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	09/12/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to keep one Resident (#45) free from neglect out of a total sample of 28 residents. Specifically, the facility failed to provide incontinence care to Resident #45 for a total of 10 hours and assisted him/her with a meal while lying in soiled incontinent briefs, resulting in a new skin impairment to the left buttock. Findings include:Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, dated March 2018, indicated the following:-Neglect as defined at 483.5 means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.-Along with staff and management, the physician will help identify situations that might constitute or could be construed as neglect; for example, inadequate prevention or care of pressure ulcers, inattention to advanced directives and resident wishes, inappropriate management of problematic behavior, recurrent failure to provide incontinence care, failure to report or evaluate significant weight loss, repeated failure to check for correct application of restraints, etc.-The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. On 9/9/25 at approximately 8:15 A.M., the surveyor observed a strong odor of urine and feces in the corridor outside of Resident #45's room. At 8:19 A.M., the surveyor entered Resident #45's room and the odor was stronger, and the Resident was observed lying on 3 incontinence pads. The Resident was unable to participate in an interview with the surveyor. Resident #45's health care proxy was unable to be contacted during survey due to being hospitalized . On 9/9/25 at 8:48 A.M., the surveyor continued to observe the odor in Resident #45's room as a Certified Nursing Assistant (CNA) entered the room to bring the Resident his/her breakfast. The CNA did not attempt to remove the soiled incontinence pads from under Resident #45 and the CNA was not observed providing any incontinence care to the Resident. The CNA then began to feed the Resident with the strong odor of urine and feces still present. On 9/9/2025 at 9:26 A.M., CNA #1 was observed entering Resident #45's room to provide incontinence care. At 9:36 A.M., the surveyor observed the 3 incontinence pads that had been removed from under Resident #45. All 3 pads were significantly soiled with urine and feces. Review of the Documentation Survey Report for September 2025, indicated the last documented time that incontinence care was provided to Resident #45 on the 9/8/25 over-night shift was 11:15 P.M., 10 hours prior to CNA #1 providing care. This indicated the facility missed 5 possible opportunities for incontinence care during this timeframe (1:15 A.M., 3:15 A.M., 5:15 A.M. and 7:15 A.M.,) in addition to not providing care prior to serving the Resident breakfast. The surveyor confirmed with the Staff Development Nurse that she was reading the time stamp on the Documentation Survey Report (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	correctly and that this was the last time care had been documented as being provided. The surveyor attempted to interview the CNA responsible for Resident #45's care on the 9/8/25 over-night shift and the CNA did not return the surveyors call during survey. Review of the admission assessment, dated 8/24/25, indicated Resident #45 was assessed to be incontinent of both bowel and bladder upon admission and required assistance from staff. Review of Resident #45's urinary incontinence care plan, initiated on 8/24/25, indicated the following intervention:-Check resident approximately every 2 hours and provide incontinence care as needed. -Provide incontinence care and apply moisture barrier as needed. Review of Resident #45's Bowel incontinence care plan, initiated on 8/24/25, indicated the following intervention:-Check resident approximately every 2 hours and provide incontinence care as needed. -Provide incontinence care and apply moisture barrier as needed. Review of Resident #45's activities of daily living care plan, initiated on 8/24/25, indicated the following intervention:-Toileting: I require 2 staff assist with toileting. Review of Resident #45's nursing progress note, dated 9/9/25, the same day as the surveyor's observations, indicated the following:-pt (patient) with new skin failure wound to L (left) buttock noted by wound MD (medical doctor) while doing wound rounds, wound measures 2.6x2x- (centimeters), new order for Triad (wound treatment) daily. Review of the wound visit notes dated 9/9/25 indicated Resident #45 had a new skin impairment to the left buttocks measuring 2.6x 2xnot measurable cm (centimeters) with the etiology of end-stage skin failure. During an interview on 9/9/2025 at 9:36 A.M., CNA #1 said Resident #45 is incontinent of bowel and bladder. CNA #1 said all residents should be checked for incontinence every two hours and provide care as needed. During an interview on 9/11/2025 at 9:04 A.M., Nurse #1 said she was unaware of Resident #45's soiled incontinence pads during the breakfast meal. Nurse #1 said failing to provide incontinent care and leaving a resident in a soiled incontinent brief would be considered a form of neglect and not providing incontinence care could lead to skin breakdown. During an interview on 9/11/25 at 9:20 A.M., Unit Manager #1 said Resident #45 is declining, is incontinent of both bowel and bladder and has fragile skin. Unit Manager #1 said a possible risk factor for developing worsening or new skin impairments would be not providing incontinence care timely and said a resident should not be lying in saturated incontinence pads and care should be provided promptly as it would increase the risk of skin breakdown. Unit Manager #1 said not providing incontinence care to a resident throughout a shift or when visibly soiled is a form of neglect. During an interview on 9/11/2025 at 10:22 A.M., the Director of Nursing said not providing necessary care to a resident, such as incontinence care, is considered neglect. The Director of Nursing said all residents should be checked for incontinence and provided care as needed every two hours and that the risk of developing skin impairments from moisture is higher when care is not provided. The Director of Nursing reviewed the documentation survey report with the surveyor and said if the CNA documented incontinence care was provided at 11:15 P.M. and there was no further documentation, then that was the last time care had been provided to the Resident. The Director of Nursing said staff not providing incontinence care to Resident #45 for an entire shift and when visibly soiled, was neglect. The Director of Nursing also said that she expects the staff to provide residents with necessary care prior to assisting them with a meal and the staff not changing Resident #45 and feeding him/her while soiled was neglect. During an interview on 9/11/2025 at 12:57 P.M., Nurse Practitioner #2 said not providing incontinence care to Resident #45 when he/she was visibly soiled is neglect.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 Residents (#45, #109, and #7) out of a total sample of 28. Specifically;1.) For Resident #45 the facility failed to provide incontinence care for the entirety of an over-night shift and the start of the morning shift, equaling a total of ten hours, resulting in skin breakdown;2.) For Resident #109 the facility failed to ensure cueing or assistance was provided for meals, resulting in Resident #109 eating 4 of 4 meals, that were not finger foods, with his/her hands; and 3.) For Resident #7, the facility failed to provide assistance with meals. Findings include:Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated as revised April 2025, indicated the following: -Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. -Appropriate care and serviced are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: c. elimination (toileting) d. dining (eating, including meals and snacks). Review of the facility policy titled, Urinary Continence and Incontinence – Assessment and Management, dated as Revised August 2022, indicated the following: -A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. 1. Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. On 9/9/25 at approximately 8:15 A.M., the surveyor observed a strong odor of urine and feces in the corridor outside of Resident #45's room. At 8:19 A.M., the surveyor entered Resident #45's room and the odor was stronger, and the Resident was observed lying on 3 incontinent pads. The Resident was unable to participate in an interview with the surveyor. Resident #45's health care proxy was unable to be contacted during survey due to being hospitalized . On 9/9/25 at 8:48 A.M., the surveyor continued to observe the odor in Resident #45's room as a Certified Nursing Assistant (CNA) entered the room to bring the Resident his/her breakfast. The CNA (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not attempt to remove the soiled incontinence pads from under Resident #45 and the CNA was not observed providing any incontinence care to the Resident. The CNA then began to feed the Resident with the strong odor of urine and feces still present. On 9/9/2025 at 9:26 A.M., CNA #1 was observed entering Resident #45's room to provide incontinence care. At 9:36 A.M., the surveyor observed the 3 incontinent pads that had been removed from under Resident #45. All 3 pads were significantly soiled with urine and feces. Review of the Documentation Survey Report for September 2025, indicated the last documented time that incontinence care was provided to Resident #45 on the 9/8/25 over-night shift was 11:15 P.M., 10 hours prior to CNA #1 providing care. This indicated the facility missed 5 possible opportunities for incontinence care during this timeframe (1:15 A.M., 3:15 A.M., 5:15 A.M. 7:15 A.M., and 9:15 A.M.) in addition to not providing care prior to serving the Resident breakfast. The surveyor confirmed with the Staff Development Nurse that she was reading the time stamp on the Documentation Survey Report correctly and that this was the last time care had been documented as being provided. Review of the admission assessment dated [DATE], indicated Resident #45 was assessed to be incontinent of both bowel and bladder upon admission and required assistance from staff. Review of Resident #45's urinary incontinence care plan, initiated on 8/24/25, indicated the following intervention: -Check resident approximately every 2 hours and provide incontinence care as needed. -Provide incontinence care and apply moisture barrier as needed. Review of Resident #45's Bowel incontinence care plan, initiated on 8/24/25, indicated the following intervention: -Check resident approximately every 2 hours and provide incontinence care as needed. -Provide incontinence care and apply moisture barrier as needed. Review of Resident #45's ADL care plan, initiated on 8/24/25, indicated the following intervention: -Toileting: I require 2 staff assist with toileting. Review of Resident #45's nursing progress note, dated 9/9/25, the same day as the surveyor's observations, indicated the following: -pt (patient) with new skin failure wound to L (left) buttock noted by wound MD (medical doctor) while doing wound rounds, wound measures 2.6x2x- (centimeters), new order for Triad (wound treatment) daily. Review of the wound visit notes dated 9/9/25 indicated Resident #45 had a new skin impairment to the left buttocks measuring 2.6x 2xnot measurable cm (centimeters) with the etiology of end-stage skin failure. The surveyor attempted to interview the CNA responsible for Resident #45's care on the 9/8/25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	over-night shift and the CNA did not return the surveyors call during survey. During an interview on 9/9/2025 at 9:36 A.M., CNA #1 said Resident #45 is incontinent of bowel and bladder. CNA #1 said all residents should be checked for incontinence every two hours and provide care as needed. During an interview on 9/10/2025 at 12:15 P.M., Unit Manager #1 said all residents should be checked for incontinence every two hours and changed as needed. Unit Manager #1 said a resident should not be lying in saturated incontinence pads and care should be provided promptly as it would increase the risk of skin breakdown. During an interview on 9/11/2025 at 9:04 A.M., Nurse #1 said