STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225370	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Woods Rehabilitation and Healthcare Ctr	73 Chestnut Street Saugus, MA 01906

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews the facility failed to ensure the building and equipment was in good condition and had a homelike environment in 38 out of 40 rooms.Findings include:Review of the facility policy titled Homelike Environment, dated revised February 2021, indicated the following:Residents are provided with a safe, clean, comfortable and homelike environment .Policy Interpretation and Implementation:2. The facility staff and management maximize, to the extent possible, the characteristics of the facility thatreflect a personalized, homelike setting. These characteristics include:a. clean, sanitary and orderly environment On 9/10/2025 at 8:30 A.M. the surveyor observed the following in the first-floor rooms:105A and B: the over the bed table laminate was peeling off.106B: the over the bed table laminate was peeling off.107A: the over the bed table laminate was peeling off, the Bathroom wall had paint missing and bubbled.108A: the over the bed table laminate was peeling off, the bathroom wall had 2 small holes.109A and B: the over the bed table's laminate was peeling off110B: the over the bed table laminate was peeling off111A: the over the bed table laminate was peeling off112A and B: the over the bed table's laminate was peeling off113A: the walls were scuffed.114A: the over the bed table laminate was peeling off and taped115A and B the over the bed table's laminate was peeling off. The bathroom doors were scuffed, the ceiling paint was bubbled and had brown spots, and a radiator panel was lifting off.116A: the corner of the wall was broken and gouged. The wall was scraped.117A and B: the over the bed table's laminate was peeling off, the wall next to the sink had holes, the corners of the walls were gouged.118A and B: the over the bed table's laminate was peeling off.119A and B: the over the bed table's laminate was peeling off and the outside wall is scraped.120: the window screen is broken.121B: the over the bed table laminate was peeling off and a radiator panel is lifting off.122A and B: the over the bed table's laminate was peeling off and the window screen was broken.123A: the wall was scuffed and bed B the over the bed table laminate was peeling off.125: the over the bed table laminate was peeling off. On 9/10/2025 at 7:50 A.M. the surveyor observed the following in the second-floor rooms:205: the walls were scraped.207: the walls were scraped, and the bathroom light didn't work.208A and C: the over the bed table's laminate was peeling off. Bed B nightstand edges chipped.209B: the over the bed table laminate was peeling off, and the wall to the left of the door was gouged and scraped.210: the outside wall was scuffed and the over the bed table laminate was peeling off.211: the wall outside the bathroom door was gouged and the bathroom light had multiple dead bugs.212A: the over the bed table laminate was peeling off.213: the outside wall was scuffed.214B: the over the bed table laminate was peeling off.215B: the over the bed table laminate was peeling off, the bathroom wall had holes, and the toilet paper holder was broken.216A: the over the bed table laminate was peeling off and the entry wall scuffed.217A: nightstand chipped, the outside wall was scuffed. Bed B the over the bed table laminate was peeling off. The bathroom had a hole in the ceiling, and the toilet paper holder was missing.218B: the over the bed table laminate was peeling off and there was a hole in the ceiling above bed C.219B: the over the bed table laminate was peeling off, Bed C the over the bed table laminate was peeling off and leaning. The bathroom toilet was full of feces and was covered with a (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Woods Rehabilitation and Healthcare Ctr	73 Chestnut Street Saugus, MA 01906

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	large clear plastic garbage bag.221A and C: the over the bed table's laminate was peeling off and the outside wall was scuffed.222: the wall outside the bathroom was gouged.223B: the over the bed table laminate was peeling off and the bathroom wall was gouged.225: the over the bed table laminate was peeling off.The radiator cover, in the hallway outside room [ROOM NUMBER], was lifting off exposing sharp edges. During an interview on 9/10/25 at 8:25 A.M., Unit manager #1 said that all needed environmental repairs should be entered into the TELS system (used to communicate environmental repair needs to the maintenance department). During an interview on 9/10/25 at 8:28 A.M., the Maintenance Director said that all of the work request orders in the TELS system have been completed as of today. He then said that he checks the system up to 8 times a day. During an interview on 9/10/25 at 10:40 A.M., the Maintenance Director said that he was not aware of any plans to purchase over the bed tables or any furniture for the resident rooms. During an interview on 9/10/25 at 10:48 A.M., the Administrator said that the above concerns should have been entered into the TELS system. The Administrator then said that she and the Maintenance Director do rounds in the facility on a monthly basis. Review of the facility document titled Monthly Environmental rounds, dated 4/30/25, indicated that only 2 over the bed tables need replacement. The document further indicated that 6 rooms on the first floor and 12 rooms on the second floor needed to be painted.Review of the facility document titled Monthly Environmental rounds, dated 5/28/25, failed to indicate that any over the bed tables need replacement. The document further