STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225016	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Nursing Center	87 Briarwood Circle Worcester, MA 01606

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 observations, interviews, and record review, the facility failed to follow professional standards of practice for food safety to prevent the potential spread of foodborne illness to facility residents on the steam table service area and on two (Bayberry Lane and [NAME] Lane) out of two facility kitchenettes. Specifically, the facility failed to ensure that:1. [NAME] Supervisor #1 changed gloves and performed appropriate hand hygiene while working on the resident food service line in the kitchenette located between the Bayberry Lane and [NAME] Lane units and handling food, clean dishes and touching equipment and surfaces in the steam table service area. 2. food items were appropriately stored in the Bayberry Lane and [NAME] Lane kitchenettes. Findings include:Review of the facility policy titled, Handwashing/Hand Hygiene, dated 2001, indicated: -all personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. -the use of gloves does not replace hand washing/hand hygiene. -perform hand hygiene before applying non-sterile gloves.-when removing gloves pinch glove at the wrist and peel away from the hand.perform hand hygiene. Review of the facility policy titled, Personal Protective Equipment - Gloves, dated 2001, indicated to wash your hands after removing gloves. Review of the facility policy for Use and Storage of Food and Beverage Brought in for Residents, undated, indicated:-it is the policy .to provide safe and sanitary storage, handling, and consumption of all foods including those brought into residents by family and other visitors.-the staff will help you ensure that all food is labeled with the following information:>Resident's name and room number.>the date the food was brought into the center.-all food brought in must be stored in a disposable microwaveable container with a tight-fitting lid. -all perishable food brought in will be discarded 3 days from the date on the label. 1. On 10/2/25 at 7:54 A.M., the surveyor observed the following during the breakfast meal service in the steam table service area:-Cook Supervisor #1 stepped away from serving food to open and reach inside a cabinet drawer to retrieve a knife and cut some sausage links. [NAME] Supervisor #1 did not change her gloves or perform hand hygiene and continued serving food and touching clean plates and utensils. -At 8:06 A.M., [NAME] Supervisor #1 removed her gloves, did not perform hand hygiene and started stacking clean plates into various cabinets in the steam table service area. -At 8:44 A.M., [NAME] Supervisor #1 was wearing gloves, removed her gloves, did not perform hand hygiene and proceeded to touch clean plates, cabinets and the food thermometer. During an interview on 10/2/25 at 8:50 A.M., [NAME] Supervisor #1 said that she should have washed her hands after removing her gloves and was unaware that she did not perform hand hygiene. During an interview on 10/2/25 at 8:55 A.M., the Food Service Director (FSD) said that [NAME] Supervisor #1 should have washed her hands after removing her gloves. 2. On 12/9/25 8:23 A.M., the surveyor observed the following in the facility kitchenettes:a) Bayberry Lane Unit: >Storage Cabinet:-three small 0.813-ounce boxes of Special K cereal, with best by date 11/12/25-one opened package of wheat bread, sealed fresh through 11/8/25>Freezer:-one opened, 16-ounce soda bottle frozen, undated>Refrigerator: -two plastic storage bags containing three, 7-ounce containers of pre-sliced cheddar cheese, undated-one large, opened coffee creamer, dated 11/7/25-one opened and resealed pumpkin pie, best if used by date 11/22/25-one plastic container of pasta with meat sauce, (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlabeled and undated-four 5.3 - ounce containers of vanilla yogurt, expiration date 11/30/25-one 5.3 - ounce container of two percent Greek yogurt, expiration date 12/8/25-one covered container of apple sauce, unlabeled and undated-one partially open to air pecan pie, dated 11/30/25 b) [NAME] Lane Kitchenette:>Refrigerator:-one sealed muffin, unlabeled and undated -one small plastic container of noodle soup, dated 11/7/25-two small, covered containers of apple sauce, dated 11/14/25-two take-out containers of turkey, mashed potatoes, stuffing, carrots, one undated, and the other dated 11/27/25-one plastic container of assorted pastries, unlabeled and undated-one Styrofoam container of grilled cheese, unlabeled and undated-one 9 - ounce microwaveable pasta bowl with vegetables with a label which read perishable, keep frozen that was stored in the refrigerator, and undated-one large plastic container of turkey soup, dated 11/30/25 During an interview on 12/11/25 at 11:28 A.M., the Administrator said that the kitchenettes are supposed to be checked for expired food every morning. During an interview on 12/11/25 at 11:48 A.M., the FSD said that the Dietary Aides should clean out the refrigerators every morning. The FSD said that the food brought in by family members and ordered by Residents should be labeled and thrown away after three days, all expired food and foods past their best buy date should be thrown away by those dates. The FSD also said these items had not been thrown away and they should have been.