STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225603	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Brook Rehabilitation and Healthcare Center	100 Amity Street Fall River, MA 02721

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for two Residents (#13 and #86), out of a total sample of 27 residents. Specifically, the facility failed:1. For Resident #13, to ensure physician's orders were complete for the management of a continuous glucose monitoring sensor and included orders to remove and change the device every 14 days; and2. For Resident #86, to complete weekly skin check documentation per physician's orders.Findings include:1. Review of the facility's policy titled Freestyle Libre 2 Flash Glucose Monitoring System, June 2023, indicated but was not limited to: -Always obtain physician’s orders for the use of fingerstick blood glucose testing via a facility approved blood glucose meter to guide treatment decisions. -Review the resident’s orders to evaluate special needs of the resident. -Review and follow manufacturer's guidelines for use. Review of [NAME] Freestyle Libre Continuous Glucose Monitoring (CGM- https://www.freestyle.[NAME]/us-en/home.html) guidelines, included but was not limited to: -the Libre CGM is a small sensor-based system that provides real-time glucose readings day and night, without fingerstick; -The sensor lasts up to 14 days, and it is recommended to rotate application site of the sensor between arms. Resident #13 was admitted to the facility in July 2025 with diagnoses including diabetes mellitus, type 2. Review of the Minimum Data Set (MDS) assessment, dated 7/29/25, indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14 out 15 and was receiving insulin. During an interview with observation on 8/25/25 at 10:42 A.M., the surveyor observed a glucometer (device used to measure blood glucose levels) on Resident #13’s nightstand. Resident #13 said the glucometer was used to check his/her blood sugar utilizing their Libre 2 monitor. He/she said their monitor was changed every 14 days and the nurses use it to check his/her blood sugar. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's Physician's Orders indicated but was not limited to: -Insulin Lispro per sliding scale: if 1 - 149 = 0 units; 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 6 units; 400 - 449 = 8 units; 450 - 499 = 10 units; 500 - 1000 = 12, subcutaneously before meals and at bedtime, 7/25/2025 Further review of Resident #13’s Physician's Orders failed to indicate orders for the use of the Libre continuous glucose monitoring device to implement the sliding scale, and orders to remove and reinsert the sensor device every 14 days. During an interview on 8/27/25 at 2:51 P.M., Nurse #1 said Resident #13 had a Libre Blood Glucose Monitor to monitor his/her blood glucose. She said she would check Resident #13's blood glucose either using his/her Libre monitor or via a fingerstick. Nurse #1 said when a resident had a Libre monitor they would need an order to change and apply a new monitor every 14 days, and an order for use of the device to obtain blood glucose levels to implement the insulin sliding scale. Nurse #1 reviewed Resident #13's medical record and said he/she did not have a physician's order to change the device every 14 days or to use the device to check his/her blood glucose. During an interview on 8/28/25 at 9:46 A.M., the Nurse Practitioner (NP) said Resident #13 had a Libre monitor and should have an order to change the monitor every 14 days and to use it to monitor their blood glucose. The NP reviewed Resident #13’s medical record and said he/she did not have an order to change the monitor or to utilize it to monitor their blood glucose levels but should have. During an interview on 8/28/25 at 12:56 P.M., the Director of Nursing (DON) reviewed Resident #13’s orders and said he/she did not have a physician's order to change the device every 14 days and to utilize the Libre to monitor their blood glucose levels but should have. 2. Resident #86 was admitted to the facility in April 2019 with diagnoses which included chronic peripheral venous insufficiency (a condition of impaired blood flow that can cause swelling, pain, and skin changes). Review of Physician’s Orders indicated, but was not limited to, the following: -Dermatological Consult related to bilateral lower extremity (BLE) skin inflammation (7/19/25); -Weekly skin check on Tuesday 7-3 shift (1/16/24). Review of the Resident's current care plan indicated, but was not limited to, the following: -I have impaired skin integrity related to bilateral lower extremity skin condition. I am at risk for skin impairment related to limited mobility, incontinence of bowel/bladder, diabetes. -Administer treatments as ordered and monitor effectiveness. Report abnormal findings to practitioner. Document findings and interventions. -Monitor for new or worsening signs and/or symptoms of complications and infection: necrosis, erythema, warmth, edema, exudate, foul odor, maceration, pain/tenderness, fever/chills, etc. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86’s medical record indicated his/her last weekly skin check was performed six weeks prior on 7/15/25 and indicated no skin issues. Review of the Resident's progress notes indicated an entry on 7/19/25 that stated the NP assessed the Resident for BLE skin buildup and discharge; new orders for labs and aerobic culture of the right lower extremity (RLE); NP prescribed Prednisone 40mg daily for 5 days, Clobetasol topically twice per day for 7 days, and a dermatology consult. During an interview on 8/28/25 at 2:05 P.M., the Director of Nursing (DON) reviewed the Resident’s medical record and said there was missing documentation of weekly skin checks. The DON said although the Resident’s legs were open to air and observed by staff during routine care, weekly skin checks should be documented in the electronic health record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure one Resident (#46), out of 27 sampled residents, and one Resident (#159), out of three closed records, received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices to achieve their highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed:1. For Resident #46, to ensure the Wound Physician's recommendations were addressed and implemented timely for a skin tear; and2. For Resident #159, to: a. Accurately transcribe the physician's order to send Resident #159 to the emergency room for evaluation, resulting in a minimum of a nine-hour delay (6/30/25 5:00 P.M. to 7/1/25 2:00 A.M.) in transferring the Resident to the hospital, and b. Report abnormal urinalysis results to the Physician in a timely manner. Findings include:1. Review of the facility's policy titled Consultant Physician Services, dated as adopted 2/2023, indicated but was not limited to the following: -Consultant physician services are available to the residents as ordered by their attending physician or physician designee. -After completion of the consult, the consultant physician will provide the facility with a consultation report which shall include any orders, recommendations, or follow up actions. -The resident’s attending physician should be informed of the recommendations, treatments, diagnostics, and medications ordered by the consultant. -Orders from the consultant physician will be entered in the resident’s medical record. Review of the facility's contract with the Wound Physician, dated 3/12/25 effective 4/1/25, indicated but was not limited to the following: -Facility Responsibilities: The facility agrees to support delivery of wound care services and commits to inform the resident’s primary care provider of the provider’s recommendations within 24 hours. Resident #46 was admitted to the facility in May 2025 with diagnoses which included a displaced left femur fracture, diabetes mellitus, history of falls, and abnormal gait/mobility. Review of the Minimum Data Set (MDS) Assessment, dated 8/27/25, indicated Resident #46 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. Additionally, he/she had a skin tear. Review of the medical record including nursing progress notes indicated he/she sustained the skin tear on 6/9/25 and a dressing was applied. Review of the Initial Wound Evaluation and Management Summary, dated 6/19/25, indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Site 1: Skin Tear of the Right Skin (full thickness), measuring 5 x 5 centimeters (cm), depth unmeasurable due to tissue overgrowth. Recommended treatment Silver sulfadiazine (topical antibiotic cream) followed by a bordered gauze dressing twice daily. Review of the Physician's Orders indicated but were not limited to the following: -Cleanse skin tear to right shin with normal saline (NS), pat dry, apply xeroform (mesh gauze occlusive dressing), followed by an ABD pad and kerlix (gauze roll) every three days for wound care (6/17/25) Review of the physician's orders failed to indicate the wound care recommendation from 6/19/25 was implemented. Review of the Wound Evaluation and Management Summary, dated 6/26/25, indicated but was not limited to the following: -Site 1: Skin Tear of the Right Skin (full thickness), measuring 5 x 4 cm, depth unmeasurable due to non-viable tissue and necrosis (dead cells or tissue). Recommended treatment Silver sulfadiazine, skin prep (breathable protective film like barrier) followed by a bordered gauze dressing twice daily. Review of the Physician's Orders indicated but were not limited to the following: -Cleanse skin tear to right shin with normal saline (NS), pat dry, apply xeroform, followed by an ABD pad and kerlix every three days for wound care (started 6/17/25 and discontinued 6/27/25) -Skin tear wound of the right shin, cleanse with NS, pat dry, apply silver sulfadiazine, skin prep border, followed by gauze island with border dressing twice daily (6/30/25) The facility failed to implement the recommendation made on 6/19/25 which was repeated on 6/26/25 until 6/30/25 (11 days later). Additionally, the treatment that was in place was discontinued on 6/27/25 