incontinence care should be provided to all residents every two hours and as needed. Nurse #1 said a risk factor for worsening or new skin impairments would be not providing incontinence care timely. Nurse #1 said she did not know Resident #45 well as she just works per diem in the facility. During a follow-up interview on 9/11/25 at 9:20 A.M., Unit Manager #1 said Resident #45 is declining, is incontinent of both bowel and bladder and has fragile skin. Unit Manager #1 said a possible risk factor for developing worsening or new skin impairments would be not providing incontinence care timely. During an interview on 9/11/2025 at 10:22 A.M., the Director of Nursing said incontinence care should be provided every 2 hours. The Director of Nursing said a possible risk factor for developing worsening or new skin impairments would be not providing incontinence care timely. The Director of Nursing reviewed the documentation survey report with the surveyor and said if the CNA documented incontinence care was provided at 11:15 P.M. and there was no further documentation, then that was the last time care had been provided to the Resident. During an interview on 9/12/25 at 11:43 A.M., the Wound Physician said a possible cause of skin breakdown could be prolonged lack of incontinence care. The Wound Doctor said Resident #45 has multiple skin impairments on his/her body and the new area discovered on 9/9/25 was determined to be skin failure due to the Resident's overall health condition. The Wound Doctor said he was not aware the Resident had been lying on soiled incontinence briefs for an extended amount of time. 2.) Resident #109 was admitted to the facility in December 2023 with diagnoses including Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/26/25, indicated Resident #109 scored a 2 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severely impaired cognition. The MDS further indicated Resident #109 had no behavior of refusing care. Review of the active Physician orders, included the following order with a start date of 12/13/23: -Heart Healthy diet/Regular texture, Regular/Thin consistency, for Dietary supplement allow finger foods. Review of the current care plan for Resident #109 includes the following care plans: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. I have an ADL Self Care Performance Deficit r/t (related to) Cognitive Impairment. Interventions include: -Monitor for any changes in ADL ability, potential for improvement, and/or inability to perform ADLs. Caregiver to report changes to Nurse/Physician and document changes in Nurses Notes. (4/1/25) -Encourage me to participate in ADLs to the fullest extent possible. (4/1/25). -EATING: I require supervision with eating and drinking. (6/27/25) 2. I have impaired cognitive function and/or impaired thought processes r/t Dementia. Interventions include: -Cue, reorient and supervise as needed. 3. There is a behavior care plan in place indicating: I have a behavior problem Potential concern r/t (related to) behavior problem Resists Care r/t dementia, he/she can hit, kick, spitting at other residents or staff, throwing food at others, trying to lift tables, and curse with care at times. No behaviors were noted during any observations throughout the survey period and review of the clinical record failed to indicate Resident #109 refused care assistance with meals. Review of the (Nurse Practitioner) NP visit note dated 8/29/25 indicated: -Resident #109 is dependent on caregivers for assistance. On 9/09/2025 at 8:46 A.M., Resident #109 was observed in the unit dining room for breakfast. Resident #109 was eating scrambled eggs and waffles covered with syrup with his/her hands. There were three staff present in the room however Resident #109 was not being provided with assistance or cueing. The surveyor continued to make the following observation: -At 8:56 A.M., Resident #109 had consumed all of the food using his/her, was then rubbing his/her fingers through syrup on the plate and licking them. Staff had not assisted or cued the Resident at any point during the observation period. On 9/09/2025 at 12:16 P.M., Resident #109 was observed in the unit dining room for lunch. Resident #109 picked up a handful of diced potatoes with his/her hands and pushed them in his/her mouth. There was a CNA standing behind a resident that was seated beside Resident #109 however the CNA did not offer assistance or cueing to Resident #109 to use a utensil. The surveyor continued to make the following observation: -At 12:18 P.M., Resident #109 picked up a handful of peas with his/her hands and pushed them in his/her mouth. The CNA was still present however did not offer assistance or cueing to use a utensil. On 9/10/2025 at 8:13 A.M., Resident #109 was observed in the unit dining room for breakfast. A CNA placed breakfast in front of Resident #109, which included an English muffin and scrambled eggs, placed a fork on the plate beside the eggs and walked away. The surveyor continued to make the following observations: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:15 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. -At 8:16 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. Three staff were at table setting up other residents' meals, however no one intervened or cued the Resident to use a utensil. -At 8:19 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. There were seven staff present in the dining room; however, no assistance or cueing was provided to Resident #109. -By 8:23 A.M., Resident #109 had completed entire plate of food by hand. On 9/11/2025 at 8:07 A.M., Resident #109 was observed in the unit dining room for breakfast. A CNA placed breakfast in front of Resident #109, which included toast with jelly and scrambled eggs. A knife was left on plate beside the eggs, but no fork was present. Following placing the meal the CNA walked away, and the surveyor continued to make the following observations: -At 8:08 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. There were several staff present in the dining room, including the Assistant Director of Nursing (ADNS), however no assistance or cueing was provided to Resident #109. -By 8:11 A.M., Resident #109 had finished eating all of the scrambled eggs with his/her hands. Review of the Certified Nursing Assistant (CNA) task documentation on 9/11/2025 at 8:27 A.M., indicated the following: -For breakfast on 9/9/25 and 9/10/25 Resident #109 required: Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance. Assistance may be provided throughout or intermittently. -For lunch on 9/9/25 Resident #109 was: Independent - Resident completes the activity by themself with no assistance from a helper. Review of the CNA task documentation failed to indicate Resident #109 refused care assistance 9/9/25-9/11/25. During an interview on 9/11/2025 at 9:32 A.M., Resident #109's CNA #2 said that Resident #109 needs one person assist with care and needs supervision with eating. CNA #2 said that Resident #109 ate his/her entire breakfast that morning independently using a fork, contrary to observation by the Surveyor. The surveyor shared the previous day's observations of Resident #109 eating other meals with his/her hands, including waffles with syrup and he said, the thing is we make sure that residents have sanitized hands before breakfast and then they can have the freedom to eat any of the food with their hands. CNA #2 said that he would not intervene and assist if a resident was eating any food with their hands because that is their right, but that utensils should be available. During an interview on 9/11/2025 at 9:41 A.M., the Assistant Director of Nursing (ADON) said that Resident #109 eats in the unit dining room and doesn't necessarily need help but needs a lot of cueing and supervision with meals. The ADON said that Resident #109 doesn't always use utensils, and we give her more finger foods so he/she can have more independence. The ADON said that staff should (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be intervening and assisting with meals when a resident needs assistance with eating. During an interview on 9/11/2025 at 10:48 A.M., the Director of Nursing said that if a resident is observed eating non finger food with their hands staff should staff intervene and offer assistance. 3.) Resident #7 was admitted to the facility in September 2024 with diagnoses including dementia and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/28/25, indicated Resident #7 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. This MDS also indicated Resident #7 was dependent on staff for assistance with eating. Review of Resident #7's plan of care related to ADL self-care performance, revised 8/26/25, indicated: -EATING: I require hands-on assistance for eating and drinking. -EATING: I require total assistance with eating and drinking. Review of Resident #7's kardex (a form indicating the level of assistance needed for resident care), dated 9/12/25, indicated: -EATING: I require hands-on assistance for eating and drinking. -EATING: I require total assistance with eating and drinking. On 9/9/25 at 8:37 A.M. to 8:48 A.M., the surveyor observed Resident #7 eating breakfast in the dining room. Resident #7 was using his/her hands to eat waffles covered in syrup. There were several staff members in the dining room, but none were offering to help or sitting with the Resident. At 8:48 A.M., the surveyor heard a table mate tell staff that Resident #7 needed help and staff said, I will get to her and walked away. On 9/9/25 at 12:17 P.M. to 12:25 P.M., the surveyor observed Resident #7 eating lunch in the dining room. Resident #7 was using his/her hands to pick chicken salad filling out of a sandwich. Resident #7 was also using his/her fingers to eat peas, which he/she dropped many of the peas onto his/her lap. There were several staff members in the dining room, but none were offering to help or sitting with the Resident. At 12:19 P.M., the surveyor heard a table mate tell staff that Resident #7 needed help and staff said He/she is feeding himself/herself like a big girl/boy and walked away. On 9/10/25 at 8:36 A.M. to 8:51 A.M., the surveyor observed Resident #7 eating breakfast in the dining room. There were several staff members in the dining room, but none were offering to help or sitting with the Resident. Resident #7 was using his/her hands to eat and English muffin and scrambled eggs. At 8:20 A.M., Resident #7 attempted to take sip of cranberry juice and spilled half a cup of his/her cranberry juice onto the English muffin and scrambled eggs. Resident #7 continued to use his/her hands to eat scrambled eggs covered in cranberry juice. At 8:30 A.M., a certified nurse assistant (CNA) removed the plate containing half of his/her juice saturated english muffin and scrambled eggs. The CNA offered Resident #7 more cranberry juice but did not offer to get new English muffin or scrambled eggs. The CNA placed a bowl of oatmeal, which was previously out of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reach of Resident #7, in front of him/her. The CNA put a spoon in the oatmeal and walked away. Resident #7 stared at the oatmeal for over five minutes before attempting to bring the spoon to his/her mouth backwards, spilling the oatmeal onto his/her lap. Resident #7 dropped the spoon on the floor. Resident #7 then begins to eat oatmeal with his/her fingers, spilling it onto his/her lap. At 8:51 A.M., a CNA asked Resident #7 if he/she was done and Resident #7 said yes. The CNA then asked Resident #7 where his/her spoon was, found it on the floor, and removed the three-quarter full oatmeal. On 9/10/25 at 12:01 P.M. to 12:15 P.M., the surveyor observed staff serve Resident #7 lunch and then walk away in the dining room. Resident #7 picked up pieces of lettuce with his/her hands. Resident #7 picked the top piece of bread of a sandwich at attempted to place it in his/her mouth but dropped it on the floor. At 12:10 P.M., a staff member came and offered to push Resident #7 closer to the table and said it looked like it was hard for him/her to reach his/her meal. At 12:15 P.M., a staff member began assisting the Resident with the meal. During an interview on 9/11/25 at 11:51 A.M., Certified Nurse Assistant (CNA) #9 said CNAs get information of the level of assistance each resident needed