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure that one Resident (#59) out of a total sample of 18 residents received treatment and care in accordance with professional standards of practice related to wound care. Specifically, the facility failed to ensure that a verbal Provider order for a treatment change on wound care was transcribed and implemented when the Resident's wound was found to have increased in size and drainage, resulting in a delay of care and placing the Resident at risk for further wound deterioration and/or infection. Findings include: Review of the facility policy titled Medication and Treatment Orders, dated 2001, included but was not limited to the following: -Orders for medications and treatments will be consistent with principles of safe and effective order writing.-Verbal orders must be recorded immediately in the resident's chart by the person receiving the order .and include the time of the order. Resident #59 was admitted to the facility in July 2018 with diagnoses including Adult Failure to Thrive and Pressure Ulcer. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #59: -had a stage two pressure ulcer (a partial-thickness skin loss, appearing as a shallow open sore with red/pink wound bed, or a blister intact or broken) that had not been present on admission or re-entry to the facility. -had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of nine out of a total possible score of 15. Review of Resident #59's Medical Record indicated that the Resident's Left Lateral Knee Wound had healed and reopened multiple times. Further review of Resident #59's medical record failed to indicate evidence of a treatment plan change ordered on 12/12/25, when the Left Lateral Knee Wound was observed to be longer and deeper, and with increased wound drainage. Review of the Person-Centered Skin Integrity Care Plan indicated Resident #59: -was at risk for skin integrity alteration due to Adult Failure to Thrive and had a Left Outer (lateral) Knee Wound, effective 7/12/18. -Interventions included but were not limited to: >Treatment as ordered, effective 7/15/25. Review of Resident #59's December 2025 Physician's orders included but were not limited to: -Wound to the left lateral knee: cleanse with soap and water, pat dry, apply Skin Prep (a liquid barrier applied to the skin to create a protective film, improving dressing adherence, reducing friction and protecting skin from irritation) to the area and apply Optifoam (medical foam wound dressing designed to absorb excess fluid, protect wounds and create optimal healing environment) dressing every five days, effective 11/7/25. Review of Resident #59's Wound and Skin Record, dated 12/12/25 included: Left Lateral Knee Wound-Left Lateral Knee Wound had deteriorated as of 12/12/25. -Wound measurements had increased in size to 1.7 centimeters (cm) long by (x) 2 cm wide x 0.3 cm deep, compared to the previous wound measurements documented on 12/5/25 of 1 cm long x 2 cm wide x 0.1 cm deep. -Comment: follow up with Nurse Practitioner (NP) for new treatment change and possible wound consult. -The Resident's treatment plan had changed. During an interview on 12/15/25 at 11:28 A.M., Nurse #3 said Resident #59's left knee wound was chronic and frequently opened, healed over and would re-open again. Nurse #3 said she was the Nurse who provided Resident #59 with wound care to the left knee on 12/12/25 and had contacted the Resident's Provider the same day because the Resident's left knee wound had deteriorated. Nurse #3 said she received a new treatment order via electronic text from the Resident's Provider on 12/12/25 but forgot to transcribe the order to the Resident's medical record that same day. Nurse #3 said the new order to clean left lateral knee with Normal Saline, apply collagen followed by Calcium Alginate and an Optifoam dressing daily for wound care should have been entered on 12/12/25. Nurse #3 said she had not entered the Resident's new treatment order that she received on 12/12/25, until three days later on 12/15/25. The surveyor and Nurse #3 reviewed Resident #59's December 2025 Treatment Administration Record (TAR) and Nurse #3 said that Resident #59 was not provided with daily wound care as ordered for the dates of 12/13/25 and 12/14/25. Nurse #3 said not transcribing the Resident's new wound care order that she received on 12/12/25, would be considered a delay in (continued on next page)

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	225016	A. Building B. Wing	12/15/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment that could result in Resident #59's left knee wound becoming infected or cause delay to the left knee wound's healing. During an interview on 12/15/25 at 1:03 P.M., the Director of Nursing (DON) said she had reviewed the texted wound care order from 12/12/25 with Nurse #3 relative to Resident #59's left knee and that the order should have been transcribed immediately on 12/12/25, not on 12/15/25. The DON said that verbal orders should be transcribed immediately to a Resident's record by the Nurse that received the verbal order. The DON said that electronic receipt of orders such as a text message or e-mail were considered types of verbal orders.