and there was no treatment in place from 6/27/25 through 6/30/25. Review of the Wound Evaluation and Management Summary, dated 7/3/25, indicated but was not limited to the following: -Site 1: Skin Tear of the Right Skin (full thickness), measuring 5 x 5 cm, depth unmeasurable due to dry fibrinous exudate (scab). Wound progress: not at goal. Recommended treatment skin prep daily followed by a bordered gauze dressing twice daily. Review of the Physician's Orders indicated but were not limited to the following: -Skin tear wound of the right shin, cleanse with NS, pat dry, apply silver sulfadiazine, skin prep border, followed by gauze island with border dressing twice daily (started 6/30/25 and discontinued 7/8/25). -Skin tear wound of the right shin, cleanse with NS, pat dry, apply skin prep and cover gauze island with border dressing daily (7/9/25) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to implement the recommendation made on 7/3/25 until 7/9/25 (6 days later). Review of the nursing and physician progress notes failed to indicate the provider was notified the next day of the consultant recommendations and did not want the orders changed at that time. During an interview on 8/28/25 at 11:35 A.M., Nurse #3 said the Unit Manager (UM) handles writing all the orders and she has nothing to do with wound rounds; the new orders just appear in the computer. During an interview on 8/28/25 at 1:03 P.M., UM #1 said Resident #46 was on a different unit in June and July, so she could not speak specifically to why those recommendations were not done, however she reviewed the medical record including wound notes, orders, and progress notes and confirmed the orders were not written timely and there were no notes indicating the physician declined the recommendations. During an interview on 8/28/25 at 2:09 P.M., the Director of Nurses (DON) said wound rounds are done on Thursdays and if the recommendations are uploaded early enough, they should be reviewed that day, if not the next day. She said if the UM is off, the expectation is the floor nurses would ensure the orders were written, but there was not a specific person assigned to ensure they were complete. When asked how a floor nurse would know if orders needed to be obtained and written she said, they might have to work on that process. 2. Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, 9324, dated as last revised April 11, 2018, indicated but was not limited to the following:-Licensed nurses accept, verify, transcribe, and implement orders.-Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Resident #159 was admitted to the facility in May 2025 with diagnoses which included: Severe sepsis with septic shock, acute kidney failure, hyponatremia, retention of urine, and generalized edema. Review of the MDS assessment, dated 6/10/25, indicated Resident #159 scored 15 out of 15 on the BIMS, indicating Resident #159 was cognitively intact. Further review of section HO100A indicated he/she had an indwelling catheter. Review of the form titled Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST), dated 5/28/25 and signed by Resident #159 indicated he/she wished to be a full code with further directions to transfer to hospital. a. Review of a Social Service note, dated 7/2/25 at 10:09 A.M., indicated Discharge Note-Resident #159 was sent to the Hospital yesterday and admitted with sepsis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #159’s Nursing Progress notes indicated the following:-6/30/25 at 9:29 P.M., Nurse #2 wrote, labs reviewed with Physician #1 order to repeat in the AM. -7/1/25 at 2:40 A.M., Nurse #7 wrote, Lab from 6/30 found with an order from Physician #1 to send to the emergency room for evaluation, discuss with patient that he/she could wait till the morning and discuss with another provider or we could send him/her now as physician recommended this morning, he/she wanted to go. Patient was transferred via ambulance to an outside hospital. Review of the medical record failed to include the 6/30/25 lab slip. During an interview on 8/27/25 at 2:45 P.M., Medical Records Staff #1 said the nurses transcribe the physician order written on the lab slips. She said the nurses can put the lab slips in the shredder bin or put them in the scan folder, and she scans them into the medical record. Medical Record Staff #1 reviewed the electronic medical record and the Blood lab results from 6/29/25 with any physician notation was not in the medical record. During a telephonic interview on 8/27/25 at 4:50 P.M., Physician #1 said he reviewed the labs for Resident #159 and faxed back to the facility to send Resident #159 to the ER for evaluation. He said his instruction was clear. The surveyor requested a copy of the lab results with his written instructions and Physician #1 agreed to send a copy. On 8/27/25 at 4:56 P.M., the surveyor received the lab results with instructions for Resident #159 from Physician #1 on the Cookside Unit fax. Review of the lab results, dated 6/30/25, indicated the following: -Specimen was