 should have referenced the resident's kardex/NA care card and asked for assistance from another nursing staff prior to the transfer. Additionally, LPN #1 identified she did not observe a gait belt or a RW on or in the area of Resident #28 after the fall. Review of the facility policy, Resident Transfer, undated, directed staff should ensure the safe and effective transfer of residents from bed to chair while preventing injury and complying with safety standards. The policy directed staff should follow the residents care plan or physician's orders and should never transfer a resident alone if the assessment indicated more than one person is needed. The policy further directed to use gait belts when appropriate.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #7) reviewed for hospice services, the facility failed to ensure hospice provided nursing and social work documentation/communication regarding hospice visits. The findings include:Resident #7 was admitted to the facility in June 2018 with diagnoses that included severe dementia with psychotic disturbances, Type 2 diabetes and was receiving hospice services since October 2024.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a short/long term memory problem, had an upper and lower extremity impairment on one side, and was dependent for oral hygiene, toilet use, dressing and personal hygiene. Additionally, the MDS indicated Resident #7 was receiving hospice services.The Resident Care Plan dated 6/4/25 identified hospice care with interventions that included hospice visits, social service as needed for emotional support, and pastoral clergy for spiritual needs, provide maximum comfort for resident, and work cooperatively with hospice team to ensure resident's emotional, spiritual, intellectual, physical and social needs are met.A physician's order dated 9/8/25 directed to provide hospice service, comfort measures, do not resuscitate, do not hospitalize and registered nurse may pronounce death. A review of Resident #7's hospice documentation on 9/9/25 revealed that hospice services (nursing and social work) were not providing the facility with any written documentation of regular scheduled or unscheduled visits. The documentation provided by hospice staff for visits was on the Visit Description Log that included the hospice employee name, discipline, and visit type (scheduled/unscheduled) but failed to include any type of notes to identify what was provided and Resident #7's response. Furthermore, there was no copy of Resident #7's care plan by hospice in the clinical record. Interview with the Hospice Team Manager on 9/9/25 at 12:15 PM noted that the facility did not require the hospice team to leave notes after visits for Resident #7. The hospice team assigned to Resident #7 wrote notes in their system for Resident #7 but did not provide the facility with that documentation. According to Hospice Team Manager, the hospice nurse and/or social worker collaborate with facility supervisor verbally after visits but did not leave any written documentation of their visits. Interview with the Social Worker (SW) #2 on 9/9/25 at 1:50 PM identified that she was unaware that hospice was not providing written documentation of visits and was unaware that the facility did not require documentation. She indicated that periodically the hospice social worker would stop by her office and verbally communicate with her regarding Resident #7.Interview with APRN #1 on 9/9/25 at 2:05 PM identified that she was not aware that hospice was not providing written documentation of visits and documentation of recommendations to the facility. APRN #1 stated that her experiences with hospice services in long term care facilities had been written documentation from hospice was in the resident's clinical record. Interview with the DNS on 9/10/25 at 8:45 AM revealed that she was not aware that hospice was not providing documentation of their visits for Resident #7. The DNS indicated that verbal communication was not sufficient and that the facility needed written documentation regarding findings, recommendations and plan of care. In addition, the DNS indicated that she was accustomed to hospice services always providing documentation of any visits, was unsure of the reason they were not providing documentation to the facility, and it was nursing's responsibility to ensure documentation of visits was provided to the facility. Interview with RN #2 on 9/10/25 at 1:30 PM identified that she was unsure why hospice was not leaving documentation for visits for Resident #7. She indicated that she was never informed that the facility did not require notes from hospice as they used to leave notes but was aware that there had been changes in the nursing management team from the hospice vendor in the last year. Furthermore, RN #2 indicated that she did not have a copy of Resident #7's care plan from hospice nor have they ever provided it to her to incorporate it into Resident #7's care plan at the facility. A review (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the Hospice Policy directed, in part, residents receiving hospice care are provided with compassionate, coordinated, and appropriate end of life care in accordance with federal and state regulations. The residents receive care that aligns with their goal, values and advance directives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy and interviews for 1 of 2 sampled residents (Resident #4) reviewed for an indwelling urinary catheter, the facility failed to ensure the drainage bag was not touching the floor. The findings include:Resident #4 was admitted to the facility in January 2024 with diagnoses that included obstructive uropathy and tubulo-interstitial nephritis (inflammation of the tubes and tissue of the kidney).