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	225016	A. Building B. Wing	12/15/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record review, the facility failed to maintain professional standards of practice relative to the care and treatment of a urinary catheter (a small, soft, flexible tube in the bladder that drains urine from the body) device for one Resident (#7) out of a total sample size of 18 residents. Specifically, the facility failed to ensure that Resident #7's urinary catheter drainage bag was not placed directly on the floor placing the Resident at risk for contamination and urinary infections. Findings include: Review of facility policy titled Catheter Maintenance of Urethral/Suprapubic, dated 7/1/11, included but was not limited to: >Purpose: To reduce the occurrence of catheter associated infections. >Procedure: Do not rest the (drainage) bag on the floor. Resident #7 was admitted to the facility in May 2024 with diagnoses including Dementia and Urine Retention. Review the most recent Minimum Data Set (MDS) assessment, dated 9/5/25, indicated Resident #7: -has severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of a total possible score of 15. -has an indwelling urinary catheter. -was receiving hospice services. -was dependent for toileting and personal hygiene. Review of Resident #7's December 2025 Physician's orders included but was not limited to: -Urinary Catheter size: 16 French (Fr)/ 10 milliliter (ml) balloon to drainage bag every day, start date 8/6/25. -Catheter Care every shift, for catheter, initiated 12/18/24. Review of Resident #7's person-centered Indwelling Urinary Catheter Care Plan, effective 5/9/25, included but was not limited to: >Goal: Resident will not exhibit signs of urinary tract infection. >Interventions: Do not allow tubing or any part of the drainage system to touch the floor. On 10/1/25 at 7:31 A.M., the surveyor observed Resident #7 in his/her bedroom lying in his/her bed with eyes closed. The surveyor observed Resident #7's urinary catheter drainage tubing hanging freely over the edge of the bed and the drainage system bag laying flat against the floor. On 12/11/25 at 8:01 A.M., the surveyor observed Resident #7 lying in his/her bed and his/her urinary catheter drainage tubing hanging freely over the edge of the bed and the drainage system bag laying on the floor. On 12/11/25 at 9:04 A.M., the surveyor and Certified Nurses Aide (CNA) #1 observed Resident #7's drainage system bag laying on the floor. During an interview at the time, CNA #1 said he was the CNA assigned to Resident #7. CNA #1 said that Resident #7 was dependent for all care and did not touch the drainage system tubing or bag him/herself. CNA #1 said a basin was supposed to be used under the drainage system bag to prevent germs from getting on the bag and causing an infection. CNA #1 said he had not provided care to Resident #7 as yet, but the basin should have already been in place from the overnight (11:00 P.M. - 7:00 A.M.) shift. During an interview on 12/11/25 at 9:09 A.M., Nurse #3 said she was the Nurse assigned to Resident #7. Nurse #3 said that a basin should be placed under Resident #7's drainage system bag to avoid contact with the floor. Nurse #3 said when Resident #7's drainage system bag was on the floor without the basin in place, the system was at risk for contamination with germs and could make the Resident sick with an infection or sepsis. During an interview on 12/11/25 at 10:30 A.M., the Infection Preventionist (IP) said the facility staff had implemented the use of basins under the drainage system bags for residents last year. The IP said that Unit Managers, Nurses and CNA's were all responsible to ensure that a basin was in place for Resident #7. The IP said that placing a protective basin under the drainage system bag was important to prevent germs or organisms from entering Resident #7's drainage system bag and bladder which could cause an infection.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and Facility Assessment Tool review, the facility failed to implement the Facility Assessment Tool's staff training/education and competencies plan, and update the Facility Assessment Tool to accurately reflect the resident population and care needs for day-to-day operations and medical emergencies for one Resident (#5) out of one applicable resident with a tunneled hemodialysis catheter (a type of central venous catheter that is inserted under the skin and tunneled into a large vein). Specifically, the facility failed to identify and ensure the need for Licensed Nurse education/training and competencies related to day-to-day care and emergency care for residents on dialysis when Resident #5 was admitted to the facility, and his/her dialysis care needs were not identified on the Facility Assessment Tool. Findings include:Review of the facility policy titled End Stage Renal Disease (ESRD), Care of a Resident with, last revised September 2010, indicated:-Residents with ESRD will be cared for according to currently recognized standards of care. -Staff caring for residents with ESRD, including residents receiving dialysis care outside of the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes, specifically:>the nature and clinical management of ESRD (including infection prevention and nutritional needs).>the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.>signs and symptoms of worsening condition and/or complications of ESRD.