STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225568	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Brook Rehabilitation and Healthcare Center	90 West Street Wilmington, MA 01887

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 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** 48138 Based on records reviewed and interviews for one of three sampled residents (Resident #1) whose comprehensive care plan indicated he/she required assistance of two staff members for transfers, the Facility failed to ensure staff consistently implemented and followed interventions in his/her care plan, when on 11/17/25, during the evening shift, Certified Nurse Aide (CNA #1), transferred Resident #1 back to bed by physically lifting him/her from his/her wheelchair and putting him/her in bed, without another staff member present to assist with the transfer. Findings include: Review of the Facility's policy, titled Care Plan, Comprehensive Person-Centered, dated as revised in March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and /or items included in the plan of care. Resident #1 was admitted to the Facility in October 2020, diagnoses included Alzheimer's, Failure to Thrive, Atrial Fibrillation and Aphasia (language disorder that affects a person's ability to communicate effectively). Resident #1 was transitioned to Hospice Services (to be provided in the facility) in September 2024, related to end of life care needs. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 09/06/24, indicated he/she was severely cognitively impaired with a score of 3 out 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that Resident #1 was dependent on staff for bathing, dressing, hygiene, transfers, bed mobility, incontinent care and was non-ambulatory. (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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(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	Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her September 2024 MDS, indicated he/she required assistance of two persons with ADL's. The Care plan indicated that Resident #1 required physical assistance of two for all transfers. Review of Resident #1's Care Card (used by the CNAs to determine individual resident care needs) indicated he/she required assistance of two staff members for transfers. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 11/18/24, indicated that Resident #1 sustained a bump above his/her left eye, bruising to his/her left eye and had left shoulder redness of unknown origin. Review of the Facility's Root Cause Analysis (RCA) document, undated, indicated CNA #1 did not review Resident #1's Care Card, transferred him/her by herself, and did not follow the Care Plan on 11/17/24, when she transferred him/her to bed. During a telephone interview on 03/3/24 at 1:54 P.M., Certified Nurse Aide (CNA) #1 said that she had worked at the Facility since November of 2024 and has been a CNA for [AGE] years. CNA #1 said she worked on 11/17/24, during the 3:00 P.M. through 11:00 P.M. shift and was assigned to provide care to Resident #1. CNA #1 said at some point during the shift (exact time unknown) she transferred Resident #1 back to bed, and had the assistance of CNA #2 with transferring Resident #1 to his/her bed. During a telephone interview on 03/04/25 at 9:14 A.M., Certified Nurse Aide (CNA) #2 said that he had worked at the Facility since November of 2024 and worked on 11/17/24, during the 3:00 P.M. through 11:00 P.M. shift. CNA #2 said that he had not provided care for Resident #1 and did not assist CNA #1 with his/her care or transfers. Although CNA # 1 said that she had an assist by CNA #2 with the transfer into bed of Resident #1, this was inconsistent with staff statements obtained by the facility related to their RCA into how Resident #1 sustained an injury of unknown origin, as well as staff interviews during this survey. During an interview on 02/27/25 at 2:15 P.M., the Director of Nurses (DON) said the Facility began an investigation after Resident #1 was noted to have a bruise on his/her left eye of unknown origin on 11/17/24 by the oncoming staff on the 11:00 P.M. to 7:00 A.M. shift. The DON said that during her investigation she became aware that CNA #1, had transferred Resident #1 on 11/17/24 without assistance of another staff member, as indicated in his/her care plan. The DON said during the investigation that CNA #1 told her she had transferred Resident #1 by herself and that she performed the transfer by reaching her arms around Resident #1's body, like she was hugging him/her, stood Resident #1 up, and pivoted him/her to a sitting position on the bed. The DON said it is her expectation that staff follow the plan of care and in this case, it was not followed.