with meals through nurse report. CAN #9 said there is no kardex used in the facility. CNA #9 said if the nurse report said a resident required total assistance or hands on assistance with meals, it meant that staff should sit down to assist with the meal as soon as the meal is served. CNA #9 said if a resident required total assistance or hands on assistance with meals, the meal should not be left before assistance is ready or the food could get cold. CNA #9 said Resident #7 did not require total assistance or hands on assistance with meals and staff never sit and assist him/her unless she needs help, which does happen sometimes. During an interview on 9/11/25 at 11:54 A.M., CNA #6 said CNAs get information of the level of assistance each resident needed with meals through nurse report and through the kardex. CNA #6 said CNAs should check the kardex every shift because resident's change and residents with dementia have difficulty communicating their needs. CNA #6 said the kardex interventions should always be followed, or if inappropriate the nurse should be notified. CNA #6 said if a resident required total assistance or hands on assistance with meals, it meant that staff should sit down to assist with the meal as soon as the meal is served. CNA #6 said Resident #7 required only set-up and assistance as needed. The surveyor and CNA #6 visualized the kardex together and CNA #6 said the kardex must be incorrect where it says EATING: I require hands-on assistance for eating and drinking and EATING: I require total assistance with eating and drinking because he/she doesn't need assistance all the time. During an interview on 9/11/25 at 12:04 P.M., the Scheduler said she assisted Resident #7 with breakfast that morning. The Scheduler says she is also a CNA and often helps with meals. The Scheduler said CNAs get information of the level of assistance each resident needs with meals through nurse report and through the kardex. The Scheduler said if a resident required total assistance or hands on assistance with meals, it meant the staff needed to sit down and assist as soon as the meal is served. The Scheduler said Resident #7 should never have had his/her meal dropped off and left without a staff member sitting to assist because he/she requires total assistance just as the Kardex indicated. During an interview on 9/12/25 at 8:48 A.M., Nurse #5 said CNAs get information of the level of assistance each resident needed with meals through nurse report and through the kardex. Nurse #5 said interventions on the care plan and Kardex should always be implemented, and if inappropriate it should be revised. Nurse #5 said if a resident required total assistance or hands on assistance with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals, it meant the staff needed to sit down and assist as soon as the meal is served. Nurse #5 said Resident #7 should never have had his/her meal dropped off and left without a staff member sitting to assist because he/she requires total assistance just as the Kardex indicated. Nurse #5 further said Resident #7 is unable to use his/her right hand at all and his/her left hand is very weak and cannot hold heavier items like his/her cup. During an interview on 9/12/25 at 9:45 A.M., the Director of Nursing (DON) said CNAs get information of the level of assistance each resident needs with meals through nurse report and through the kardex. The DON said interventions on the care plan and Kardex should always be implemented, and if inappropriate it should be revised. The DON said if a resident required total assistance or hands on assistance with meals, it meant the staff needed to sit down and assist as soon as the meal is served. The DON said Resident #7 should have had staff sitting with him/her to assist with meals as indicated in his/her Kardex and care plan.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide necessary treatment, services, and/or interventions to promote healing and prevent new ulcers from developing for four Residents (#45, #2, #17, and #23), who had pressure ulcers, out of 28 total sampled residents. Specifically,1a.) For Resident #45, the facility failed to implement a wound intervention resulting in deterioration of wound,1b.) For Resident #45, the facility failed to ensure staff provided prompt incontinence care to prevent new skin breakdown,2a.) For Resident #2, the facility failed to address and implement wound clinic recommendations for pressure ulcers to right and left buttocks, 2b.) For Resident #2, the facility failed to assess and document the measurements of the right and left buttock wounds weekly as ordered,3a.) For Resident #17, the facility failed to address and implement multiple wound care treatment recommendations for a left heel pressure related deep tissue injury (DTI) wound as recommended by the hospice wound nurse,3b.) For Resident #17, the facility failed to assess and document the measurements of a left heel pressure related deep tissue injury (DTI) wound at least weekly as required,4a.) For Resident #23, the facility failed to assess, document, measure, and stage pressure ulcers upon admission and weekly as ordered.4b.) For Resident #23, the facility failed to ensure that skin assessments were completed and documented at least weekly as ordered. Findings include: Review of the facility policy titled Pressure Ulcer/Skin Breakdown – Clinical Protocol, dated April 2014, indicated the following: -The nursing staff and attending physician will assess and document an individual's significant risk factors for developing pressure sores; For example, immobility, recent weight loss, and a history of pressure ulcers. -In addition, the nurses shall describe and document/report the following: a. full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. -the physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents have indicated for type of skin alteration. Review of the facility policy titled Prevention of Pressure Injuries, dated April 2020, indicated the following: -Purpose: the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. -Risk assessment: 1. Assess the resident on admission for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes and condition. -Skin Assessment: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the residence risk factors, and prior to discharge. 3c. Wash skin after any episodes of incontinence. -Prevention: -2. Clean promptly after episodes of incontinence. 1.) Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. 1a.) Review of the skin assessment, dated 8/24/25, indicated Resident #45 was admitted with a skin impairment to the coccyx. The skin assessment failed to both describe what type of skin impairment was on the coccyx or measure the area. Review of the Admission/readmission Screener assessment, dated 8/24/25, indicated Resident #45 was admitted with an open area to the coccyx. The assessment failed to include measurements of the area. Review of the Treatment Administration Record (TAR) for August 2025 indicated the treatment prescribed for Resident #45's coccyx wound, initiated on 8/25/25, was saline wash, pat dry and apply barrier cream every day and evening shift. On 8/26/25, Resident #45 was evaluated by the Wound Physician. The evaluation indicated the following: -Resident #45 had a stage 3 pressure area to the coccyx measuring 1.6 x .9 x .3 cm (centimeters) with a total surface area of 1.44 cm2 (squared centimeters). -Treatment plan: Primary Dressing(s) Alginate calcium apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Secondary Dressing(s) Gauze island w/ bdr (with border) apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Review of Resident #45's physician orders failed to indicate this treatment was implemented after the wound physician visit. On 9/2/25, Resident #45 was again evaluated by the Wound Physician. The evaluation indicated the following: -Resident #45 had a stage 3 pressure area to the coccyx measuring 2.2 x 1.4 x .3 cm (centimeters) with a total surface area of 3.08 cm2 (squared centimeters), doubling in size from the previous week. -Treatment plan: Primary Dressing(s) Alginate calcium apply once daily and as needed: if saturated, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/25 at 11:43 A.M., the Wound Physician said he has been treating Resident #45 for the past three weeks. The Wound Physician said he expects all wound recommendations he makes to be implemented and has never been told by the physician at the facility that a recommendation was not appropriate. The Wound Physician said Resident #45's skin is very fragile and not following his recommendations could potentially cause the wound to worse. The Wound Physician said he was unaware that from 8/26/25 to 9/2/25 his recommendation of treatment was not followed. During an interview on 9/11/2025 at 12:57 P.M., Nurse Practitioner #2 said she was not made aware of the wound physician recommendations on 8/26/25. Nurse Practitioner #2 said she and the physician always agree with the treatment recommendations made by the Wound Physician because he is the specialist and had she known about the recommendations, they would have been put into place. During an interview on 9/12/25 at 10:01 A.M., Nurse #9 said she worked the day shift on 9/8/25 and did not complete Resident #45's treatment to his/her coccyx. Nurse #9 said her day was too busy and she did not have time to complete the treatment. 1b.) On 9/9/25 at approximately 8:15 A.M., the surveyor observed a strong odor of urine and feces in the corridor outside of Resident #45's room. At 8:19 A.M., the surveyor entered Resident #45's room and the odor was stronger, and the Resident was observed lying on 3 incontinence pads. The Resident was unable to participate in an interview with the surveyor. Resident #45's health care proxy was unable to be contacted during survey due to being hospitalized . On 9/9/25 at 8:48 A.M., the surveyor continued to observe the odor in Resident #45's room as a Certified Nursing Assistant (CNA) entered the room to bring the Resident his/her breakfast. The CNA did not attempt to remove the soiled incontinence pads from under Resident #45 and the CNA was not observed providing any incontinence care to the Resident. The CNA then began to feed the Resident with the strong odor of urine and feces still present. On 9/9/2025 at 9:26 A.M., CNA #1 was observed entering Resident #45's room to provide incontinence care. At 9:36 A.M., the surveyor observed the 3 incontinence pads that had been removed from under Resident #45. All 3 pads were significantly soiled with urine and feces. Review of the Documentation Survey Report for September 2025, indicated the last documented time that incontinence care was provided to Resident #45 on the 9/8/25 over-night shift was 11:15 P.M., 10 hours prior to CNA #1 providing care. This indicated the facility missed 5 possible opportunities for incontinence care during this timeframe (1:15 A.M., 3:15 A.M., 5:15 A.M. and 7:15 A.M.,) in addition to not providing care prior to serving the Resident breakfast. The surveyor confirmed with the Staff Development Nurse that she was reading the time stamp on the Documentation Survey Report correctly and that this was the last time care had been documented as being provided. The surveyor attempted to interview the CNA responsible for Resident #45's care on the 9/8/25 over-night shift and the CNA did not return the surveyors call during survey. Review of Resident #45's nursing progress note, dated 9/9/25, the same day as the surveyor's observations, indicated the following: -pt (patient) with new skin failure wound to L (left) buttock noted by wound MD (medical doctor) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while doing wound rounds, wound measures 2.6x2x- (centimeters), new order for Triad (wound treatment) daily. Review of the wound visit notes dated 9/9/25 indicated Resident #45 had a new skin impairment to the left buttocks measuring 2.6x 2xnot measurable cm (centimeters) with the etiology of end-stage skin failure. During an interview on 9/11/2025 at 9:04 A.M., Nurse #1 said she was unaware of Resident #45's soiled incontinence pads during the breakfast meal. Nurse #1 said failing to provide incontinent care and leaving a resident in a soiled incontinent brief, even for a short amount of time could lead to skin