STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225740	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunt Nursing & Rehab Center	90 Lindall Street Danvers, MA 01923

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure treatment and care in accordance with professional standards of practice were implemented for one Resident (#35) out of a total of 29 sampled Residents. Specifically, the facility failed to obtain an initial treatment order for an open skin area and failed to ensure Resident #35 was seen timely by the wound physician. Subsequently, Resident #35 had an open area for approximately 12 days before being seen by the wound physician and having an ordered treatment. Findings include: Review of the National Library of Medicine article titled Wound Dressings dated 1/23/24 indicated: When the skin is compromised due to wounds, a complex healing process is triggered by various cell types and microenvironments. Choosing the proper wound dressing is crucial to accelerate healing, reduce treatment costs, and improve the patient's overall well-being.Review of the facility's Skin Integrity Management policy dated as revised 12/3/25 indicated: When a skin breakdown is identified, report this timely to medical practitioner and resident representative as required by policy. Obtain wound treatment order. Obtain referral to wound consultant who will partner with facility nurse in conducting wound assessment and treatment review. Every treatment recommendation will be reviewed timely with the resident's primary Medical Practitioner.Resident #35 was admitted to the facility in April 2013 with diagnoses including cerebral palsy, dysphagia and cognitive communication disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #35 is mildly cognitively impaired, as evidenced by a score of 11 out of a possible 15 on the Brief Interview for Mental Status exam. During an interview on 2/10/26 at 7:49 A.M., the surveyor observed Resident #35 resting on an air mattress (a specialty mattress utilized to redistribute pressure on the body). Resident #35 said he/she had a wound on his/her buttock that the nurses come in daily to take care of it. Resident #35 said the wound was new. Review of Resident #35's care plans indicated: Resident is at high risk for pressure ulcer development r/t (related to) incontinence of bowel and bladder and physical limitations. Interventions: Observation of skin condition during care - report pink, red or open areas to nurse. Update physician of new skin conditions and obtain orders. Review of the progress note written by Nurse #2, dated 12/3/25, indicated: Resident had a large bowel movement and went to bed with call light within reach, it was also noticed that resident had an open area around the coccyx area, which was cleaned with normal saline and covered with border foam. During an interview on 2/11/2026 at 7:49 A.M., Nurse #2 said the Certified Nursing Aides (CNAs) had alerted her that Resident #35 had identified a skin area after receiving care on the 3:00 - 11:00 evening shift. Nurse #2 said the area wasn't open but was reddened (contradicting the written note) and she put a dressing in place and alerted the oncoming staff. Review of the Dietary Progress note dated 12/4/25 indicated: Alerted by nursing re: open area to coccyx. Resident eats well. Plan is for resident to been by wound MD, will follow for any changes in skin. Review of the Risk Meeting Notes indicated: 12/4/26: Resident with new open area, will see wound MD Monday, (12/8/25).12/12/26: Resident not seen by wound MD, will be seen on Monday (12/15/25). Review of the Wound Physician note dated 12/15/25 indicated: Non-pressure wound to the left buttock, full thickness. Etiology unknown2 CM (centimeters) x 3 CM x .1 CM Exudate: moderate sero-sanguinous (a type of wound drainage that is a combination of serous (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluid (clear or yellow) and sanguineous fluid (blood), light pink, watery mixture)Grimacing notedDressing Treatment Plan: Alginate Calcium with silver (an absorbent wound dressing), apply twice daily and as needed. Gauze sponge sterile apply twice daily and as needed. Review of the physician order dated 12/15/25 indicated: To open area L (left) buttock day and evening: wash with NS (normal saline) apply calcium alginate with silver, cover with gauze skin prep peri wound. Review of Resident #35's clinical record indicated that Resident #35 was not seen by the Wound Physician until 12/15/25; approximately 12 days after the area was identified. Additionally, there were no treatment orders to the area implemented prior to 12/15/25. During an interview on 2/11/2026 at 9:34 A.M., Physician #1 said that initial treatment orders are implemented until a resident can be seen by the Wound Physician. Physician #1 said that he defers treatment recommendations for wounds to the Wound Physician. Physician #1 said that he was not aware there were no initial treatment orders for Resident #35's open area or the delay in Resident #35 being seen by the Wound Physician. During an interview on 2/11/26 at 9:43 A.M., Unit Manager #1 said that the Wound Physician comes in on Mondays and rounds with the Wound Nurse who then inputs the recommendations into the electronic record as orders. Unit Manager #1 said that initial treatment orders implemented until the Wound Physician can see the Resident and open areas require a dressing. Unit Manager #1 said she did not know why Resident #35 did not have initial treatment orders implemented when the wound was first noted and did not know why the Wound Physician did not see the Resident until 12/15/25. The Wound Physician was unavailable for interview. During an interview on 2/11/2026 at 11:53 A.M., the Wound Nurse said she rounds with the Wound Physician in the facility on Mondays. The Wound Nurse said that Resident #35 has had a chronic area that drains, and an open area does require a dressing. The Wound Nurse said she did not know why Resident #35 was not seen until 12/15/25 by the Wound Physician. During an interview on 2/12/2026 7:11 A.M., the Director of Nursing (DON) said that the facility is working on developing a new system related to skin management and treatment orders. The DON said she did not know why Resident #35 was not seen by the Wound Physician until 12/15/25 or why an initial treatment was not implemented.