indicated that four of the six rooms on the first floor that needed to be painted were completed and none of the12 rooms on the second floor had been painted.Review of the facility document titled Monthly Environmental rounds, dated 6/30/25, failed to indicate that any over the bed tables need replacement. The document further indicated that the same four of the six rooms on the first floor that needed to be painted were completed and none of the12 rooms on the second floor had been painted.Review of the facility document titled Monthly Environmental rounds, dated 7/30/25, failed to indicate that any over the bed tables need replacement. The document further indicated that the same four of the six rooms on the first floor that needed to be painted were completed and none of the12 rooms on the second floor had been painted.The surveyor then asked for any purchase orders for over the bed tables in the past six months and the Administrator produced a document titled Purchase Order #CWR175978, dated 9/10/25 at 11:34 A.M., for 44 over the bed tables. The Administrator said that she could not find any other purchase orders.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to ensure staff treated residents in a dignified manner during the dining experience for one Resident (#69) out of a total of 25 sampled residents.Findings include: Review of the facility policy titled Dignity, revised and dated February 2021, indicated the following: - Residents are treated with dignity and respect at all times.-Provided with a dignified dining experience.Resident #69 was admitted to the facility in August 2025 with diagnoses including hemiplegia and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/27/25, indicated that Resident #69 was unable to conduct a Brief Interview for Mental Status exam and was severely cognitively impaired. Further review of the MDS indicated that Resident #69 is dependent on staff for eating and received a mechanically altered therapeutic diet. On 9/9/25 at 8:40 A.M., a staff member was observed feeding Resident #69 who was lying in bed while standing over them, not at eye level. The bed was low to the ground. On 9/9/25 at 12:11 P.M., a staff member was observed feeding Resident #69 who was lying in bed while standing over them, not at eye level. The bed was low to the ground. On 9/10/25 at 8:34 A.M., a staff member was observed feeding Resident #69 who was lying in bed while standing over them, not at eye level. The bed was low to the ground. On 9/10/25 at 12:17 P.M., a staff member was observed feeding Resident #69 who was lying in bed while standing over them, not at eye level. The bed was low to the ground. During an interview on 9/10/25 at 12:30 P.M., Unit Manager #1 said staff should not be standing over residents while assisting them with feeding. During an interview on 9/10/25 at 12:44 P.M., the Director of Nursing said staff should not be standing over residents while assisting them with feeding and should be at eye level.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, policy and record review the facility failed to ensure weights were obtained for one Resident (#17) out of a total sample of 25 residents. Specifically, for Resident #17 who was assessed as malnourished, the facility failed to obtain his/her weight on readmission or his/her weekly weight per the physician's orders. Findings include:Review of the facility policy titled Weight Assessment and Intervention, dated March 2022, indicated Residents are weighed upon admission and at intervals established by the interdisciplinary team. Resident #17 was readmitted to the facility in September 2025 with diagnoses that included traumatic subdural hemorrhage with loss of consciousness, dysphagia, cognitive communication deficit. Review of Resident #17's Minimum Data Set (MDS), dated [DATE], indicated a score of 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Review of Resident #17's physician order, dated 9/4/25, indicated weekly weights. Review of Resident #17's weights indicated:-8/13/25 110 lbs (pounds) -8/20/25 148.8 lbs No other weights were obtained. Review of Resident #17's nutritional risk assessment, dated 8/21/25, indicated the Resident was malnourished. Monitor weekly weights. Review of Resident #17's nutritional care plan, dated 8/21/25, indicated Obtain weights at ordered intervals. During an interview on 9/10/25 at 11:45 A.M., the Dietitian said Resident #17 is a very vulnerable resident and there have been issues obtaining weights in general. The Dietitian said when a resident is readmitted to the facility the expectation is that staff obtain the weight within 24 hours. The Dietitian said she would expect that the Resident's order for weekly weights would be completed. The Dietitian said it is important to know the resident's weight because his/her weight that was originally obtained on admission was most likely wrong, and the Resident should have been reweighed but was not. During an interview on 9/10/25 at 12:10 P.M., Nurse #1 said when a new admission or readmission comes in, we weigh the resident immediately and put the weight in the electronic medical record (PCC). Nurse #1 said if a resident is a weekly weight the nurse will tell the Certified Nurse Aide (CNA) assigned and then document the weight into PCC. Nurse #1 said there is not a weight book on this floor, the CNA's obtain the weight and tell the nurse who is on duty, then the nurse documents it in PCC. During an interview on 9/10/25 at12:11 P.M., CNA #2 said the staff weigh residents right when they come back from the hospital and tell the nurse the weight and they will put the weight into the computer. CNA #2 said if a resident is a weekly weight or if a weight is needed the nurse will tell the CNA to get the weight.