collected on 6/30/25 at 5:17 A.M. and reported on 6/30/25. -Results indicated multiple abnormal values. -The written instructions from Physician #1 at the bottom of the page indicated: Two arrows pointing at the words ER evaluation. -There were no instructions noted to repeat labs in the morning. -The original fax time stamp printed indicated it was faxed from the Cookside Unit to the physician’s office on 6/30/25 at 1:06 P.M. -Time stamp on the fax from the physician to the surveyor on 8/27/25 matched the actual time surveyor received the fax, 8/27/25 at 4:56 P.M. Review of facility form titled Skilled Nursing Facility to Hospital Transfer Form, dated 7/1/2025, indicated Resident #159 was transferred to the hospital on 7/1/25 at 2:11 A.M., a minimum of 9 hours after the facility would have received the fax from Physician #1’s office. During an interview on 8/27/25 at 4:10 P.M., Nurse #1 said the process is to print the lab results in the morning and for Physician #1, he wants the lab slips faxed over to his office, and he faxes back written instructions on the lab slip. Nurse #1 said once you receive the fax back, you transcribe the order and write a note and then you can shred the written communication, or you can put it in the scan folder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/25 at 4:17 P.M., Nurse #2 said he found Resident #159’s lab slip on the desk and thought the physician’s written instructions said to repeat labs in the A.M. Nurse #2 said he wrote a note to repeat labs in the A.M., and left the lab slip on a pile of other papers. Nurse #2 said the next day, Nurse #7 told him, she sent Resident #159 to the hospital. Nurse #2 said, Nurse #7 told him she saw the lab slip on the desk and knew Physician’s #1’s writing and read the order on the lab slip to send Resident #159 to the hospital. Nurse #2 said the lab slip was sent over during the day shift. Nurse #2 said he interpreted the physician instructions differently than Nurse #7. During an interview on 8/27/25 at 4:58 P.M., Nurse #2 viewed the faxed lab results and said it looks like the physician wrote re-evaluation. He said he can now see the “ER evaluation”. During an interview on 8/28/25 at 7:35 A.M., the DON said the first nurse misread the physician instructions, and the 11-7 nurse who knew the physician better read it as send the Resident to the ER. During an interview on 8/28/25 at 8:30 A.M., with both Physician #1 and the DON present, Physician #1 said if the lab slip was sent to my office at 1:00 P.M, he would have acted upon and returned it to the facility within 1-2 hours. Physician #1 said the lab results were not faxed over to the facility after 5:00 P.M. Physician #1 said he was sending out Resident #159 for low sodium and would not have expected it to be a 911 call but would expect the Resident to go to the hospital within a couple hours. Physician #1 confirmed the written instructions on the lab slip said to send to ER, not repeat labs in the A.M. b. Review of Resident #159’s urinalysis, collected on 6/27/25 and reported to the facility on 6/29/25 at 9:52 A.M., indicated abnormal results with greater than 100,000 CFU/ML of klebsiella pneumonia, ESBL. Review of Nursing Progress notes, dated 6/27/25 at 4:43 A.M., Nurse #7 wrote, Urine obtained. Results pending. Review of Social service note, dated 6/27/25 at 3:34 P.M., this morning, interdisciplinary team discussed Resident #159. Foley was taken out this morning, Lab work ordered to determine fluid restriction and sodium tablets. Review of Nursing progress note, dated 6/30/25 at 3:51 P.M., written by the DON, Resident noted with overall decline, failed voiding trial x 2, noted with increased pain and edema in lower extremities, Doppler completed and noted without Deep vein thrombosis (DVT). Resident does continue to voice he/she would like to go home but does not feel he/she is ready. Nursing continues to work on pain management and Foley training has been complicated by poor dexterity. Labs today are significant for elevated white blood cell (WBC) and urine culture with bacteria. Call to physician (MD) to report labs a (sic) decline. Surveyor requested DON obtain a copy from Physician #1’s office of the urinalysis. Review of Nursing Notes, dated 6/29/25, did not indicate abnormal urinalysis lab results were communicated with physician and/or his designee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/25 at 4:28 P.M., the DON said she called Physician #1’s office, and they do not have a copy of the lab results or fax which would have been sent back to the facility. The DON said she checked the electronic communication system used to communicate with physicians and said there was no notification to the physician or his designee with the results of the urinalysis on 6/29/25. Further review of the electronic medical record indicated there were no physician or Nurse Practitioner documentation of the abnormal urinalysis results reported to the facility on 6/29/25.