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to implement a recommendation by the optometrist for one Resident (#26) out of a total sample of 29 residents. Findings include:Resident #26 was admitted to the facility in May 2022 with diagnoses including spina bifida, colostomy, hypertension, major depressive disorder, and anxiety. Review of Resident #26's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status (BIMS) examination score of 15 out of a possible 15, indicating he/she is cognitively intact. The MDS also indicated Resident #26 is dependent in staff for activities of daily living and wears corrective lenses. During an interview on 2/10/26 at 8:02 A.M., Resident #26 said he/she was seen by the eye doctor a few months back and recommended cataract surgery for his/her left eye. Resident #26 said he/she has not been informed if an appointment has been made and is worried his/her vision is getting worse.Review of Resident #26's medical record indicated a consent for ophthalmology services was signed 5/6/22.Review of Resident #26's medical record indicated he/she was last seen by optometrist on 5/15/25 and 10/24/25 with the following recommendations:-5/15/25: PLAN:1. Cataract surgery recommended, ophthalmology consult, follow up 5-6 months, Referral Ophthalmology Consult: Please make next available appt for cataract surgery, can try OCB [NAME] [PHONE NUMBER]. 2. Monitor IOP, follow up 5-6 months, Referral Ophthalmology Consult: pt needs further testing, OCT/VF can try OCB [NAME] [PHONE NUMBER]. 3. Monitor Follow up, Comprehensive 5/15/26.-10/24/25: PLAN-1. Cataract surgery recommended: Ophthalmology consult, follow up: Priority Comprehensive 5/15/25, Referral-Ophthalmology Consult please make next available ophthalmology appointment for cataract surgery consult. 2. Monitor IOP, follow up: Priority Comprehensive 5/15/25, Referral Ophthalmology Consult-please also make glaucoma testing appointment.Further review of Resident #26's medical record failed to indicate the recommendations made by the optometrist on 5/15/25 and 10/24/25 were implemented.During an interview on 2/12/26 at 7:22 A.M., Unit Manager #1 said when the eye doctor has recommendations, the doctor will let us know before leaving the facility and we will review the recommendations with the resident. The appointment is then made with the recommended doctor or a local doctor that takes the resident's insurance. Unit Manager #1 said it is the expectation that we would follow the doctor's recommendations and she was unaware that an appointment had not been made for Resident #26.During an interview on 2/12/26 at 9:26 A.M., the Director of Nursing said all recommendations made by the optometrist are reviewed by the unit manager and if the resident agrees the appointment would be made. The Director of Nursing said she would expect the appointment to be made after receiving the recommendation from the provider.

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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. Based on observation, record review and interview, the facility failed to implement treatment orders as recommended by the Wound Physician for one Resident (#85) out of a total of 29 sampled Residents. Specifically, the facility failed to implement betadine treatment to a right heel deep tissue injury (DTI; a wound that occurs related to pressure) for approximately 43 days. Findings include: Review of the Skin Integrity Management policy dated as revised 12/3/25 indicated: When a skin breakdown is identified, report this timely to medical practitioner and resident representative as required by policy. Obtain wound treatment order. Obtain referral to wound consultant who will partner with facility nurse in conducting wound assessment and treatment review. Every treatment recommendation will be reviewed, timely with the resident's primary Medical Practitioner.Resident #85 was admitted to the facility in August 2025 with diagnoses including neuro cognitive disorder with Lewy bodies and Parkinsons disease. Review of the Minimum Data Set Assessment 11/18/25 indicated Resident #85 was unable to participate in the Brief Interview for Mental Status Exam and is severely cognitively impaired. On 2/10/26 at 8:11 A.M. the surveyor observed Resident #85 resting on an air mattress (a specialty mattress utilized to redistribute pressure on the body). Resident #85 was unable to participate in the interview process. Review of Resident #85's care plans indicated: 9/24/25: Suspected Deep Tissue Injury (DTI) Interventions: Treatment to area per physician's order. Refer to wound specialist if indicated/ordered. Review of the Wound Physician note dated 12/15/25 indicated: Unstageable DTI of the right medial heel. Treatment plan: Betadine apply once daily and as needed, ABD (abdominal) pad apply once daily and as needed gauze roll 4.5 apply once daily and as needed, paper tape once daily and as neededAdditional review of the Wound Physician notes dated 12/22/25, 12/29/25, 1/5/26, 1/12/26, 1/19/26, all indicated betadine apply once daily and as needed if saturated soiled or dislodged. ABD pad apply once daily, gauze roll and paper tape as the primary treatment for Resident #85's right heel. Review of the physician orders and Treatment Administration Records dated December 2025 and January 2026 indicated the following treatment orders for Resident #85's right heel: Skin Prep Wipes Pad 1 pad topical day shift for alteration in skin integrity. Wash R medial heel with NS (normal saline) Apply skin prep cover with ABD pads. Wrap with gauze roll secured with tape. effective 12/1/25-1/26/26.On 1/27/26, Resident #85's orders changed to: R (right) medial heel DTI oint (ointment) with betadine over with ABD, gauze roll and secure with tape; approximately 43 days after the Wound Physician initially recommended the use of betadine. During an interview on 2/11/26 at 9:34 A.M., Physician #1 said that he defers to the Wound Physician for treatment orders for skin injuries.During an interview on 2/11/2026 at 9:43 A.M., Unit Manager #1 said that the Wound Nurse rounds with the Wound Physician on Monday's and inputs the treatment recommendations as orders into the electronic recordUnit Manager #2 and the Wound Physician were unavailable for interview.During an interview on 2/12/26 at 9:09 A.M., the Wound Nurse said that she was not aware that the Betadine Treatment was not implemented for Resident #85.During an interview on 2/12/2026 at 7:11 A.M., the Director of Nursing said that there had been issues with transcription of orders and the facility was rolling out a new program related to wounds and inputting orders. The DON said she was not aware that Resident #85's orders for betadine were not implemented.