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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 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. Based on observation, interview, and record review, the facility to ensure that services provided met professional standards for one Resident (#69), out of 25 total sampled residents. Specifically, for Resident #69, the facility failed to ensure that his/her air mattress was functioning.Findings include:Review of the manufacturers User Manual for the air mattress system indicated the following: -Power switch is at the right side of the control unit.-Turn ON/OFF the power, the pump will start/stop operation. -A visible indicator (green) tells the pressure has reached a preset or user-defined level. -A visible indicator (yellow or red) warns the pressure is below a preset or user-defined level. Operating Instructions4. Turn on the control unit's power. The indicator of the power switch will come on. The control unit starts to pump air into the mattress. Resident #69 was admitted to the facility in August 2025 with diagnoses including hemiplegia (weakness on one side of the body) and dysphagia (difficulty swallowing).Review of the most recent Minimum Data Set (MDS) assessment, dated 8/27/25, indicated that Resident #69 was unable to conduct a Brief Interview for Mental Status exam and was severely cognitively impaired. Further review of the MDS indicated that Resident #69 is dependent on staff for Activities of Daily Living. The MDS also indicated that the Resident is at risk for developing pressure injuries and had a pressure reducing device for bed.On 9/9/25 at 7:52 A.M., the surveyor observed Resident #69 sleeping in bed. Resident #69 had an air mattress on his/her bed. The air mattress was not functioning, and the power switch was turned off.On 9/9/25 at 8:40 A.M., the surveyor observed Resident #69 sitting in bed with a staff member was assisting with the breakfast meal. Resident #69 had an air mattress on his/her bed. The air mattress was not functioning, and the power switch was turned off.On 9/9/25 at 12:11 P.M., the surveyor observed Resident #69 sitting in bed as a staff member was assisting with the lunch meal. Resident #69 had an air mattress on his/her bed. The air mattress was not functioning, and the power switch was turned off.On 9/10/25 at 8:06 A.M., the surveyor observed Resident #69 sleeping in bed. Resident #69 had an air mattress on his/her bed. The air mattress was not functioning, and the power switch was turned off.On 9/10/25 at 8:34 A.M., the surveyor observed Resident #69 sitting in bed as a staff member was assisting with the breakfast meal. Resident #69 had an air mattress on his/her bed. The air mattress was not functioning, and the power switch was turned off.During an observation and interview on 9/10/25 at 11:10 A.M., Certified Nursing Assistant (CNA) #2 and CNA #3, CNA #2 said the air mattress is on and functioning and said she does not touch the air mattress but know it is on because the resident is comfortable. CNA #3 said the air mattress box does not have lights and said the air mattress is working and proceeded to press her hand into the air mattress leaving an indent in the mattress when she removed her hand. The air mattress on the bed remained deflated and not functioning during this time.During an observation and interview on 9/10/25 at 11:32 A.M., Unit Manager #1 checked the air mattress setting and function on Resident #69's bed. He said the air mattress is not getting power and is not functioning. The surveyor and the Unit Manager observed the electrical cord to the air mattress was unplugged and not getting any power. The surveyor pushed the on/off button, and the unit did not have power. Unit Manager #1 said the power cord is too long and needs an extension cord because it keeps coming out of the wall. Review of most recent Norton Assessment (An assessment to determine a resident's risk for skin breakdown), dated 8/22/25, indicated a score of 12, which indicates high risk for skin breakdown.Review of Resident #69's active physician orders indicated: Air Mattress on bed, check inflation (set according to patient preference) and function q (every) shift. Every shift for Prevention. Start Date 8/27/25.During an interview on 9/10/25 at 11:26 P.M., Nurse #1 said she would have expected the staff who provided care to Resident #69 to notice the air mattress was not functioning. Nurse #1 said that Resident #69 did not have any open skin areas but is on hospice and in bed all day and needs an air mattress to prevent skin breakdown.During an interview on 9/10/25 at 11:36 P.M., Unit Manger #1 said Resident #69's air mattress was unplugged and not functioning and said that staff should have noticed the mattress was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not functioning. Unit Manager #1 said air mattresses should have a physician's order indicating the appropriate setting, and to check the function of the mattress. She said a non-functioning air mattress places the resident at risk for skin breakdown.During an interview 9/10/25 at 12:44 P.M., The Director of Nurses (DON) said that all residents on an air mattress should have a physician's order followed and said staff must check the function every shift. The DON said that he would expect any staff who enter the room to notice if the air mattress is not functioning. The DON further said that a non-functioning air mattress places the resident at risk for skin breakdown.

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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 observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for three Residents (#17, #68 and #41), out of a total sample of 25 residents. Specifically, 1. For Resident #17, the facility failed to ensure a physician's order was obtained for the use of his/her helmet indicating to staff when to wear and safety precautions.2. For Resident #68 the facility failed to follow a physician's order for a dressing change to the left shin wound.3. for Resident #41 the facility failed to follow a physician's order for a dressing change to the left heel wound.Findings include:1. Resident #17 was admitted to the facility in August 2025 with diagnoses that included traumatic subdural hemorrhage with loss of consciousness, dysphagia, cognitive communication deficit. Review of Resident #17's Minimum Data Set (MDS), dated [DATE], indicated a score of 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS also indicated he/she is dependent on staff for activities of daily living. On 9/9/25 at 8:01 A.M. and throughout survey, the surveyor observed Resident #17 in bed awake at times, being boosted for meals in bed by staff, being provided care in bed and a helmet was observed on his/her nightstand. Review of Resident #17's physician orders on 9/9/25 at 10:30 A.M., failed to indicate an order for the use of the helmet or any precautions for his/her craniotomy. Review of Resident #17's nursing admission note, dated 8/7/25, indicated Pt (patient) underwent evacuation of hematoma. Wears helmet at all times. Review of Resident #17's initial encounter Nurse Practitioner progress note, dated 8/7/25, indicated: Patient has a surgical incision which was evaluated by neurosurgery on July 10 which has not healed sufficiently. Patient needs to wear helmet all the time. Review of Resident #17's nursing progress note, dated 8/20/25, indicated Many attempts to get out of bed unassisted, non-compliant with safety precautions, bed in low position, call light in reach, helmet on. Review of Resident #17's Medical Doctors (MD) and medical directors progress note, dated 8/21/25, indicated Patient needs to wear helmet all the time. Review of Resident #17's Nurse Practitioner progress note, dated 9/3/25, indicated Patient needs to wear helmet all the time. Keep helmet on to protect patient's skull from trauma. Review of