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact and was totally dependent on staff for assistance with activities of daily living (ADLS). Additionally, the MDS identified Resident #4 had an indwelling urinary catheter. The Resident Care Plan dated 6/19/25 identified a urinary catheter as a concern with interventions that included changing the catheter bag as needed, keep below the level of the bladder, document any pain/discomfort and monitor for signs of infection.A physician's order dated 7/9/25 directed to change catheter monthly on the 28th of each month, provide meatal hygiene once a day, and catheter care once a shift.Observations on 9/8/25 at 11:10 AM, 9/9/25 at 1:00 PM and 9/10/25 at 12:30 PM identified Resident #4's urinary catheter drainage bag was attached to the back of his/her wheelchair with the drainage bag touching the floor.An Interview with Registered Nurse (RN) #1 on 9/10/25 at 1:00 PM identified that a urinary catheter drainage bag should not be touching the floor due to infection control concerns as the floor was not a clean surface. RN #1 indicated that it was the nurse aides (NA) responsibility to ensure that the drainage bag was never touching the floor.Interview and observation with NA #1 on 9/10/25 at 1:10 PM identified Resident #4's was sitting in his/her wheelchair in the bedroom with the urinary catheter drainage bag touching the floor. NA #1 indicated that the urinary drainage bag should not be touching the floor as it was an infection control issue. NA #1 stated that Resident #4 was not on her assignment but would adjust the urinary drainage bag immediately.An interview with the Infection Preventionist (ICN) on 9/10/25 at 1:15 PM identified that urinary drainage bags should not touch the floor. The ICN indicated that Resident #4's urinary drainage bag was not touching the floor earlier and that it must be related to how it was placed on the back of the wheelchair. Furthermore, the ICN indicated that he would assess how the urinary drainage bag was being attached to the back of the wheelchair to ensure that it does not touch the floor.Interview with NA #3 on 9/10/25 at 2:00 PM indicated that Resident #4 was on her assignment on 9/10/25 and that she provided catheter care to the resident. NA #3 did not recall the urinary drainage bag touching the floor and was aware that it should not be touching the floor.A review of the policy Foley Catheter Care and Use dated September 2001, directed, in part, that the collection bag and/or tubing are not allowed to touch the floor or other contaminated objects such as the wheels of chairs.

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 (Resident #2, Resident #53 and Resident #55) sampled closed records reviewed, the facility failed to ensure the ombudsman was notified of the resident discharges. The findings include 1.Resident #2's diagnoses included urinary tract infection (UTI), myocardial infarction (heart attack), and benign prostatic hyperplasia. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact, had an indwelling catheter, required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers.The Resident Care Plan (RCP) dated 3/10/25 identified Resident #2 had an indwelling catheter upon admission. Interventions included changing the catheter bag as needed, monitor/document pain/discomfort due to the catheter, and monitor/record/report to physician signs/symptoms of UTI (pain, burning, blood tinged urine, urine cloudiness, foul smelling urine). a. A nursing note dated 3/21/25 at 10:20 AM identified Resident #2 was sent to the hospital for evaluation and treatment for respiratory distress, abnormal blood work, and abdominal pain. A nursing note dated 3/25/25 at 9:53 PM identified Resident #2 was readmitted to the facility from the hospital with a diagnosis of severe sepsis related to a UTI complicated by obstructive pyelonephritis. b. A nursing note dated 5/19/25 at 3:16 PM identified Resident #2 was transferred to the hospital for a cystoscopy procedure. A nursing note dated 5/19/25 at 3:32 PM identified Resident #2's responsible party notified the facility Resident #2 was admitted to the hospital following a shaking episode in the recovery room after his/her cystoscopy procedure. A nursing note dated 6/9/25 at 9:46 PM identified Resident #2 was re-admitted to the facility from the hospital at 8:45 PM with a diagnosis of sepsis due to UTI with septic shock, new onset of atrial fibrillation, myocardial infarction, right thumb cellulitis, and pulmonary infiltrates. c. A nursing note dated 6/22/25 at 2:05 PM identified Resident #2 was sent to the hospital for evaluation and treatment related to Resident #2's complaints of nausea with no appetite, coughing, wheezing, shaking, diminished lung sounds, and a temperature of 101.8 degrees Fahrenheit. A nursing note dated 6/23/25 at 1:02 AM identified Resident #2 was admitted to the hospital with a diagnosis of UTI. A nursing note dated 6/26/25 at 9:55 PM identified Resident #2 was readmitted to the facility from the hospital at 5:30 PM with a diagnoses of UTI with sepsis and parainfluenza. 