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure one Resident (#46), out of a total sample of 27 residents, received the necessary care and treatment to prevent and promote healing of pressure injuries. Specifically, the facility failed to ensure Wound Physician recommendations were addressed and implemented timely. Findings include: Review of the facility's policy titled Pressure Ulcer /Skin Breakdown - Clinical Protocol, dated as last revised 3/2014, indicated but was not limited to the following:-The physician will authorize pertinent orders related to wound treatments.-The physician will help identify medical interventions related to wound management. Review of the facility's policy titled Consultant Physician Services, dated as adopted 2/2023, indicated but was not limited to the following:-Consultant physician services are available to the residents as ordered by their attending physician or physician designee.-After completion of the consult, the consultant physician will provide the facility with a consultation report which shall include any orders, recommendations, or follow up actions.-The resident's attending physician should be informed of the recommendations, treatments, diagnostics, and medications ordered by the consultant. -Orders from the consultant physician will be entered in the resident's medical record. Review of the facility's contract with the Wound Physician, dated 3/12/25, effective 4/1/25, indicated but was not limited to the following:-Facility Responsibilities: The facility agrees to support delivery of wound care services and commits to inform the resident's primary care provider of the Provider's recommendations within 24 hours. Resident #46 was admitted to the facility in May 2025 with diagnoses which included a displaced left femur fracture, diabetes mellitus, history of falls, and abnormal gait/mobility. Review of the Minimum Data Set (MDS) assessment, dated 8/27/25, indicated Resident #46 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. Additionally, he/she was a risk for pressure ulcers, and had one unhealed unstageable pressure injury (pressure injury where the depth of tissue damage cannot be determined due to the presence of slough (yellow/green/grey dead tissue) or eschar (thick, leathery layer of dead tissue) covering the wound bed). Review of the medical record, including nursing progress notes, indicated the pressure ulcer was observed on 6/8/25, the Nurse Practitioner (NP) was notified and a treatment ordered. Review of the Initial Wound Evaluation and Management Summary, dated 6/19/25, indicated but was not limited to the following:-Site 2: Unstageable Deep Tissue Injury (DTI- purple/maroon discoloration due to prolonged pressure) of the left medial heel, measuring 4 x 5.5 centimeters (cm), intact blood-filled purple/maroon discoloration. Recommended treatment was skin prep (breathable protective film like barrier) once daily. Review of the Physician's Orders indicated but were not limited to the following:-Apply skin prep to left heel every day shift for wound care. (6/17/25) Review of the Wound Evaluation and Management Summary, dated 8/7/25, indicated but was not limited to the following:-Site 2: Unstageable (due to necrosis-dead cells or tissues) of the left medial heel, measuring 2. 5 x 2.1 cm x depth not measurable due to presence of non-viable tissue and necrosis. Thick adherent devitalized necrotic tissue 100%, Wound progress not at goal. Recommended treatment skin prep peri wound, Apply collagen sheet (gel sheet to maintain a moist wound environment), calcium alginate (highly absorbent/promotes moist healing environment), and Santyl (wound gel to debride necrotic tissue) followed by gauze island dressing once daily. Review of the physician's orders indicated the wound care order was not implemented until 8/12/25 (five days after he/she was seen by the wound care physician). Review of the Wound Evaluation and Management Summary, dated 8/21/25, indicated but was not limited to the following:-Site 2: Unstageable (due to necrosis) of the left medial heel, measuring 2 x 2 cm x depth not measurable due to tissue overgrowth. Recommended treatment skin prep peri wound, Apply collagen sheet and calcium alginate followed by gauze island dressing once daily. Review of the physician's orders indicated the wound care order was not implemented until 8/26/25 (five days after he/she was seen by the wound care physician. Review of the nursing and physician progress notes failed to indicate the provider was notified the next day of the consultant's recommendations and did not want the order changed at that time. Further review of the physician's progress note, dated 8/21/25, indicated Resident #46 was followed by the wound physician for the decubitus ulcer on the left heel and they agree with all recs. During an interview on 8/28/25 at 11:35 A.M., Nurse #3 said Unit Manager (UM) #1 already did wound rounds with the wound physician earlier this morning. She said UM #1 usually is not here on Thursdays, so UM #2 or a desk nurse will do rounds. She said they handle writing all the orders and she has nothing to do with wound rounds; the new orders just appear in the computer. During an interview on 8/28/25 at 1:03 P.M., UM #1 said she did