Resident #17's Occupational Therapy progress note, dated 9/8/25, indicated Precautions / Contraindications: helmet OOB (out of bed) Craniotomy precautions. Review of Resident #17's fall risk assessment, dated 8/20/25, indicated he/she scored a 12 indicating moderate fall risk. Review of Resident #17's medical record indicated only a behavioral care plan was developed for a one time refusal of helmet use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record indicated on his/her behavioral documentation for the helmet use indicated no refusals and only one documented nursing note indicated a refusal from the Resident. During an interview on 9/10/25 at 7:55 A.M., Certified Nurse Aide (CNA) #1 said they are unsure of when the helmet needs to be on but could ask the nurse, but the Resident does not have it on now. CNA #1 said the Resident needs to be boosted for meals when in bed and gets his/her activities of daily living in bed and that is done without a helmet on. CNA #1 says the Resident does get out of bed at times and is a fall risk. During an interview on 9/10/25 at 8:05 A.M., Nurse #1 said she has taken care of Resident #17 before and thinks the helmet only needs to be on when he/she is out of bed. Nurse #1 said the admitting nurse should go through the admission paperwork and write orders for the helmet but did not. During an interview on 9/10/25 at 10:35 A.M., Nurse Practitioner (NP) #1 said Resident #17 is a very vulnerable resident as he/she recently had a craniotomy and does not have his/her skull to protect part of the brain anymore. The NP said his/her helmet should always be on because that was what neurology had recommended. The NP said he/she is at risk for injury as he/she could fall out of bed as they are a fall risk, and any rolling could cause his/her head to go into the side rail and half of his/her head is very soft. The NP said she would expect an order would be in place so staff are aware that he/she has a helmet and when it should be on. During an interview on 9/10/25 at 10:52 A.M., the Occupational Therapist (OT) said there should be orders in place for Resident #17's helmet use so the whole team is aware of the plan of care for the Resident. The OT said the Resident is at risk for falls. During an interview on 9/10/25 at 11:56 A.M., the Director of Nurses (DON) said there should have an order in place on admission for the use of the Resident's helmet, so everyone is aware of what the Resident needs. The Resident is a fall risk and has a craniotomy which leaves the brain at risk. 2. Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol indicated that the physician will authorize pertinent orders related to wound treatments, including wound cleansing and dressings. Resident #68 was admitted to the facility in July 2025 with diagnoses including pathological trimalleolar fracture of the left lower leg. Review of the physician's orders dated September 2025 indicated the following order: Left shin wound in the evening for left shin wound, clean with NS (normal saline) apply border dressing q (every) day. On 9/9/25 at 8:35 A.M. the surveyor observed Resident #68 with a gauze dressing covering an ABD (abdominal) pad, to the left lower leg dated 9/7/25. During an interview on 9/09/25 at 1:38 P.M. Nurse #3 and the surveyor observed Resident #68 with a dressing to the left shin dated 9/7/25. Nurse #3 said that the dressing should have been changed on 9/8/25 as the order is for a daily dressing change to the left shin. Nurse #3 also said that the dressing on the wound was not what the physician ordered. During an interview on 9/10/25 at 12:25 P.M. the Director of Nursing said that the nurses are (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to follow the physician's orders for dressing changes. 3. Resident #41 was admitted to the facility in July 2025 with diagnoses including adult failure to thrive, malnutrition and trochanteric fracture of the right femur. Review of the care plan dated 9/5/25 indicated a focus for the following: I have skin breakdown; non pressure wound of the left heel and unstageable DTI (deep tissue injury, a type of pressure related skin injury) of the right heel. Review of the physician's orders dated September 2025 indicated the following order: Left heel; cleanse with normal saline, pat dry and apply xeroform followed by an island dressing one time a day. Review of the Treatment Administration Record (TAR) dated September 2025 indicated that on 9/2/25 the wound area on the left heel was c/d/i (clean, dry and intact). Further review indicated that on 9/3/25 through 9/9/25 the wound area on the left heel was open with a scant amount of drainage. On 9/9/25 at 7:45 A.M., and 10:13 A.M., the surveyor observed Resident #41 in bed with gauze dressings covering both feet including heels. The surveyor then observed each of the dressings were dated 9/7/25. During an interview on 9/9/25 at 1:40 P.M. Nurse #3 and the surveyor observed Resident #41 in bed with a dressing to both feet dated 9/7/25. Nurse #3 said that the dressing should have been changed on 9/8/25 as the order is for a daily dressing change to the left heel. Nurse #3 then said that she wasn't sure why there was a dressing to the right heel as she was just back from vacation. During an interview on 9/10/25 at 12:25 P.M. the Director of Nursing said that the nurses are supposed to follow the physician's orders for dressing changes, and the dressing should have been changed on 9/8/25.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Woods Rehabilitation and Healthcare Ctr	73 Chestnut Street Saugus, MA 01906

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review and interview the facility failed to develop a treatment for a pressure area on the right heel for one Resident (#41) out of a total sample of 25 residents.Findings include:Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 2001, indicated that the physician will authorize pertinent orders related to wound treatments, including wound cleansing and dressings. Resident #41 was admitted to the facility in July 2025 with diagnoses including adult failure to thrive, malnutrition and trochanteric fracture of the right femur. Review of the care plan dated 9/5/25 indicated a focus for the following: I have skin breakdown; non pressure wound of the left heel and unstageable DTI (deep tissue injury, a type of pressure related skin injury) of the right heel. Review of the physician's orders dated September 2025 indicated the following order: Left heel; cleanse with normal saline, pat dry and apply xeroform followed by an island dressing one time a day. Further review failed to indicate a treatment for pressure area of the right heel. Review of the Treatment Administration Record (TAR) dated September 2025 indicated that on 9/2/25 the wound area on the left heel was c/d/i (clean, dry and intact). Further review indicated that on 9/3/25 through 9/9/25 the wound area on the left heel was open with a scant amount of drainage. Further review failed to indicate a treatment to the right heel. On 9/9/25 at 7:45 A.M., and 10:13 A.M., the surveyor observed Resident #41 in bed with gauze dressings covering both feet including heels. The surveyor then observed each of the dressings were dated 9/7/25. During an interview on 9/9/25 at 1:40 P.M. Nurse #3 and the surveyor observed Resident #41 in bed with a dressing to both feet dated 9/7/25. Nurse #3 said that the dressing should have been changed on 9/8/25 as the order is for a daily dressing change to the left heel. Nurse #3 then said that she was told that Resident #41 had a DTI to the right heel but hadn't seen it yet. During an interview on 9/10/25 at 12:25 P.M. the Director of Nursing said that the nurses are supposed to follow the physician's orders for dressing changes, and the dressing should have been changed on 9/8/25. He then said that all pressure areas should have a treatment order and be monitored.