breakdown. During an interview on 9/11/25 at 9:20 A.M., Unit Manager #1 said Resident #45 is declining, is incontinent of both bowel and bladder and has fragile skin. Unit Manager #1 said a possible risk factor for developing worsening or new skin impairments would be not providing incontinence care timely and said a resident should not be lying in saturated incontinence pads and care should be provided promptly as it would increase the risk of skin breakdown. During an interview on 9/11/2025 at 10:22 A.M., the Director of Nursing said all residents should be checked for incontinence and provided care as needed every two hours and that the risk of developing skin impairments from moisture is higher when care is not provided. The Director of Nursing reviewed the documentation survey report with the surveyor and said if the CNA documented incontinence care was provided at 11:15 P.M. and there was no further documentation, then that was the last time care had been provided to the Resident. During an interview on 9/11/2025 at 12:57 P.M., Nurse Practitioner #2 said not providing incontinence care to Resident #45 when he/she was visibly soiled could potentially increase risk of skin breakdown. During an interview on 9/12/25 at 11:43 A.M., the Wound Physician said a possible cause of skin breakdown could be prolonged lack of incontinence care. The Wound Doctor said Resident #45 has multiple skin impairments on his/her body and the new area discovered on 9/9/25 was determined to be skin failure due to the Resident's overall health condition. The Wound Doctor said he was not aware the Resident had been lying on soiled incontinence briefs for an extended amount of time. 3.) Resident #17 was admitted to the facility in March 2024 with diagnoses including failure to thrive and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/28/25, indicated Resident #17 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This MDS also indicated Resident #17 had one unstageable pressure injury presenting as deep tissue injury. On 9/10/25 at 7:39 A.M., the surveyor observed Resident #17 in bed with his/her left heel offloaded in a pressure reducing boot. Resident #17 said he/she has a wound on his/her left heel that was caused from his/her mattress. 3a.) Review of Resident #17's nursing progress notes indicated the following written by Unit Manager #2: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/4/25: CNA (certified nurse assistant) reported new area to left heel. 2x2 (centimeters) DTI (deep tissue injury) on left heel dry, eschar. -8/5/25: Hospice recommendation: if heel intact, paint with betadine (a topical antiseptic containing iodine). If the area opens, apply calcium alginate (a highly absorbent type of wound treatment) and cover with DPD (dry protective dressing). Review of Resident #17's physician orders failed to indicate any wound treatment from 8/4/25 through 8/7/25. Review of Resident #17's physician order, initiated 8/8/25 (three days after first recommended), indicated: -Paint left heel with betadine swab. Review of Resident #17's hospice routine visit progress note, dated 8/11/25, indicated: -Only open area on left heel. Wound not open at present, but looks like it could open so POC (plan of care) updated if that occurs. Family and facility agree with POC. Review of Resident #17's hospice wound recommendation, dated 8/11/25, indicated: -Wound recs (recommendations): Left heel paint with iodine to dry eschar, cover with ABD (abdominal pad, a type of dressing), secure with sock every day. If it opens and drainage starts: clean with cleanser, cut to fit alginate, ABD pad, wrap, change 2-3 times per week. Review of Resident #17's medical record, dated 8/11/25 to 8/25/25 failed to indicate the wound recommendation to cover with ABD pad from hospice was addressed or implemented. The physician's order to paint left heel with betadine swab remained in place during this time. Review of Resident #17's Treatment Administration Record (TAR), dated 8/17/25 to 8/25/25, indicated a new order to document answer to question Is there drainage present? from left heel wound, initiated 8/17/25. This TAR indicated the nurses documented yes there was drainage on 9 out of the 9 days from 8/17/25 to 9/11/25. The physician's order to paint left heel with betadine swab remained in place during this time and failed to indicate any additional physician's orders for any other types of wound dressing. Review of Resident #17's hospice routine visit progress note, dated 8/25/25, indicated: -Heal [sic] is open and advised to use alginate on open area. Wound no changes except drainage small amt (amount) s/s (serosanguineous, a type of wound drainage). Son updated. Family and facility agree with POC. Review of Resident #17's medical record, dated 8/25/25 to 9/11/25, failed to indicate the wound recommendation to use alginate on open wound was addressed or implemented. Review of Resident #17's Treatment Administration Record (TAR), dated 8/26/25 to 9/11/25, indicated the physician's order to answer the question Is there drainage present? from left heel wound, initiated 8/17/25 had nurses documented yes there was drainage on 13 out of the 15 days (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from 8/17/25 to 9/11/25. The physician's order to Paint left heel with betadine swab remained in place during this time and failed to indicate any additional physician's orders for any other types of wound dressing. On 9/10/25 at 12:09 P.M., the surveyor observed Nurse #7 perform wound care for Resident #17's left heel DTI pressure wound. The surveyor observed a red, open wound approximately the size of a quarter. Nurse #7 said this was an open wound with red granulation tissue in the wound bed. Nurse #7 said there was no dressing in place and that there is no physician's order to apply any dressings. Nurse #7 applied betadine to the wound bed and said this was the only wound treatment ordered to be completed. During an interview on 9/10/25 at 12:48 P.M., Unit Manager #2 said the Hospice Wound Nurse follows Resident #17'S left heel wound, and the Hospice Wound Nurse makes wound treatment recommendations to the Hospice Nurse Practitioner (NP), who would notify them of any necessary orders. Unit Manager #2 said if the wound had drainage then it must be an open wound. Unit Manager #2 said the left heel wound has had a small opening with drainage for quite some time, but since it's only a small opening hospice wishes to continue betadine only without any calcium alginate. Unit Manager #2 said she never notified the facility physician of any wound treatment recommendations for calcium alginate or any other type of dressing. Unit Manager #2 further said she was unaware that ABD pads required a physician's order. During a telephone interview on 9/11/25 at 9:03 A.M., the Hospice Wound Nurse said she had made the recommendation for calcium alginate when the wound opened, but it's the facilities responsibility to notify the facility NP to approve any of the recommendations for wound treatments. The Hospice Wound Nurse said she had observed the nurses apply ABD pads to Resident #17's left heel during her routine visits during the past month and was unaware that there was not an order for an ABD pad. During a telephone interview on 9/11/25 at 10:09 A.M., the facility Nurse Practitioner (NP) #1 said his first day working for the facility was 8/25/25. NP #1 said Resident #7 had an intact DTI and would expect the facility to notify him to approve all hospice wound treatment recommendations. NP #1 was unaware that Resident #17's DTI had opened and had drainage. NP #1 said the facility never notified him of this change but should have. NP #1 said the facility never addressed the hospice recommendation for calcium alginate but would have approved it if he had been notified. NP #1 said any open wound should have a dressing in place to protect from infection and Resident #17 should have had a dressing ordered for his/her open left heel wound. NP #1 further said application of ABD pads to a wound require a physician's order. During an interview on 9/11/25 at 10:45 A.M., the Director of Nursing (DON) said hospice wound treatment recommendations should be reviewed with the facility NP #1. The DON said if NP #1 did not approve the recommendations, then it should be documented somewhere in the medical record. The DON said ABD pads require a physician's order for application. The DON said the wound treatment recommendation for calcium alginate should have been addressed but was not. The DON further said if a wound has drainage, then it should have a dressing on it. The DON said if there was no physician's order for a dressing, the nurse should have notified the provider that it required one but did not. 3b.) Review of Resident #17's plan of care related to left heel suspected deep tissue injury, initiated 8/4/25, indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evaluate and document healing progress. Report significant changes and declines to the provider and follow-up as indicated. Document findings and interventions in nurse's notes. Review of Resident #17's medical record indicated the last left heel DTI wound measurements documented were on 8/25/25 by the Hospice Wound Nurse, which was 16 days prior. The measurements on 8/25/25 indicated Resident #17's left heel wound was 3 centimeters (cm) in length and 3 cm in width. Review of Resident #17's entire medical record, including consultant hospice progress notes, failed to indicate Resident #17's left heel DTI was measured on 9/2/25 and 9/8/25. During an interview on 9/10/25 at 12:48 P.M., Unit Manager #2 said Resident #17's wound should have been measured weekly by the nurse responsible for the Resident. Unit Manager #2 said this was communicated to the nurses through the physician order on the assigned shift. The surveyor and Unit Manager #2 reviewed Resident #17's electronic medical record, and Unit Manager #2 said there was no physician's order in place. Unit Manager #2 said since this physician's order to measure the left heel DTI was not in place, the wound was not measured but should have been on 9/2/25 and 9/8/25. During this interview, Unit Manager #2 was unaware that hospice had any measurements documented in hospice progress notes and said the facility, not hospice, was responsible for measuring Resident #17's left heel DTI wound. Review of Resident #17's physicians orders, dated 8/4/25 to 9/11/25, failed to indicate need to measure his/her left heel DTI weekly. During a telephone interview on 9/11/25 at 9:03 A.M., the Hospice Wound Nurse said the facility is responsible for measuring Resident #17's left heel DTI, but if she happens to measure it herself, she documents it such as in her hospice progress note on 8/25/25. During a telephone interview on 9/11/25 at 10:09 A.M., the facility Nurse Practitioner (NP) #1 said he expected Resident #17's left heel DTI to be measured weekly by the facility. During an interview on 9/11/25 at 10:45 A.M., the Director of Nursing (DON) said Resident #17's left heel DTI should have been measured weekly but was not. 2.) Resident #2 was admitted to the facility in July 2025 with diagnoses including peripheral vascular disease, type 2 diabetes, muscle wasting and atrophy and dependance on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/31/25, indicated Resident #2 scored a 15 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) score indicating intact cognition. The MDS further indicated Resident #2 had one stage 3 and one unstageable pressure ulcer. On 9/9/25 at 8:38 A.M., the surveyor observed Resident #2 lying in his/her bed on an air mattress, his/her legs had dressing on them dated 9/8/25. Resident #2 said he/she has wounds on her buttocks. Review of Resident #2's physician orders indicated the following: -Date initiated 7/31/25; Normal saline wash (NSW) pat dry apply alginate then border gauze right (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gluteal every day shift. -Date initiated 9/8/25, Normal saline wash pat dry apply gauze impregnated with 1/4 strength Dakins, cover with gauze island dressing left buttock every day shift. Review of the medical record indicated Resident #2 went to a wound clinic appointment on 8/14/25 with the following wound care instructions. -Plan; bilateral ischial pressure ulcer, irrigate with normal saline, lightly pack wound with 0.125% Dakins moist gauze packing, mepilex border lite dressing or equivalent. Change dressing twice a day. Review of the treatment administration record (TAR) for August 2025 indicated the following treatment orders. -NSW pat dry apply alginate then border gauze to right gluteal every day shift, 8/14/25 through 9/10/25 - Normal saline wash pat dry apply gauze impregnated with 1/4 strength Dakins, cover with gauze island dressing left buttock every day shift. 