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	225603	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Brook Rehabilitation and Healthcare Center	100 Amity Street Fall River, MA 02721

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews and record review, the facility failed to ensure monthly Medication Regimen Review (MRR) recommendations made by the pharmacy consultant were addressed timely and maintained as part of the permanent medical record for two Residents (#16 and #5), out of a total sample of 27 residents. Specifically, the facility failed:1. For Resident #16, to ensure the April 2025 and May 2025 consultant pharmacist recommendations were maintained as part of the permanent medical record and acted upon timely to assess the need for Meclizine (an anticholinergic medication used to treat nausea, vomiting and dizziness) and to obtain an A1c (blood test that measures an average blood sugar level over a period of two to three months); and2. For Resident #5, to ensure the April 2025, May 2025, and July 2025 consultant pharmacist recommendations were maintained as part of the permanent medical records and acted upon timely to sequence multiple as needed pain medications and to obtain labs related to specific medication use. Findings include:Review of the facility's policy titled Pharmacy Services-Role of the Consultant Pharmacist, revised April 2019, indicated but was not limited to the following: -The consultant pharmacist will provide specific activities related to medication regimen including: -a documented review of the medication regime of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; -appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated; -providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review 1. Resident #16 was admitted to the facility in April 2021 with diagnoses including type 2 diabetes mellitus, hypertension, and major depression disorder. Review of the medical record indicated the consultant pharmacist made recommendations for Resident #16 in April 2025 and May 2025 and generated a report to be acted upon and reported to the physician, however, the surveyor was unable to locate either the 4/28/25 or the 5/30/25 MRR report in the Resident's medical record. During an interview on 8/27/25 at 10:59 A.M., Nurse #3 and the surveyor reviewed Resident #16’s medical record and could not locate the MRR reports for April 2025 or May 2025. Nurse #3 said she was not sure how the pharmacy recommendations were addressed. Nurse #3 said she believed the Unit Managers (UM) took care of them. On 8/27/25 at 11:30 A.M., the Director of Nursing (DON) provided the surveyor with a printed copy of the April and May reports. Review of the 3/15/25 Consultant Pharmacist Recommendations to Prescriber report for Resident #16 indicated the following recommendation: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pt is currently receiving Meclizine which is a highly anticholinergic medication. Please consider discontinuing or re-evaluating for necessity. Meclizine is also on the Beer’s list. Review of the current Physician’s Orders included the following medication: -Meclizine HCL oral tablet 12.5 milligrams (MG) give 12.5 MG by mouth every 12 hours as needed for dizziness, dated 2/26/24. Further review of the medical record failed to indicate the physician addressed the consultant pharmacist's recommendation by discontinuing or documenting the necessity for the use of Meclizine. Review of the 5/30/25 Consultant Pharmacist Recommendations to Prescriber report for Resident #16 indicated the following recommendation: -The following are labs recommended to upload for monitoring the patient’s medication treatment as well as the recommended minimum collection frequency: -Antidiabetic meds: A1C q3m -If unavailable, please consider ordering the labs. Review of current Physician's Orders included the following medications: -Insulin Glargine Subcutaneous Solution 100 Unit/milliliter (ML) (insulin Glargine) Inject 65 units subcutaneously in the morning related to type 2 diabetes mellitus with hyperglycemia, dated 5/24/2025 -Insulin Glargine Subcutaneous Solution 100 Unit/ML (insulin Glargine) Inject 10 units subcutaneously at bedtime related to type 2 diabetes mellitus with hyperglycemia, dated 5/24/2025 -Novolog Solution 100 Unit/ML (Insulin Aspart) inject as per sliding scale: -if 150-199 give 4 units subcutaneously -200-249 give 6 units subcutaneously -250-299 give 8 units subcutaneously -300-349 give 10 units subcutaneously -350-399 give 12 units subcutaneously -400-499 give 14 units subcutaneously before meals for diabetes. Notify MD if blood sugar less than 70 or greater than 450 dated 8/26/25 -Metformin Tablet 500 milligrams (mg) give one tablet orally two times a day for diabetes (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the laboratory reports noted an A1c was last collected on 2/21/25. The A1c results