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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. Based on observation, interview and record review, the facility failed to maintain a safe environment for two Residents (#35, and #6) out of a total sample of 25 residents to prevent accidents/incidents. Specifically:1. For Resident #35, the facility failed to provide a lid for hot coffee and supervision during meals resulting in the Resident spilling hot coffee onto his/her chest, potentially putting the resident at risk for burns.2. For Resident #6, the facility failed to provide a lid for hot coffee and supervision during meals, potentially putting the resident at risk for burns.Findings include:1. Resident #35 was admitted to the facility in April 2014 and has diagnoses that include athetoid cerebral palsy (condition affecting movement and posture), osteoarthritis (joint disease-causing pain and stiffness), gastro esophageal reflux disease (heartburn), and hemiplegia and hemiparesis (complete paralysis of one side of the body, hemiparesis refers to weakness on one side, allowing for some movement), and type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 6/18/25, indicated Resident #35 had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15 which indicated moderately impaired cognition. Review of the MDS indicated that Resident #35 requires setup assistance with meals. Review of Resident #35's Quarterly Evaluation Packet dated 6/18/25, indicated Resident #35's Hot Liquid Risk Score was 2-4 Moderate Risk. Safety Interventions included:-Resident to use a cup with a lid.-Resident to be screened by PT/OT for hot liquid safety.-Staff to assist Resident with all hot liquids. Review of Resident #35's medical record failed to indicate that he/she was screened by PT/OT for hot liquid safety after the 6/18/25 assessment.Review of Resident #35's ADL (Activities of Daily Living) care plan dated 12/30/24, indicated:- I require set-up assistance [i.e., opening packages, cutting meat, arranging plate, etc.] I am supervised with eating and drinking. Date Initiated: 7/15/25.-PT/OT evaluation and treatment as ordered. Date Initiated: 12/26/22.Review of Resident #35's care plans failed to indicate interventions for hot liquid safety were updated after the 6/18/25 assessment.On 9/9/25 at 12:28 P.M., the surveyor observed Resident #35 sitting, tilted back in a wheelchair in the communal dining room during the lunch meal. Resident #35 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. There was no lid placed on the table. Staff were present in the dining room passing out breakfast trays, hot coffee and beverages. Resident #35's hands were shaking as he/she was observed spilling the hot coffee onto his/her chest and coffee was visible on his/her shirt. The Resident could be heard saying I spilled it on my shirt. It's hot. Nurse #2 observed the coffee spilling on Resident #35 and said, Are you okay? and then proceeded to walk out of the dining room to assist with passing out breakfast trays.Review of Resident #35's diet slip did not indicate the need for lids with coffee.Review of Resident #35's medical record failed to indicate a skin check was completed after Nurse #2 observed the Resident spill coffee on his/her shirt.On 9/10/25 at 8:04 A.M., the surveyor observed Resident #35 sitting, tilted back in a wheelchair in the communal dining room during the breakfast meal. Resident #35 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. Staff were present in the dining room passing out breakfast trays including hot coffee and beverages.During an interview on 9/10/25 at 8:10 A.M., Supervisor #1 said Resident #35 requires supervision with meals due to cerebral palsy and said he/she can pick up finger foods and drinks but needs help. During an interview on 9/10/25 at 11:40 A.M., Unit Manager #1 said he was not aware that Resident #35 had spilled coffee on his/her chest and said he would expect to be notified and said it is an incident that should have been documented on a skin check and reported.During an observation and interview on 9/10/25 at 11:55 A.M., Supervisor #1 said Resident #35 had a Hot Liquid Assessment completed and needs cups with lids and assistance with hot liquids because he/she has trouble with getting foods and fluids to his/her mouth due to physical limitations and said she was not aware that Resident #35 had spilled coffee on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his chest yesterday. Supervisor #1 reviewed the medical record and said there is no documentation that a skin assessment was completed and no progress notes indicating that Resident #35 was assessed by the nurse. Supervisor #1 said Resident #35 must have a skin check and interventions in place to ensure he/she is using lids on the hot coffee cups and is getting assistance with drinking coffee to prevent burns. The Supervisor and the surveyor observed Resident #35's chest and his/her skin was clear. Supervisor #1 said she was going to report the concerns and make sure Resident #35's interventions are implemented. During an interview on 9/10/25 at 12:02 A.M., Nurse #2 said she checked Resident #35's chest after he/she finished eating lunch yesterday, but she did not document it and did not tell anyone about the spilled coffee and said she should have told someone and reported it. Nurse #2 said she worked until 11:00 P.M. yesterday and got busy and forgot. On 9/10/25 at 12:16 P.M., the surveyor walked into the dining room and immediately observed Resident #35 sitting, tilted back in a wheelchair in the communal dining room. Resident #35 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. There was no lid placed on the table. There were no staff present in the dining room during as they were in the hall passing out lunch trays, hot coffee and beverages. Resident #35's hands were shaking as he/she was observed spilling the hot coffee onto his/her chest and coffee was visible on