8/14/25- 9/8/25. Review of Resident #2's medical record, dated 8/14/25 to 9/10/25 failed to indicate that the wound care instructions from 8/14/25 had been acknowledged and transcribed appropriately to indicate treatment to be completed twice a day. Review of Resident #2's progress notes indicated the following: -8/26/25; Dressing done to buttocks wound right buttock foul smelling 100% slough, left buttock red scant serous drainage. Patient left facility to go to hospital wound appointment at 1 pm via ambulance, meds (sic) given prior to leaving. -9/7/25; patient alert and oriented compliant with care able to make needs known, no distress noted, no c/o GI upset, no n/v/d, good appetite, no s/s of hypo/hyperglycemia. No c/o urinary sx, prn dilaudid administered once in the morning for c/o breakthrough pain to ble (bilateral lower extremity) with effect. R buttock wound is stable no s/s of infection, wound bed pink with small amount of slough, mod amount of ss drainage, no odor. L buttock wound unchanged, 100% slough to wound bed, small amount of ss drainage, surrounding skin intact, faint odor, no s/s of infection afebrile. Air mattress in place and functioning, BP elevated prior to meds, received meds as ordered, no s/s of active bleeding, BLE dsg intact, pt prefers to stay in bed will continue to monitor. [sic] -9/11/25; Treatment done to left ischium 100% slough foul smelling area cleansed with normal saline with small amount of frank red blood return after cleansing, measurements 3-centimeter (cm) x 3.5cm x 3cm peri-wound 100% granulation. Right ischium measures 3cm x1cm x0cm, 75% granulation with 25% slough surrounding tissue 100% granulation. Patient tolerated treatment well, denies pain. (Hospital) wound clinic appointment 9/18/25 for follow up scheduled. [sic] During an interview on 9/11/25 at 8:46 A.M., Nurse #4 said Resident #2's wounds to the buttocks are scheduled to be changed once daily. She said when the residents return from any medical appointment the nurses are responsible for any recommendations provided then would notify the nurse practitioner and transcribe them as orders. Nurse #4 said Resident #2's recommendations were (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not acknowledged as the treatment orders had not changed. During an interview on 9/11/25 at 8:53 A.M., Unit Manager (UM) #1 said the nurses are responsible for acknowledging any recommendations. She said the nurse practitioner is then made aware and the recommendations would be documented as the orders. UM #1 said Resident #2's wound clinic recommendations were not acknowledged. During an interview on 9/11/25 at 10:02 A.M., the Director of Nursing said nurses are responsible for acknowledging the recommendations, she said if the wound recommendations are not followed the wounds could get worse. During an interview on 9/11/25 at 12:58 P.M., Nurse Practitioner (NP) #2 said she does not recall being informed of the wound recommendations for Resident #2, she said she never goes against recommendations not unless there is medical contraindication. 2b.) Review of Resident #2's care plan related to pressure ulcer, initiated 8/9/25, indicated the following. -Monitor and document changes in skin status such as appearance, color, wound healing, s/sx of infection, changes in wound size or stage, to physician or designee as clinically indicated. Review of Resident #2's physician orders indicated the following: -7/27/25- Measure wound weekly location right gluteal every day shift every Tuesday. -7/31/25- Measure wound weekly location left gluteal every day shift every Tuesday. Review of Resident #2's medical record indicated the last recorded wound measurements for the left and right buttock were documented on 8/12/25 by the Wound Physician. The wounds measured as follows. -Left lower buttock stage 4 pressure wound measuring 5.8x 3.9x no measurable cm. -Right lower buttock stage 3 pressure wound measuring 4.8x3.2x0.3cm Review of Resident #2's medical record failed to indicate the wounds were measured from 8/12/25 to 9/10/25. Review of Resident #2's Treatment Administration Record (TAR) from 8/12/25 to 9/10/25 failed to indicate wound measurements were documented. During an interview on 9/11/25 at 8:46 A.M., Nurse #4 said wound measurements should be documented weekly according to the physician orders. She said staff were used to the Wound Physician measuring the wounds but since the resident started going to an outside clinic staff should have been measuring the wounds. During an interview on 9/11/25 at 8:53 A.M., Unit Manager (UM) #1 said the treatment nurse should document the wound measurements weekly on the TAR as it is a physician order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/25 at 10:02 A.M., the Director of Nursing said nurses are responsible for measuring the wounds and documenting in the TAR, especially since Resident #2 was not being followed by the in house Wound physician and that physician orders should be followed. 4.) Resident #23 was admitted to the facility in September 2025 with diagnoses including diabetes, spinal cord abscess, and left heel pressure ulcer. &nb

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for three Residents (#2,#34 and #93) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 28 residents. Specifically, the facility failed to ensure the ordered fluid restriction amounts in milliliter were tallied and documented every shift. Findings include: Review of the facility policy titled ?Encouraging and Restricting Fluids', October 2010, indicated the following but not limited to:-Verify that there is a physician's order for this procedure.-The following information should be documented in the resident's medical record; the amount in (ML) milliliter of fluids consumed by the resident during the shift.-If the resident refused the treatment, the reason (s) why and the intervention taken. 1.) Resident #2 was admitted to the facility in July 2025 with diagnoses including end stage renal disease and dependance on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/31/25, indicated Resident #2 scored a 15 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) score indicating intact cognition. The MDS further indicated Resident #2 was dependent on renal dialysis. Review of Resident #2's physician order, dated 7/29/25, indicated the following:-1800 ML fluid restriction: Nursing total 360 ml; 120ml days, 120ml evening, 120ml nights. Dietary total 1440ml; 720ml breakfast, 360ml lunch, 360ml dinner every shift for nutrition. Review of Resident #2's plan of care for dialysis, date initiated 7/25/25, indicated the following:-Maintain fluid restriction as ordered. Review of Resident #2's Treatment Administration Record (TAR) from 7/29/25 to 9/10/25 failed to indicate the total amount of fluids in ML the Resident consumed per shift. During an interview on 9/10/25 at 11:54 A.M., Nurse #3 said fluid restriction should be followed as ordered, nurses are responsible for documenting the amount the residents have consumed per shift and that 11-7 shift nurse would total the entire amount consumed per day. Nurse #3 said if a resident on fluid restriction consumes excessive amounts over their restriction, it could lead to medical complications especially being on dialysis like Resident #2. During an interview on 9/10/25 at 12:11 P.M., Unit Manager #1 said nurses are responsible for documenting the amounts in milliliter consumed by the residents every shift. She further said 11-7 nurses would tally up the total amount consumed in 24 hours. If there is any discrepancy the nurse practitioner is made aware. During an interview on 9/11/25 at 10:25 A.M., the Director of Nursing said the fluid restriction orders are broken down by the amounts and nurses are responsible for documenting the consumed amounts every shift. She further said monitoring fluid restrictions would prevent residents from developing complications such as fluid volume overload. 2.) Resident #34 was admitted to facility in August 2024 with diagnoses including end stage renal disease dependent on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/7/25, indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) score indicating intact cognition. The MDS further indicated that the Resident was dependent on renal dialysis. On 9/9/25 at 12:28 P.M., the surveyor observed Resident #34 having lunch. On his/her tray were the following fluids: milk, cranberry juice and coffee. Resident #34's meal slip did not indicate fluid restriction status. Resident #34 said he was not aware that he/she was on fluid restrictions. Review of Resident #34's physician order, dated 5/16/25, indicated the following:-1800 ML fluid restriction: Nursing total 360 ml; 120ml days, 120ml evening, 120ml nights. Dietary total 1440ml; 720ml breakfast, 360ml lunch, 360ml dinner every shift for nutrition. Review of Resident #34's plan of care for dialysis, date initiated 8/26/25, indicated the following intervention.-Maintain fluid restriction as ordered. Review of Resident #34's Medication Administration Record (MAR) from 5/16/25 to 9/10/25 failed to indicate the total amount of fluids in ML the Resident consumed per shift. During an interview on 9/10/25 at 11:44 A.M., Certified Nursing Assistant (CNA) #2 said he was not aware of any residents on the unit who were on fluid restriction. He said if a resident was on fluid restriction it would be indicated on their meal ticket. During an (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 9/10/25 at 11:47 A.M., Nurse #2 said Resident #34 was on dialysis and on fluid restrictions. She said the amount of fluids consumed by the resident should be documented in milliliters (ML) in the medication administration record to monitor resident for fluid overload. During an interview on 9/10/25 at 12:11 P.M., Unit Manager #1 said nurses are responsible for documenting the amounts in milliliters consumed by the residents every shift. She further said 11-7 nurses would tally up the total amount consumed in 24 hours. If there is any discrepancy the nurse practitioner is made aware. During an interview on 9/11/25 at 10:25 A.M., the Director of Nursing said the fluid restriction orders are broken down by the amounts and nurses are responsible for documenting the consumed amounts every shift. She further said monitoring fluid restrictions would prevent residents from developing complications such as fluid volume overload. 3.) Resident #93 was admitted to the facility in July 2025 with diagnoses including end stage renal disease, dependence on renal dialysis and acute on chronic diastolic congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the Resident scored a 3 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) score indicating severe impaired cognition. The MDS further indicated the Resident was dependent on dialysis. On 9/9/25 at 8:54 A.M., the surveyor observed Resident #93 eating breakfast. On the Resident's tray were the following fluids, milk, juice and coffee. Review of Resident #93's physician order dated 8/22/25, indicated the following:-2000 ML fluid restriction: Nursing total 320ML; 120ML days, 120ML evenings, 80ML nights. Dietary total 1680ML; 720ML breakfast, 480ML lunch, 480ML dinner every shift for nutrition. Review of Resident #93's plan of care for dialysis, date initiated 7/3/25, indicated the following intervention.-Maintain fluid restriction as ordered. Review of Resident #93's Medication Administration Record (MAR) from 8/22/25 to 9/10/25 failed to indicate the total amount of fluids in MLs the Resident consumed per shift. During an interview on 9/10/25 at 12:11 P.M., Unit Manager #1 said nurses are responsible for documenting the amounts in milliliters consumed by the residents every shift. She further said 11-7 nurses would tally up the total amount consumed in 24 hours. If there is any discrepancy the nurse practitioner is made aware. During an interview on 9/11/25 at 10:25 A.M., the Director of Nursing said the fluid restriction orders are broken down by the amounts and nurses are responsible for documenting the consumed amounts every shift. She further said monitoring fluid restrictions would prevent residents from developing complications such as fluid volume overload.