flagged high at 7.9 out of a reference range of 4.1-6.0. Further review of the medical record failed to indicate the physician addressed the consultant pharmacist's recommendation by ordering an A1c every 3 months. During an interview on 8/28/25 at 9:49 A.M., UM #1 reviewed the April and May pharmacy recommendations. The UM said the reports were usually e-mailed to her and she would print out and give them to the physician to address the recommendations. The UM said she would then in return review the recommendations and make any needed changes in the resident’s medical record. The recommendations were then scanned into the resident’s medical record. The UM said the pharmacy recommendations from April and May were not addressed. The UM said that the facility had switched to a new pharmacy around May 2025. The UM said she had not received any recommendations by e-mail during the transition. The UM said she had informed the DON, and she had started to receive the pharmacy recommendations in June. During an interview on 8/28/25 at 1:00 P.M., the DON said she did not keep copies of the pharmacy recommendations. The DON said the Unit Managers were responsible for making sure pharmacy recommendations were reviewed and completed by the physicians. The DON said the recommendations should have been addressed but were missed with the changeover in pharmacies. 2. Resident #5 was admitted to the facility in February 2025 with diagnoses which included artificial knee joint, morbid obesity, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment, dated 8/1/25, indicated Resident #5 was administered an antipsychotic medication. Review of the medical record indicated the consultant pharmacist made recommendations for Resident #5 in April 2025 and May 2025 and generated a report to be acted upon and reported to the physician, however, the surveyor was unable to locate either the 4/29/25 or the 5/30/25 MRR report in the Resident's medical record. On 8/28/25 at approximately 10:30 A.M., the DON provided the surveyor with a printed copy of the April and May reports. Both reports were unsigned by the provider. Review of the MRR, dated 4/29/25, indicated Resident #5 was taking multiple as needed (PRN) pain medications requiring sequencing, which is typically done by assigning intensity of pain to each agent. Please consider providing pain scales or severities within the order to provide direction for administration. Acetaminophen (APAP) and Hydrocodone-APAP. Review of the MRR, dated 5/30/25, indicated labs were recommended to upload for monitoring of the patient's medication treatment as well as the recommended minimum collection frequency. Antipsychotics: Lipids every 12 months and Allopurinol/Uloric: uric acid level annually. If unavailable, please consider ordering the labs. Review of the medical record failed to indicate the pain medications were sequenced, failed to indicate the requested labs were ordered, and failed to indicate the recommendations were reviewed and declined by the provider. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/25 at 11:35 A.M., Nurse #3 said the Unit Managers handle the pharmacy recommendations. During an interview on 8/28/25 at 1:03 P.M., UM #1 said the pharmacy recommendations go to all the UMs, and we get them to the providers. She said there was an issue in the spring and for some reason she was not getting them, so they were not done. During an interview on 8/28/25 at 2:09 P.M., the DON said all the pharmacy recommendations should be addressed within the month. She said they did not keep the forms once the orders were written all the time, but she should. She said she was unaware the recommendations from April and May were never addressed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure the main kitchen walk-in refrigerator was maintained in a sanitary and safe condition. Findings include:1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's policy titled Sanitization, revised November 2022, indicated but was not limited to the following:-The food service area is maintained in a clean and sanitary manner.Policy Interpretation and Implementation:-All kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. -All utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. On 8/25/25 at 8:00 A.M. and on 8/28/25 at 11:14 A.M., the surveyor observed in the walk-in refrigerator:-shelving with several areas of rust;-shelving with extensive patchy areas of raised yellow, powdery substance;-black powdery buildup on the walk-in refrigerator wall inches away from raw onions stored in a mesh bag;-debris and spillage underneath shelving including brown and black colored spillage underneath an area of shelving that contained raw meat and/or poultry;-debris and black buildup along the perimeter and in the corners of the floor. During an interview on 8/28/25 at 2:27 P.M., the Food Service Director (FSD) and surveyor observed the shelving and floor in the walk-in refrigerator. The FSD said the walk-in refrigerator should be kept in a clean and sanitary condition.