his/her shirt. The Resident could be heard saying I just spilled coffee on myself again. The surveyor had to alert staff in the hall that the Resident spilled hot coffee on his chest.During an interview on 9/10/25 at 12:25 P.M., Unit Manager #1 said the Resident should not be drinking coffee without a lid, and he/she needs to be supervised and should not have been given hot coffee during the lunch meal.At 12:30 P.M., The surveyor used a thermometer to check the temperature of the coffee cup Resident #35 was drinking from and the temperature of the coffee was 130 degrees Fahrenheit; approximately 14 minutes after the Resident spilled the coffee.During an interview on 9/10/25 at 12:36 P.M., the Director of Nurses (DON) said he was not made aware of the incident and said it is concerning for safety and said a skin assessment should have been done immediately yesterday when the nurse witnessed the Resident spill the coffee on his/her chest. The DON said Resident #35's care plan, Kardex and diet slip should have been updated after the hot liquid assessment and said interventions should have been followed to ensure lids were used and safety was maintained. The DON said staff should have been supervising the Resident in the dining room.During an interview on 9/10/25 at 12:45 P.M., the Regional Nurse said interventions related to the hot liquid assessment should have been followed and said Resident #35 should have been supervised while drinking the hot coffee and said it is concerning for burns. During an interview on 9/10/25 at 2:00 P.M., the Food Service Director (FSD) said Residents who require lids on coffee cups would have it written on the diet slip indicating a lid was needed and said he was notified earlier today that Resident #35 needed a lid, so the diet sip was just updated. The FSD showed the surveyor a form titled Dietary Communication -For Long Term Care Menu. The form indicated Resident #35 required adaptive equipment Needs cup with lid for hot liquids all meals dated 9/10/25 signed by licensed Nurse. The FSD said Resident #35 is the only resident who requires Lids on hot coffee and said no other Residents have that listed on the diet slip.2. Resident #6 was admitted to the facility in March 2021 and has diagnoses that include type two diabetes mellitus, lack of coordination and anxiety disorder.Review of the Minimum Data Set (MDS) assessment, dated 8/6/25, indicated Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 which indicated moderate cognitive impairment. Review of MDS indicated that Resident #6 requires setup assistance with meals. Review of Resident #6's Quarterly Evaluation Packet dated 5/2/25 and 8/5/25, indicated Resident #6 's Hot Liquid Risk Score was 01- Low Risk. Safety Interventions included:-Resident to use a cup with a lid.-Resident to be screened by PT/OT for hot liquid safety.-Staff to assist Resident with all hot liquids. Review of Resident #6's risk for burns care plan date Initiated, 5/2/25, indicated, I am at risk for spills and burns from hot liquids r/t (related to):-Resident to be screened by PT/ OT for hot liquids safety.-Resident to use a cup with a lid.-Staff to assist Resident with all hot (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liquids.Review of Resident #6's ADL (Activities of Daily Living) care plan dated 8/6/25, indicated:- I require set-up assistance [i.e., opening packages, cutting meat, arranging plate, etc.] eating and drinking. Date Initiated: 08/20/2024On 9/9/25 at 8:36 A.M., the surveyor observed Resident #6 in his/her room, sitting up in bed, during the breakfast meal. Resident #6 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. There was no lid placed on the table. No staff were present in the room, and the curtain was pulled halfway across the bed. The Resident was not visible from the hall.On 9/9/25 at 12:15 P.M., the surveyor observed Resident #6 in his/her room, sitting up in bed, during the lunch meal. Resident #6 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. There was no lid placed on the table. No staff were present in the room, and the curtain was pulled halfway across the bed. The Resident was not visible from the hall.On 9/10/25 at 8:01 A.M., the surveyor observed Resident #6 in his/her room, sitting up in bed, during the breakfast meal. Resident #6 picked up a mug containing hot coffee and began to drink from the mug. The mug did not have a lid, and steam could be seen coming from the cup. There was no lid placed on the table. No staff were present in the room, and the curtain was pulled halfway across the bed. The Resident was not visible from the hall.Review of Resident #6's diet slip did not indicate the need for lids with coffee.During an interview on 9/10/25 at 9:07 A.M., Nurse #1 said Resident #6 does not leave the room for meals and said he/she needs assistance with setup and is independent with eating.During an interview on 9/10/25 at 11:16 A.M., the Supervisor said Resident #6 was evaluated for hot liquids and requires assistance with meal set up and said the care plan must be followed. The Supervisor said Resident #6 should have lids with hot coffee and be supervised during meals to prevent spills from hot liquids during meals and said the diet slip should indicate the need for lids.During a follow up interview on 9/10/25 at 11:22 A.M., Unit Manager #1 said he expects staff to follow care plan interventions for supervision with hot liquids with lids and said the plan of care needs to be followed. The Unit Manager said the diet slip should indicate a need for lids on coffee cups as it is an intervention.During an interview on 9/10/25 at 12:44 P.M., the Director of Nurses (DON) said Resident #6's care plan should have been followed, and the diet slip should have been updated after the hot liquid assessment and said interventions should have been followed to ensure lids were used and safety was maintained. The DON said staff should have been supervising the Resident during the meals due to the risk of burns with the coffee.During an interview on 9/10/25 at 2:02 P.M., the Food Service Director (FSD) said Resident #6 does not have lids listed on the diet slip and said there is only one resident who requires Lids on hot coffee in the facility. The FSD said he has not received any documents or requests for Resident #6 to have lids because he saves all communication logs.