2. Resident #53 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, cellulitis of the left lower limb and acute osteomyelitis. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 was severely cognitively impaired and required substantial/maximal assistance with bed mobility and was dependent with toileting and transfers. A nursing progress note dated 6/24/25 at 1:36 PM identified Resident #53 was having difficulty speaking, had garbled speech and was unable to follow commands at 12:40 PM. A Registered Nurse (RN) assessment was completed, and the Advanced Practice Registered Nurse (APRN) was notified. Resident #53 was transferred by ambulance to the hospital emergency department for further evaluation. A social service progress note dated 6/26/25 at 2:27 PM identified Resident #53 remained hospitalized , was transferred to another hospital and a bed hold policy was mailed to the resident's responsible party. Review of the facility census list for Resident #53 identified the resident was transferred to the hospital on 6/24/25 and was discharged from the facility on 7/1/25. 3. Resident #55 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease with dyskinesia, fracture of the left clavicle, and a history of falling. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 was moderately cognitively impaired and required substantial/maximal assistance with bed mobility and toileting and was dependent with transfers. The Resident Care Plan (RCP) dated 6/20/25 identified Resident #55 was admitted to the facility for short term rehabilitation and had a self-care performance deficit. Interventions included the resident would have a physical and occupational therapy evaluation and staff were to provide the resident with the necessary assistance for transfers, toileting, eating and bed mobility. An APRN progress note dated 6/25/25 at 9:50 AM identified Resident #55 had improved and was scheduled to be discharged from the facility on 6/27/25. A social service progress note dated 6/26/25 at 12:03 PM identified Resident #55's discharge was planned for 6/27/25 and the residents responsible party was the primary caregiver and did not want a home care referral at this time. A nursing progress note dated 6/27/25 at 5:18 PM identified Resident #55 was discharged home with his/her responsible party at 1:30 PM. Review of the facility census list for Resident #55 identified the resident was admitted to the facility on [DATE] and was discharged from the facility on 6/27/25. Interview with Social Worker (SW) #2 on 9/10/25 at 1:30 PM identified she did not send notifications of discharges and transfers to the Ombudsman, and it was the Director of Nurses (DNS) who was responsible. Interview with the DNS on 9/10/25 at 1:32 PM identified she did not send notifications regarding discharges and transfers to the Ombudsman, and she would need to find out who was responsible. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Another interview with the DNS on 9/12/25 at 8:50 AM identified the Administrator was putting the discharge and transfer notifications into the ombudsman portal and all of the required notifications would be completed shortly. The DNS indicated upon surveyor inquiry it was discovered the required resident discharge and transfer notifications were not being made to the Ombudsman by the prior DNS since late 2023 and subsequent to surveyor inquiry, the Administrator was ensuring their error was corrected. The DNS identified she had only been in her current position for 4 weeks and was not aware it was her responsibility to notify the Ombudsman regarding discharges and transfers. An interview with the Administrator on 9/12/25 at 9:40 AM identified the last time the Ombudsman was notified of a resident discharge or transfer at the facility was in 8/2023. The Administrator indicated it was the responsibility of the DNS to notify the Ombudsman and she was not aware the required notifications were not being completed or why the prior DNS did not do them. The Administrator identified she would be changing the task responsibility of Ombudsman notifications of facility discharges and transfers to the social worker. Another interview with the Administrator on 9/12/25 at 11:02 AM identified she had completed the 2023-2025 ombudsman notifications for resident discharges and transfers at the facility and documentation was provided. Review of facility policy, Policy for Notification of Discharge or Transfer to Long-Term Care Ombudsman, undated, directed in compliance with federal and state regulations, the facility must send a copy of the notice of discharge or transfer to a representative of the Office of the State Long-Term Care Ombudsman.