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, test trays, and interviews, the facility failed to a.) provide the residents of the facility palatable food on 2 out of 3 units and b.) serve the residents in the facility that are on a pureed diet what was listed on the menu. Findings include:Review of the facility policy titled Food Temperature & Batch Cooking, undated, indicated the following:-Food should be served at proper temperature to ensure food safety and palatability. Batch cooking is encouraged to cook foods in smaller batches and serve immediately to maintain temperature, quality and safety.4. Acceptable serving temperatures are:Item: Minimum: Maximum: Potatoes, pasta, rice: >/=140 but preferably 160-175 degreesVegetables: >/=140 but preferably 160-175 degreesPureed foods, hot: >/=140 but preferably 160-175 degrees Pureed meals were observed on 9/9/25 and 9/10/25 on the Concord Unit. The meals consisted of 3 mounds of unrecognizable food, did not include gravy on the meat and looked unappetizing. Resident council meeting was held on 9/10/25 at 10:31 A.M. During the meeting several residents complained that the hot food served at the facility was cold at times. A test tray of the puree meal was conducted on the Concord Unit on 9/10/2025 at 12:21 P.M. with the following results:-Potatoes with gravy: 112 degrees Fahrenheit, tasted warm not hot. -Pureed meat with gravy: 102 degrees Fahrenheit, tasted lukewarm not hot. The meat was not flavorful, and the surveyor was unable to determine the type of meat it was. -Green vegetable: 98 degrees Fahrenheit, tasted warm not hot. A test tray was conducted on the [NAME] Unit On 9/10/2025 at 12:33 P.M., with the following results:-Eggplant parmesan: 130 degrees Fahrenheit, tasted warm not hot. -Spaghetti: 140 degrees Fahrenheit, tasted warm not hot. -Salad: 70 degrees Fahrenheit, not crispy and not served with dressing. Review of the facility menu indicated the lunch meal on 9/9/25 was pork with potatoes and green peas. During an interview on 9/10/2025 at 1:20 P.M., the Food Service Director (FSD) was informed of the temperatures of the test trays and said the hot food should have been warmer and the cold food colder. The FSD said the main lunch item today was eggplant, however the residents in the facility on a pureed diet received the same lunch left over from yesterday because eggplant doesn't look good pureed. The FSD said residents should not be getting the same meal two days in a row and he did not consult with the Registered Dietitian regarding the menu change. During an interview on 9/10/2025 at 1:33 P.M., the Administrator said the facility does not do test trays to ensure palatability meets the facility expectation. The Administrator said he expects the food served to be at the appropriate temperature and a hot meal should taste hot and a cold meal taste cold. He also said he expects that the meals served is what is on the menu and if the kitchen deviates from the menu that the Registered Dietitian be notified and involved.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure a dignified dining experience for three Residents (#109, #16 and #45) out of a total sample of 28 residents. Specifically,1. For Resident #109, the facility failed to provide assistance with eating, and the Resident resorted to eating non-fingerlike food with his/her hands for four entire meals. 2. For Resident #16, the facility failed to be seated at eye level while feeding the Resident. 3. For Resident #45, the facility failed to provide incontinence care prior to being served and was assisted with his/her meal while lying on top of soiled incontinence pads and with the odor of urine and feces present. Findings include: Review of the facility policy titled Dignity, dated as revised February 2021, indicated: 1.) Residents are treated with dignity and respect at all times. 5.) When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience. 1.) Resident #109 was admitted to the facility in December 2023 with diagnoses including Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/26/25, indicated Resident #109 scored 2 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severely impaired cognition. The MDS further indicated Resident #109 had no behavior of refusing care. Review of the active Physician orders, included the following order with a start date of 12/13/23: -Heart Healthy diet/Regular texture, Regular/Thin consistency, for Dietary supplement allow finger foods. Review of Resident #109's activity of daily living care plan includes the following interventions: -Monitor for any changes in ADL ability, potential for improvement, and/or inability to perform ADLs. Caregiver to report changes to Nurse/Physician and document changes in Nurses Notes. (4/1/25) -Encourage me to participate in ADLs to the fullest extent possible. (4/1/25). -EATING: I require supervision with eating and drinking. (6/27/25) Review of Resident #109's behavior care plan indicated the following: I have a behavior problem Potential concern r/t (related to) behavior problem Resists Care r/t dementia, he/she can hit, kick, spitting at other residents or staff, throwing food at others, trying to lift tables, and curse with care at times. On 9/09/2025 at 8:46 A.M., Resident #109 was observed in the unit dining room for breakfast. Resident #109 was eating scrambled eggs and waffles covered with syrup with his/her hands. There (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were 3 staff present in the room, however Resident #109 was not being provided with assistance or cueing. The surveyor continued to make the following observations: -At 8:56 A.M., Resident #109 had consumed all of the food using his/her, was then rubbing his/her fingers through syrup on the plate and licking them. Staff had not assisted or cued the Resident at any point during the observation period. On 9/09/2025 at 12:16 P.M., Resident #109 was observed in the unit dining room for lunch. Resident #109 picked up a handful of diced potatoes with his/her hands and pushed them in his/her mouth. There was a Certified Nursing Assistant (CNA) standing behind a resident that was seated beside Resident #109, however the CNA did not offer assistance or cueing to Resident #109 to use a utensil. The surveyor continued to make the following observations: -At 12:18 P.M., Resident #109 picked up a handful of peas with his/her hands and pushed them in his/her mouth. The CNA was still present, however did not offer assistance or cueing to use a utensil. On 9/10/2025 at 8:13 A.M., Resident #109 was observed in the unit dining room for breakfast. A CNA placed breakfast in front of Resident #109, which included an English muffin and scrambled eggs, placed a fork on the plate beside the eggs and walked away. The surveyor continued to make the following observations: -At 8:15 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. -At 8:16 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. Three staff were at table setting up other residents' meals, however no one intervened or cued the Resident to use a utensil. -At 8:19 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. There were seven staff present in the dining room; however, no assistance or cueing was provided to Resident #109. -By 8:23 A.M., Resident #109 had completed eating his/her entire plate of food by hand. On 9/11/2025 at 8:07 A.M., Resident #109 was observed in the unit dining room for breakfast. A CNA placed breakfast in front of Resident #109, which included toast with jelly and scrambled eggs. A knife was left on plate beside the eggs, but no fork was present. Following placing the meal, the CNA walked away and the surveyor continued to make the following observations: -At 8:08 A.M., Resident #109 picked up a fistful of eggs and pushed them into his/her mouth. There were several staff present in the dining room, including the Assistant Director of Nursing (ADNS), however no assistance or cueing was provided to Resident #109 to use a utensil. -By 8:11 A.M., Resident #109 had finished eating all of the scrambled eggs with his/her hands. No behaviors were noted during any observations throughout the survey period and review of the clinical record failed to indicate Resident #109 refused care assistance with meals. During an interview on 9/11/2025 at 9:32 A.M., CNA #2 said that Resident #109 needs one person assist with care and needs supervision with eating. CNA #2 said that Resident #109 ate his/her entire (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast that morning independently using a fork, contrary to observation by the Surveyor. The surveyor shared the previous day's observations of Resident #109 eating other meals with his/her hands, including waffles with syrup and he said, the thing is we make sure that residents have sanitized hands before breakfast and then they can have the freedom to eat any of the food with their hands. CNA #2 said that he would not intervene and assist if a resident was eating any food with their hands because that is their right, but that utensils should be available. During an interview on 9/11/2025 at 9:41 A.M., the Assistant Director of Nursing (ADON) said that Resident #109 eats in the unit dining room and doesn't necessarily need help but needs a lot of cueing and supervision with meals. The ADON said that Resident #109 doesn't always use utensils and we give him/her more finger foods so he/she can have more independence. The ADON said that it is not a dignified dining experience for a resident to be eating non finger like food with their hands. During an interview on 9/11/2025 at 10:48 A.M., the Director of Nursing said that it is not a dignified dining experience for a resident to be eating non-finger like food with their hands. 2.) Resident #16 was admitted to the facility in January 2025 with diagnoses including Alzheimer's disease and anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/24/25, indicated Resident #16 was assessed by staff to have severely impaired cognition. Review of the active Physician orders for Resident #16, include the following order with a start date of 2/01/25: -Regular diet Mechanical soft texture, regular/thin consistency, give finger food for dietary supplement. Review of the current Activities of Daily Living (ADL) care plan included the following intervention: -EATING: I require supervision with eating and drinking. On 9/09/2025 at 12:15 P.M., Resident #16 was observed seated in the unit dining room for lunch. A Certified Nursing Assistant (CNA) was observed standing behind Resident #16's chair in the dining room. The CNA occasionally leaned over Resident #16's left shoulder to scoop up food with a utensil and feed it to Resident #16. The surveyor continued to make the following observation: -At 12:21 P.M., the CNA sat down in a chair behind Resident #16, leaned over the left side of Resident #16's chair and while petting Resident #16's hair fed him/her a spoonful of food. On 9/10/2025 at 8:17 A.M., Resident #16 was observed seated in the unit dining room for breakfast. A CNA placed a breakfast plate in front of the resident and walked away. The surveyor continued to make the following observations: -At 8:20 A.M., Resident #16 slept at the table and had made no attempt to self-feed. Seven staff were present in the dining room, however none woke the Resident or sat down to offer feeding assistance. -At 8:22 A.M., a CNA stood behind Resident #16's chair, shook his/her shoulder while saying wake up its time to eat, then walked away without sitting down to offer assistance. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:44 A.M., a CNA stood behind Resident #16, put a spoon in his/her hand and put the spoon into the oatmeal then walked away. Resident let go of the spoon, closed his/her and made no attempt to self-feed. During an interview on 9/11/25 at 8:58 A.M., CNA #7 said that Resident #16 requires assist with meal and that staff should be seated if able when feeding resident but sometimes there is furniture or other residents in the way and then it is okay to stand. During an interview on 9/11/2025 at 9:00 A.M., CNA #6 said that it is the expectation that staff be seated at eye level when feeding residents. During an interview on 9/11/2025 at 9:56 A.M., the Assistant Director of Nursing (ADON) she said that staff should be seated at eye level when feeding residents. She said that the hospice CNA often stands while feeding despite education. She said that the CNA working today is new and probably needs more education because it is not okay to stand while feeding. During an interview on 9/11/2025 at 10:45 A.M., the Director of Nursing (DON) said staff should be seated at eye level while providing assistance with feeding. The DON further said that if the ADON is aware that the hospice CNA has been educated repeatedly and continues to stand while feeding, the education is not effective and that the facility CNAs need education. 3.) Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. On 9/9/25 at approximately 8:15 A.M., the surveyor observed a strong odor of urine and feces in the corridor outside of Resident #45's room. At 8:19 A.M., the surveyor entered Resident #45's room and the odor was stronger, and the Resident was observed lying on three incontinence pads. The Resident was unable to participate in an interview with the surveyor. Resident #45's health care proxy was unable to be contacted during survey due to being hospitalized . On 9/9/25 at 8:48 A.M., the surveyor continued to observe the odor in Resident #45's room as a Certified Nursing Assistant (CNA) entered the room to bring the Resident his/her breakfast. The CNA did not attempt to remove the soiled incontinence pads from under Resident #45 and the CNA was not observed providing any incontinence care to the Resident. The CNA then began to feed the Resident with the strong odor of urine and feces still present. On 9/9/2025 at 9:26 A.M., CNA #1 was observed entering Resident #45's room to provide incontinence care. At 9:36 A.M., the surveyor observed the three incontinence pads that had been removed from under Resident #45. All three pads were significantly soiled with urine and feces. During an interview on 9/9/2025 at 9:36 A.M., CNA #1 said Resident #45 is incontinent of bowel and bladder. CNA #1 said all residents should be checked for incontinence every two hours and provide care as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/2025 at 10:22 A.M., the Director of Nursing said that eating a meal while soiled with urine and feces is not dignified and care should have been provided to Resident #45 before the staff started assisting him/her with his/her breakfast.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to notify the physician of a significant change in the Resident's skin condition for two Residents (#45 and #17) out of a total sample of 28 residents. Specifically:1.) For Resident #45, the facility failed to notify the provider of a new skin breakdown on the buttocks. 2.) For Resident #17, the facility failed to notify the provider of a change in wound condition and obtain wound care orders when his/her left heel pressure related deep tissue injury (DTI) opened and had new drainage.Findings include: 1.) Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinent care. Review of Resident #45's initial wound evaluation and management summary, dated 8/26/25, indicated the Resident had the following skin impairments on admission: -Stage 3 pressure wound to the coccyx, -DTI (deep tissue injury) to the left lateral foot, -DTI to the left lateral fifth toe, -DTI to the left medial foot, and -DTI to the left medial first toe. Review of the 9/9/25 nursing note indicated the following: -Pt (patient) with new skin failure wound to L (left) buttock noted by wound MD (medical doctor) while doing wound rounds, wound measures 2.6x2x- (centimeters), new order for Triad (wound treatment) daily. Review of the wound visit notes dated 9/9/25 indicated Resident #45 had a new skin impairment to the left buttocks measuring 2.6x 2xnot measurable cm (centimeters) with the etiology of end-stage skin failure. Review of the full electronic medical record failed to indicate the facility notified the nurse practitioner or physician of the new skin impairment on Resident #45's buttock. During an interview on 9/11/2025 at 9:04 A.M., Nurse #1 said all new skin impairments must be reported to the physician or nurse practitioner. Nurse #1 said she works at the facility as a per diem nurse and was not aware if the nurse practitioner or physician were notified of Resident #45's new skin impairment to the buttocks. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 9/11/25 at 9:20 A.M., and 2:02 P.M., Unit Manager #1 said the physicians and/or nurse practitioners need to be notified of any new skin impairments as it is a change in status for a resident. Unit Manager #1 said Resident #45 has fragile skin and had a recent new skin impairment discovered by the facility on 9/9/25 and she did not notify the physician of the Resident's change in status. During an interview on 9/11/2025 at 10:22 A.M., the Director of Nursing said the development of a new skin impairment would be considered a change of status and she would expect the nursing staff to notify the physician or nurse practitioner of this change. The Director of Nursing said she was unaware if the nursing staff had notified the physician or nurse practitioner and that if they had notified the medical team there would be a nursing note indicating this. During an interview on 9/11/2025 at 12:57 P.M., Nurse Practitioner #2 said she was never notified of the new skin impairment to Resident #45's buttock. Nurse Practitioner #2 said she would have expected the facility to notify her of such a change in status. Nurse Practitioner #2 said she was unaware if the Physician was notified as she was in the facility on 9/9/25. During a follow-up interview on 9/11/2025 at 1:49 P.M., Nurse Practitioner #2 said she had spoken to the Physician who said she was not notified of the change of status to Resident #45's skin. 2.) Resident #17 was admitted to the facility in March 2024 with diagnoses including failure to thrive and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/28/25, indicated Resident #17 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This MDS also indicated Resident #17 had one unstageable pressure injury presenting as deep tissue injury. On 9/10/25 at 7:39 A.M., the surveyor observed Resident #17 in bed with his/her left heel offloaded in a pressure reducing boot. Resident #17 said he/she has a wound on his/her left heel that was caused from his/her mattress. Review of Resident #17's nursing progress notes indicated the following written by Unit Manager #2: -8/4/25: CNA (certified nurse assistant) reported new area to left heel. 2x2 (centimeters) DTI (deep tissue injury) on left heel dry, eschar. -8/5/25: Hospice recommendation: if heel intact, paint with betadine (a topical antiseptic containing iodine). If the area opens, apply calcium alginate (a highly absorbent type of wound treatment) and cover with DPD (dry protective dressing). Review of Resident #17's active physician order, initiated 8/8/25, indicated: -Paint left heel with betadine swab. Review of Resident #17's hospice routine visit progress note, dated 8/11/25, indicated: -Only open area on left heel. Wound not open at present, but looks like it could open so POC (plan of care) updated if that occurs. Family and facility agree with POC. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #17's hospice wound recommendation, dated 8/11/25, indicated: -Wound recs (recommendations): Left heel paint with iodine to dry eschar, cover with ABD (abdominal pad, a type of dressing), secure with sock every day. If it opens and drainage starts: clean with cleanser, cut to fit alginate, ABD pad, wrap, change 2-3 times per week. Review of Resident #17's Treatment Administration Record (TAR), dated 8/17/25 to 8/25/25, indicated a new order to document answer to question Is there drainage present? from left heel wound, initiated 8/17/25. This TAR indicated the nurses documented yes there was drainage on 9 out of the 9 days from 8/17/25 to 9/11/25. The physician's order to Paint left heel with betadine swab remained in place during this time and failed to indicate any additional physician's orders for any other types of wound dressing. Review of Resident #17's hospice routine visit progress note, dated 8/25/25, indicated: -Heal [sic] is open and advised to use alginate on open area. Wound no changes except drainage small amt (amount) s/s (serosanguineous, a type of wound drainage). Son updated. Family and facility agree with POC. Review of Resident #17's medical record, dated 8/25/25 to 9/11/25, failed to indicate the wound recommendation to use alginate on open wound was addressed or implemented. Review of Resident #17's Treatment Administration Record (TAR), dated 8/26/25 to 9/11/25, indicated the physician's order to answer the question Is there drainage present? from left heel wound, initiated 8/17/25 had nurses documented yes there was drainage on 13 out of the 15 days from 8/17/25 to 9/11/25. The physician's order to Paint left heel with betadine swab remained in place during this time and failed to indicate any additional physician's orders for any other types of wound dressing. On 9/10/25 at 12:09 P.M., the surveyor observed Nurse #7 perform wound care for Resident #17's left heel pressure wound. The surveyor observed a red, open wound approximately the size of a quarter. Nurse #7 said this was an open wound with red granulation tissue in the wound bed. Nurse #7 said there was no dressing in place and that there is no physician's order to apply any dressings. Nurse #7 applied betadine to the wound bed and said this was the only wound treatment ordered to be completed. During an interview on 9/10/25 at 12:48 P.M., Unit Manager #2 said the hospice wound nurse follows Resident #17's left heel wound, and the hospice wound nurse gives wound treatment recommendations to the Hospice Nurse Practitioner (NP), who would notify them of any necessary orders. Unit Manager #2 said if wound had drainage, then it must be an open wound. Unit Manager #2 said the left heel wound has had a small opening with drainage for quite some time, but since it's only a small opening hospice wishes to continue betadine only without any dressing. Unit Manager #2 said she never notified the facility physician of any wound treatment recommendations for calcium alginate or any other type of dressing. During a telephone interview on 9/11/25 at 9:03 A.M., the Hospice Wound Nurse said she had made the recommendation for calcium alginate when the wound opened, but it's the facilities responsibility to notify the facility NP to approve any of the recommendations for wound treatments. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/11/25 at 10:09 A.M., the facility Nurse Practitioner (NP) #1 said his first day working for the facility was 8/25/25. NP #1 said Resident #7 had an intact DTI and would expect the facility to notify him to approve all hospice wound treatment recommendations. NP #1 was unaware that Resident #17's left heel DTI had opened and had drainage. NP #1 said the facility never notified him of this change but should have. NP #1 said the facility never addressed the hospice recommendation for calcium alginate but would have approved it if he had been notified. NP #1 said any open wound should have a dressing in place to protect from infection and Resident #17 should have had a dressing ordered for his/her open left heel wound. During an interview on 9/11/25 at 10:45 A.M., the Director of Nursing (DON) said hospice wound treatment recommendations should be reviewed with the facility NP #1. The DON said if NP #1 did not approve the recommendations, then it should be documented somewhere in the medical record. The DON said the wound treatment recommendation for calcium alginate should have been addressed but was not. The DON further said if a wound has drainage, then it should have a dressing on it. The DON said if there was no physician's order for a dressing, the nurse should have notified the provider that it required one but did not. REFER TO F686.