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician reviewed the pharmacy monthly medication review within 30 days for one (Resident #32) out of a total of 26 sampled residents. Findings include:Review of the facility's policy titled Medication Regimen Review dated July 2025 indicated:A licensed pharmacist reviews the medication regimen of each resident at least monthly.Time Frame for Reporting:- Within three business days of the MRR (medication regimen review), the consultant pharmacist provides a written report to the attending physician for each resident identified as having a medication irregularity that is deemed not life-threatening.- The consultant pharmacist provides the director of nursing services and medical director with a written, signed, and dated copy of all medication regimen reports., the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. - Irregularities that do not present a risk to a person's life, health, or safety will be addressed within 30 days of receiving the MMR from the consultant pharmacist. Resident #32 was admitted to the facility in August 2025, and has active diagnoses which include diabetes mellitus, kidney disease and hypertension. Review of Resident #32's Minimum Data Set assessment dated [DATE] indicated a Brief Interview for Mental Status score of 8, indicating moderately impaired cognition.Review of Resident #32's physician orders on 9/9/25 indicated:Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (Fluticasone Umeclidinium Vilanterol) dated 8/6/25.Acetaminophen Oral Tablet 325 MG (Acetaminophen). Give 2 tablets by mouth every 6 hours as needed for pain dated 8/5/25.Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk). Give 17 grams by mouth every 24 hours as needed for Constipation dated 8/5/25.Review of Resident #32's medical record indicated that on 8/7/25 the consulting pharmacist generated an MMR report for the physician to review new recommendations. The medical record did not include this report.On 9/9/25 at 2:17 P.M., the surveyor requested from the Director of Nursing (DON) Resident #32's MMR report dated 8/7/25. The DON provided the report on 9/10/25.Review of Resident #32's MMR Consultant Pharmacist Recommendations to Nursing, dated 8/7/25 indicated:1. Please add a max daily dose of 3 grams to the Acetaminophen orders from all sources.2. Resident is receiving Trelegy Ellipta Inhaler. Please add rinse mouth after using to order and MAR to avoid thrush formation.3. Recommend updating the current polyethylene glycol (Miralax) order to include the following directions: Mix 17 grams (1 capful) in at least 4 ounces of liquid and take by mouth.Review of Resident #32's MMR Consultant Pharmacist Recommendations to Nursing indicated the physician initialed his/her agreement to the recommendations. The physician's initial was not dated. Review of Resident #32's physician's orders on 9/10/25 indicated the consulting pharmacist's recommendations were updated on this same day, 9/10/25; 35 days after the pharmacist wrote the report.The surveyor reviewed Resident #32's physician orders on 9/10/25 and these included:Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (Fluticasone Umeclidinium Vilanterol). Rinse mouth to avoid thrust formation dated 9/10/25Acetaminophen Oral Tablet 325 MG (Acetaminophen). Give 2 tablets by mouth every 6 hours as needed for pain. Maximum daily dose of 3 grams dated 9/10/25.Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk). Give 17 grams by mouth every 24 hours as needed for Constipation. Mix 17 grams (1 capful) in at least 4 ounces of liquid and take by mouth dated 9/10/25.During an interview on 9/10/25 at 12:33 P.M., the DON and Regional Nurse said it is the facility's policy to address irregularities that do not present a risk to a person's life, health, or safety within 30 days of receiving the MMR from the consultant pharmacist.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and records reviewed, the facility failed to ensure it was free from a medication error rate of greater than 5% when one nurse observed made four errors out of 26 opportunities, resulting in a medication error rate of 15.38 %. Those errors impacted three Residents (#85, #99 and #22), out of seven residents observed.Findings include:Review of the facility policy titled, Administering Medications, dated as revised April 2019, indicated the following: Medications are administered in a safe, and timely manner, and as prescribed.3. Staff schedules are arranged to ensure that medications are administered without unnecessary interruptions.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before or after meal orders). Review of the facility policy titled, Insulin Administration, dated August 2021, indicated the following: 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. The following observations were made during the medication pass on the second-floor unit: 1a. Resident #85 was admitted to the facility in July 2025 with diagnoses including type two diabetes mellitus, morbid severe obesity, and anxiety.On 9/10/25 at 8:25 A.M., the surveyor observed Nurse #1 administer the following medications to Resident #85:-6 Units Insulin Lispro (fast-acting medication to manage blood sugar levels), via subcutaneous injection.Review of the active physician's orders indicated the following:- Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 6 unit subcutaneously with meals for Type 2 diabetes. Start Date 7/30/25. Scheduled for 8:00 A.M.The medications were administered after the breakfast meal was consumed by