>how to recognize and intervene in medical emergencies such as hemorrhages and septic infections. >how to recognize and manage equipment failure or complications (according to the type of equipment used in the facility). -the resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Review of the Facility Assessment Tool, updated 6/30/25, included the following: -The facility accepted residents with renal insufficiency, Renal Failure and End Stage Renal Disease (ESRD). -The facility employs a clinical screener.who reviews the clinical information on every referral to ensure that the nursing center is competent to provide care to the patients. -The Director of Nursing will then ensure that the nursing staff receives the appropriate education and supervision to care for the patients. -The nursing center subscribes to a company that provides information, guidance, policies, procedures, and competencies for resident care. -Policies will be reviewed as needed for new regulations, clinical care, etc.-If a new clinical procedure is needed within the nursing center, policies, procedures/competences will be reviewed and educated. -Outside assistance/education from other professionals may be sought out to ensure the nursing staff's ability to be competent. Further review of the Facility Assessment Tool failed to indicate any evidence that the facility identified residents who received dialysis care of any kind as part of the resident population they served and did not have evidence of a competency/education plan in place to address the dialysis population's needs. Resident #5 was admitted to the facility in May 2025 with diagnoses including Acute Kidney Failure and fluid overload. Review of Resident #5's Care Plan titled Renal Disease, last reviewed 8/20/25 indicated:-the Resident has chronic renal failure-Interventions for:>outpatient dialysis care >provide education regarding dialysis treatments>monitoring labs, vital signs, and weight Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #5:-was unable to complete the Brief Interview for Mental Status (BIMS) examination as evidenced by a score of 0 out of a total of 15 possible points-has end stage renal disease-received dialysis Review of Resident #5's December 2025 Physician's orders indicated:-[Dialysis Facility Name] Monday, Wednesday, Friday at 10:30 A.M. to 12:00 P.M., original order date 9/19/25-Left chest wall: monitor port site for signs and symptoms of infection, monitor that dressing is clean, dry and intact, notify Physician if any signs and symptoms of infection, original order date 5/15/25-monitor vital signs three times a week on dialysis days, every (continued on next page)

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	225016	A. Building B. Wing	12/15/2025

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monday, Wednesday, and Friday on 7:00 A.M. - 3:00 P.M., [sic] original order date 8/5/25 On 12/10/25 at 9:50 A.M., the surveyor observed Resident #5 in sitting in a wheelchair in his/her bedroom. During an interview at the time, the Resident said that he/she has a dialysis port located on his/her left chest. The surveyor did not observe any type of clamp or emergency equipment in the room or in any of the drawers to address any potential dialysis access cite complications. During an interview on 12/11/25 at 3:44 P.M., Nurse #2 said that no emergency equipment is required to be kept at Resident #5's bedside should an urgent situation with the Resident's dialysis port arise. Nurse #2 also said that there was no emergency equipment located in Resident #5's bedroom. During an interview on 12/11/25 at 4:49 P.M., the Director of Nursing (DON) said that the facility did not require Nurses to have competency or training in the care or monitoring of Resident #5's dialysis port because the facility did not access the port or change the dressing. The DON also said that Resident #5 would not require emergency supplies at the bedside like dressings or a clamp. During an interview on 12/15/25 at 9:55 A.M., the Administrator said that the purpose of the Facility Assessment Tool is to assess the clinical, physical, educational, and environmental needs of the building for its residents and staff. The Administrator also said that dialysis should have been included in the Facility Assessment, and it had not been included. During an interview on 12/15/25 at 10:53 A.M., Administrator said that there was no evidence that the facility nursing staff had received education or demonstrated competency to care for residents with ESRD or was on dialysis.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, interviews, and records reviewed, the facility failed to conduct an inspection of the mattress and bed rail to identify areas of possible entrapment for one Resident (#3) of two applicable residents, out of a total sample of 18 residents. Specifically, the facility failed to inspect Resident #3's mattress and bed rail for entrapment risk when the facility changed the Resident's mattress from a standard pressure reducing mattress to an air mattress and the Resident used a quarter length upper bed rail in the upward position when in bed with a gap observed between the air mattress and bed rails. Findings include:Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guide to Reduce Entrapment, dated 3/10/06, indicated the following:- .air mattress replacements, and similar pressure reduction products that have therapeutic benefits such as reducing pressure on skin are easily compressed by the weight of a patient and may pose an additional risk of entrapment when used with conventional hospital bed systems.