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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. Based on observation, record review and interview the facility failed to ensure care was provided in accordance with professional standards of practice for one Resident (#25) out of a total sample of 28 residents. Specifically, for Resident #25 the facility failed to identify a skin area on weekly skin checks and failed to obtain a physician's treatment order for the area. Findings include:Resident #25 was admitted to the facility in November 2023 with diagnoses including Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/27/25, indicated that on the Brief Interview for Mental Status exam Resident #25 scored a 5 out of a possible 15, indicating severely impaired cognition. The MDS failed to indicate any areas on his/her skin. Review of Resident #25's care plan indicates an Activity of Daily Living (ADL) care plan that indicates the following interventions:-Provide skin inspections daily during care. Observe for redness, open areas scratches, cuts, bruises etc. Report abnormal findings to Physician and document in Nurse's notes, start date 3/27/25.-PERSONAL HYGIENE: I am dependent on staff for grooming/personal hygiene, start date 3/27/25. The care plan failed to indicate any skin lesions or areas on Resident #25's nose. Review of the most recent Skin assessment, dated 9/8/25, failed to indicate any skin impairments or lesions on Resident #25's nose. Review of the active Physician's orders, indicated an order with a start date of 6/18/25, for weekly skin checks. The orders failed to indicate a treatment order for the area on Resident #25 nose. Review of the September 2025 Treatment Administration Record (TAR) failed to indicate a treatment order for the area on Resident #25 nose. Review of September 2025 clinical progress notes failed to indicate Resident #25 had an area/lesion on his/her nose or that the Physician was notified of any skin changes. On 9/09/2025 at 8:32 A.M., Resident #25 was observed seated in unit dining room waiting for breakfast. Resident #25 had a red and raised area on his/her nose that appeared approximately 1/5 inch in size with a dried dark red substance on it. On 9/09/2025 at 9:08 A.M., Resident #25 approached the nurse's station and spoke to the Assistant Director of Nursing (ADON). When the ADON turned away, Resident #25 said to the surveyor that the area on his/her nose used to be cancer, and they took care of it but that he/she thinks it is coming back. During a follow-up interview with Resident #25 on 9/12/2025 at 8:17 A.M., the area on Resident #25's nose remained clearly visible. Resident #25 said that it is now really sore and that he/she is sure that the cancer is back but that no one has looked at it or put anything on it. Resident #25 asked the surveyor if help could be obtained to get someone to look at it. During an interview with Resident #25's Certified Nursing Assistant (CNA) #5 on 9/12/2025 at 8:23 A.M., she said that Resident #25 needs assistance with care. CNA #5 said that Resident #25 has a cut on his/her nose that he/she scratches, that he/she has had it for about a week and that she reported it to the Nurse on 9/9/25. During an interview with Resident #25's Nurse #6 on 9/12/2025 at 8:26 A.M., she said that she noticed the area on Resident #25's nose on 9/8/25. Nurse #6 reviewed the record and said that Resident #25 does not have a treatment order for the area on his/her nose and that she had not notified the Physician (MD) or Nurse Practitioner (NP) when she observed it on 9/8/25. She said that the reason the MD/NP would be notified is so that they can give an order for how to treat the area. Nurse #6 said that the area should have been documented on the 9/8/25 skin assessment but had not. During an interview with the Director of Nursing (DON) on 9/12/2025 8:34 A.M., she said that she is aware of the area on Resident #25's nose because it is visible, that it has been there for some time and that Resident #25 often picks at it. The DON said that the area should have been noted on the weekly skin assessments and that the MD/NP should have been notified about the area to determine if they wanted to give a treatment order for it. As well, she said that the family should have been notified by the facility staff when the area was first observed. The DON was not aware that Resident #25 reports a history of skin cancer and said the facility should follow-up with the family. During an interview with Resident #25's daughter on 9/12/2025 at 10:24 A.M., she said that Resident #25 had had the area on his/her nose for about a year but that the facility has never mentioned it to her. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Daughter said that the ADON called her a short while ago and that she reported to the ADON that Resident #25 has had cancer 2-3 times including on his/her nose and one time requiring chemo and radiation.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one Resident (#109) out of a total sample of 28 residents maintained an acceptable parameter of nutritional status. Specifically, the facility failed to implement weekly weights as ordered by a physician for a Resident who was at risk for, and had experienced, clinically significant weight gain. Findings include:Review of the facility policy titled Weight Assessment and Intervention, revised March 2022, indicated, but was not limited to, the following:-Resident weights are monitored for undesirable or unintended weight loss or gain.-Residents are weighed upon admission and at intervals established by the interdisciplinary team.-Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation.-The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/(usual weight) x 100]:-A. 1 month - 5% weight loss is significant; greater than 5% is severe.-B. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe.-C. 6 months - 10% weight loss is significant; greater than 10% is severe.-If the weight change is desirable, this is documented. Resident #109 was admitted to the facility in December 2023 with a diagnosis of hyperlipidemia and morbid (severe) obesity due to excess calories. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #109 scored 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #109's nutrition care plan indicated the Resident had a nutritional problem or potential nutritional problem related to dietary restriction with history of hyperlipidemia and risk for further weight gain with the following interventions:-Obtain weights at ordered intervals. Review of Resident #109's active physician orders indicated the following order:-Weights weekly, initiated 6/18/25. Review of Resident #109's weights/vitals report indicated the following recorded weights:-5/7/25 - 167.9 Lbs. (pounds)-5/15/25 - 168.7 Lbs.-6/4/25 - 171.8 Lbs.-6/25/25 - 170.0 Lbs.-7/2/25 - 173.4 Lbs.-8/1/25 - 182.0 Lbs.-9/2/25 - 186.9 Lbs. Further review of Resident #109's weights indicated that Resident #109 had experienced a clinically significant weight gain of 8.4% of total body weight in three months (from 5/7/25 to 8/1/25). Review of the Resident's weights also failed to indicate that weights were obtained weekly or that a reweight was taken until a month later, which indicating continued weight gain, to confirm the significant weight gain initially recorded on 8/1/25. Review of Resident #109's medical record failed to indicate that the Resident had refused to be weighed. Review of the Registered Dietitian (RD) Assessment, dated 6/21/25, indicated that Resident #109 had a BMI (body mass index) of 33.5 (categorically obese) and that it was appropriate to continue on a heart healthy diet to avoid weight gain. Review of the RD progress note, dated 9/11/25, indicated that Resident #109 had experienced a significant and unplanned weight gain. The RD note indicated the RD discussed the Resident's weight gain with the Nurse Practitioner (NP) and that it was decided to continue with weekly weights. The RD note indicated that a psychiatric evaluation was in place to review the Residents' medication as this may contribute to weight gain and that nursing was educated to provide healthy snacks in between meals. Review of the NP progress note, dated 9/11/25, indicated a recommendation to monitor Resident #109's weekly weights closely, check appropriate labs and that the Resident could benefit from a psychiatric evaluation. During an interview on 9/11/25 at 10:45 A.M., Certified Nursing Assistant (CNA) #4 said that residents are weighed monthly, but a nurse will tell them if a resident needs to be weighed on a weekly basis. CNA #4 said that Resident #109 had been weighed monthly, not weekly. The CNA and RD reviewed the assignment sheets and weight logs on the unit and confirmed that Resident #109 had been getting weighed monthly, not weekly. During an interview on 9/11/25 at 9:12 A.M., Nurse #5 said nurses and CNA's weigh all residents at the beginning of each month and that if there was a weight discrepancy that the staff would reweigh the resident. Nurse #5 said he would expect nurses to enter resident weights into (continued on next page)

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	09/12/2025

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the electronic medical record. Nurse #5 said Resident #109 had gained weight and that he would expect the Resident to be weighed weekly if there was a physician order for it. During interviews on 9/11/25 at 9:25 A.M. and 10:25 A.M., the RD said that she checks the weekly weight report for any weight changes and that she would expect that a resident with a significant weight change to be reweighed immediately. The RD said that she would expect a resident to be weighed weekly if the Resident had an order for weekly weights and that if the Resident refused to have his/her weight taken that this would be documented. The RD said weekly weights should have been taken for Resident #109, as the Resident was at risk for weight gain, but were not. The RD said the Resident should remain on weekly weights to monitor the Residents weight gain. During an interview on 9/11/25 at 10:04 A.M., Physician #2 said Resident #109 had gained weight. Physician #2 said he would expect an order for weekly weights to be followed and that all physician orders should be either followed, discontinued or modified. During an interview on 9/11/25 at 11:24 A.M., the Director of Nursing (DON) said that an order for weekly weights should be followed, and if the order was not necessary that the order should have been modified; the DON said that if a resident refused resident weights that this would be documented.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of staff employee files and interviews, the facility failed to ensure incontinence care was provided to one Resident (#45) by licensed staff out of a total sample of 28 residents. Findings include: Resident #45 was admitted to the facility in [DATE] with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. On [DATE] at 9:36 A.M., the surveyor observed two staff providing incontinence care to Resident #45. One staff member was wearing scrubs while the other was dressed in business casual attire. The surveyor asked the staff member not wearing scrubs what her role was in the facility. She said she was the admissions director and also a Certified Nursing Assistant (CNA). The surveyor requested to see the admission Director's employee file with a current CNA license. During an interview on [DATE] at 9:00 A.M., the Administrator said that the admissions director was not licensed as a certified nursing assistant. He further said she should not have been providing direct care to the residents. During an interview on [DATE] at 9:08 A.M., the admission Director said that she was licensed as a certified nursing assistant (CNA), but her license expired in 2022, and she had not renewed it. She said that on the [DATE] when she went by Resident #45's room she saw the resident without clothing and instinctively went in and provided personal care. The admission Director said she does not work as a CNA at the facility and has not received education from the facility regarding providing incontinence care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to complete daily documentation for one Resident (#45) out of a total sample of 25 residents. Findings include: Resident #45 was admitted to the facility in August 2025 with diagnoses of sacrum pressure ulcer, congestive heart failure, stroke and chronic kidney disease. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #45 is incontinent of both bowel and bladder and is dependent on staff for incontinence care. Review of the (activity of daily living) ADL documentation for the month of September 2025 indicated the following missing documentation:-11 out of 31 eating opportunities for documentation were missing.-6 out of 31 bladder care opportunities for documentation were missing.-6 out of 31 bowel care opportunities for documentation were missing.-6 out of 31 personal hygiene opportunities for documentation were missing.-6 out of 31 dressing opportunities for documentation were missing.-6 out of 31 bed mobility opportunities for documentation were missing.-6 out of 31 transfers opportunities for documentation were missing.-6 out of 31 lying to sitting opportunities for documentation were missing.-6 out of 31 toilet transfer opportunities for documentation were missing.-6 out of 31 wheelchair opportunities for documentation were missing.-6 out of 31 walking opportunities for documentation were missing.-5 out of 11 shower/bath opportunities for documentation were missing. During an interview on 9/12/25 at 8:48 A.M., the Staff Educator said expectation is that staff document completely upon providing care or task completion. During an interview on 9/12/25 at 10:40 A.M., the Director of Nursing said documentation is done on point of care (POC) and ideally should be done as soon as possible. The Director of Nursing said there should be no holes in the documents as this would lead to an inaccurate medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews and policy review the facility failed to implement appropriate infection practices. Specifically, a staff did not wear gloves while handling dirty linen. Findings include:Review of facility policy titled 'Personal Protective Equipment-Gloves' dated July 2009, indicated the following but not limited to:-Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non intact skin.-All employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin.-Wash your hands after removing gloves. On 9/9/25 at 9:36 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 open soiled linen with bear hands, the soiled linen consisted of wet used towels, an adult brief with feces and a heavily soiled bed soaker. During an interview on 9/9/25 at 9:36 A.M., CNA #1 said she always wears gloves, and she was not sure why she touched the soiled linen without gloves. During an interview on 9/9/25 at 9:37 A.M., CNA #3 said all staff should wear gloves while providing care and handling soiled linen. During an interview on 9/10/25 at 12:18 P.M., Unit Manager #1 said staff should wear gloves while handling dirty linen as it is for universal precautions for infections. During an interview on 9/11/25 at 10:45 A.M., the Director of Nursing said the expectation is staff would wear gloves while handing dirty linen. During an interview on 9/12/25 at 8:48 A.M., the Staff Educator/ Infection Prevention Nurse said the expectation is that staff wear gloves when handling soiled linen. She further said the expectation is communicated upon hire and with annual competency.