Resident #85.1b. Resident #99 was admitted to the facility in August 2025 with diagnoses including type one diabetes mellitus, encephalopathy, and cognitive communication deficit.On 9/10/25 at 8:27 A.M., the surveyor observed Nurse #1 administer the following medication to Resident #99:-10 Units Insulin Lispro, via subcutaneous injection.Review of the active physician's orders indicated the following:-Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 10 units subcutaneously with meals related to type 1 diabetes mellitus without complications. Start Date 9/4/25. Scheduled for 8:00 A.M.The medications were administered after the breakfast meal was consumed by Resident #99.1c. Resident #22 was admitted to the facility in October 2024 with diagnoses including type two diabetes mellitus and congestive heart failure. On 9/10/25 at 8:42 A.M., the surveyor observed Nurse #1 administer the following medications to Resident #22:-20 Units Insulin Lispro, via subcutaneous injection.-2 Units Insulin Lispro, via subcutaneous injection.Review of the active physician's orders indicated the following:-Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 20 unit subcutaneously in the morning related to type 2 diabetes mellitus without complications. Start Date10/5/24. Scheduled for 8:00 A.M.-Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. Greater than 400 give 12 units and call MD/NP, subcutaneously with meals related to type 2 diabetes mellitus without complications. Start Date 10/5/24. Scheduled for 8:00 A.M.The medications were administered after the breakfast meal was consumed by Resident #22. During an interview on 9/10/25 at 9:05 A.M., Nurse #1 said she should have administered the medications prior to or during the breakfast meal and said she took the blood sugar levels at 7:20 A.M. and was unable to complete the insulin administration because she had to assist with checking the breakfast trays and got behind. During an interview on 9/10/25 at 12:50 P.M., the Director of Nursing said nurses should follow the physician order and administer medications as ordered and said the insulin should be given just prior to or with the breakfast meal and not after.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview the facility failed to maintain accurate medical records for two Residents (#41 and #68) out of a total sample of 25 residents. Specifically, the facility failed to accurately document on the Treatment Administration Record that treatments were not completed as ordered for Resident #41 and Resident #68.Review of the facility policy titled Charting and documentation dated revised July 2017 indicated that documentation in the medical record will be objective, complete and accurate. Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol indicated that the physician will authorize pertinent orders related to wound treatments, including wound cleansing and dressings. 1. Resident #41 was admitted to the facility in July 2025 with diagnoses including adult failure to thrive, malnutrition and trochanteric fracture of the right femur.Review of the care plan dated 9/5/25 indicated a focus for the following: I have skin breakdown; non pressure wound of the left heel and unstageable DTI (deep tissue injury, a type of pressure related skin injury) of the right heel. Review of the physician's orders dated September 2025 indicated the following order: Left heel; cleanse with normal saline, pat dry and apply xeroform followed by an island dressing one time a day. Review of the TAR dated September 2025 indicated that on 9/2/25 the wound area on the left heel was c/d/i (clean, dry and intact). Further review indicated that on 9/3/25 through 9/9/25 the wound area on the left heel was open with a scant amount of drainage. Further review indicated that on 9/8/25 the nurse documented that they had completed the treatment to the left heel as ordered. On 9/9/25 at 7:45 A.M., and 10:13 A.M., the surveyor observed Resident #41 in bed with gauze dressings covering both feet including heels. The surveyor then observed each of the dressings were dated 9/7/25. During an interview on 9/9/25 at 1:40 P.M. Nurse #3 and the surveyor observed Resident #41 in bed with a dressing to both feet dated 9/7/25. Nurse #3 said that the dressing should have been changed on 9/8/25 as the order is for a daily dressing change to the left heel. Nurse #3 said that the nurse should not document in the medical record that they completed a dressing change when they had not. During an interview on 9/10/25 at 12:25 P.M. the Director of Nursing said that the nurses are supposed to follow the physician's orders for dressing changes. The DON then said that nurses should not be documenting in the medical record that they completed a dressing change when they had not.2. Resident #68 was admitted to the facility in July 2025 with diagnoses including pathological trimalleolar fracture of the left lower leg. Review of the physician's orders dated September 2025 indicated the following order: Left shin wound in the evening for left shin wound, clean with NS (normal saline) apply border dressing q (every) day. On 9/9/25 at 8:35 A.M. the surveyor observed Resident #68 with a gauze dressing covering an ABD (abdominal) pad, to the left lower leg dated 9/7/25. Review of the Treatment Administration Record dated 9/8/25 indicted that the nurse documented that they had completed the ordered treatment for the dressing change on 9/8/25 as ordered. During an interview on 9/9/25 at 1:38 P.M. Nurse #3 and the surveyor observed Resident #68 with a dressing to the left shin dated 9/7/25. Nurse #3 said that the dressing should have been changed on 9/8/25 as the order is for a daily dressing change to the left shin. Nurse #3 also said that the dressing on the wound was not what the physician ordered. Nurse #3 then said that the nurses should not be documenting in the medical record that they had completed a dressing change when they had not.