-When these types of mattresses compress, the space between the mattress and the bed rail may increase and pose an additional risk of entrapment.-While entrapments have occurred with the use of . air mattress replacements, these products are excluded from the dimensional limit recommendations, except for those spaces within the perimeter of the rail.-This partial exemption is due to the highly compressible nature of these mattresses, which poses technical difficulties with measuring certain dimensional gaps in these types of products.-Additional caution should be taken when using these products to ensure a tight fit of the mattress to the bed system. If a powered air mattress is replacing a mattress on a bed system that meets the recommendations in the guidance with the original mattress, the resulting bed system with the new air mattress may still pose a risk of entrapment. Review of the facility's policy titled Bed Rail Safety, dated 8/10/10, indicated the following:-It was the facility's policy to take all reasonable steps to ensure the safety and independence of its residents .-Environmental Services shall be responsible for measuring bed rails to assure compliance with FDA guidelines for zones 1-4 indicated in the publication Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.-Pressure reducing mattress replacement systems are mandated to comply with guidelines. Resident #3 was admitted to the facility in May 2025 with diagnoses including Glaucoma, Frailty, and Impaired Mobility and Activities of Daily Living (ADLs). Review of the Side Rail Rationale Screen, dated 5/5/25, indicated Resident #3:-had a history of falls.-was on medication which required increased safety precautions.-expressed desire to have side rails raised while in bed.-side rails are indicated and serve as an enabler to promote independence. Review of Resident #3's ADL and Mobility Care Plan, initiated 5/5/25, indicated the Resident used quarter length bed rails to increase bed mobility and transfers. Review of Resident #3's Physician orders, dated 5/12/25, indicated: Air mattress, check setting and function. Review of the Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated Resident #3: -was moderately cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of eight out of 15 total possible points. -required partial/moderate assistance to roll left and right in bed. Review of Resident #3's Medication Administration Records (MAR) for May 2025 through December 2025 indicated the Resident had an air mattress in place every day the Resident was in the facility between 5/12/25 through 12/11/25. On 10/1/25 at 8:10 A.M., the surveyor observed the following in Resident #3's room:-The Resident was in bed.-The mattress on the bed was an air mattress.-The left quarter length bed rail (on the Resident's right side) was in the raised position.-A small gap (approximately one inch) between the left side of the air mattress and the raised left side quarter length bed rail.-The right side of the Resident's bed (on the Resident's left side) was positioned against the wall. On 12/12/25 at 12:30 P.M., the surveyor observed the following in Resident #3's room:-The Resident was sitting up in bed eating lunch.-The right side of the bed was positioned directly against the wall. -The left quarter length bed rail was in the raised position.-A small gap (approximately one inch) between the left side (continued on next page)

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	225016	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the air mattress and the raised left quarter length bed rail. Review of the facility's Bedframe Checklist, undated, failed to indicate any evidence that the Resident's bed equipment had been assessed relative to entrapment risk on/or after the Resident's air mattress was placed on 5/12/25. During an interview on 12/11/25 at 4:11 P.M., the Director of Nursing (DON) said that Resident #3's mattress was changed from a standard pressure redistribution mattress to an air mattress on 5/12/25. The DON said that the Nursing staff were not responsible to change the mattresses on the beds and that mattress changes were only completed by the Maintenance Director. During an interview on 12/11/25 at 4:40 P.M., the Maintenance Director said that he was responsible to assess residents bed equipment for entrapment risk. The Maintenance Director said when an air mattress was required for a resident, a Nurse would alert him of the need for the mattress to be changed. The Maintenance Director said he was responsible to remove the standard pressure redistribution mattress from the bed and replace it with an air mattress. The Maintenance Director said that when he placed the air mattress on the bed, he was responsible to assess the fit of the mattress with the bed rails for potential entrapment. The Maintenance Director said that once the assessment was completed, he was required to log the assessment and results on the facility's Bedframe Checklist. The Maintenance Director said he could not recall when the air mattress was placed on Resident #3's bed, and he could not say that he remembered assessing for entrapment risk when the air mattress was placed. The Maintenance Director said there was no evidence logged on the facility's Bedframe Checklist that Resident #3's bed was assessed for entrapment risk any time after the air mattress was placed on the Resident's bed.