STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225767	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Brooksby Village	400 Brooksby Village Drive Peabody, MA 01960

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure two Residents (#48, #5) were free from unnecessary psychotropic medications by ensuring a reassessment of an as needed (PRN) psychotropic medication after 14 days, out of a total sample of 19 residents. Findings include: Review of facility policy titled Psychoactive Medications, dated as revised 4/25, indicated the following: -Residents on PRN (as needed) psychoactive medications will be evaluated by a physician before extending use past 14 days. 1. Resident #48 was admitted to the facility in June 2024 with diagnoses that included hypertensive chronic kidney disease, retention of urine, adult failure to thrive, and chronic pain. Review of Resident #48's most recent Minimum Data Set (MDS) assessment, dated 12/23/25, indicated he/she scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Review of Resident #48's discontinued order with a start date of 9/25/25 and discontinued date of 12/22/25, indicated give Ativan (a benzodiazepine medication) 0.5 mg (milligrams) as needed every four hours. Review of Resident #48's physician order, dated 12/22/25, indicated give Ativan 0.5 mg as needed every four hours for 30 days. During an interview on 1/21/26 at 10:34 A.M., Nurse #1 said that the initial orders for the as needed Ativan should have had a 14 day stop date then should have been reviewed by the doctor before December. During an interview on 1/21/26 at 2:00 P.M., the Director of Nurses said that when a psychotropic medication is ordered as needed the initial order needs a 14 day stop date then needs to be reevaluated by the provider. 2. Resident #5 was admitted to the facility in June 2025 with diagnoses that included unspecified dementia, severe with anxiety and need for assistance with personal care. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 12/29/25, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated the use of antianxiety medications. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's active physician's orders indicated the following: -Lorazepam (a benzodiazepine medication) 0.5 mg (milligram) tablet, one tablet as needed every four hours, dated 12/23/25. Review of physician's orders failed to indicate a stop date for the Lorazepam order. Review of Resident #5's active care plan indicated the following: -Because I am taking psychotropic drugs monitor me for sleepiness, drooling, increased confusion, restlessness, change in posture and involuntary movements. During an interview on 1/21/26 at 10:40 A.M., the surveyor and Unit Manager #2 reviewed the medical record, and he said the current order for Lorazepam did not have a stop date and that one needed to be added. Unit Manager #2 said there should be a stop date for any as needed psychotropic medication, but for Resident #5, there is not. During an interview on 1/21/26 at 12:17 P.M., the Director of Nurses said that any psychotropic medication, that is ordered on an as needed basis must have a stop date and be reevaluated for use by the provider.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to implement the plan of care for one Resident (#9) out of a total sample of 19 residents. Specifically, for Resident #9 the facility failed to place foam booties and hand rolls as ordered.Findings include:Review of the facility policy titled Care/Service Plans, dated 5/21, failed to indicate that the plan of care is to be followed by staff. Resident #9 was admitted to the facility in August 2025 with diagnoses including Parkinson's disease, dementia and depression. Review of the physician's orders dated January 2026 indicated an order for foam boots to bilateral feet when in bed. Further review indicated the following order: Following A.M., care, place carrot to right hand as tolerated. During P.M. care, remove carrot to right hand and place hand rolls in both hands. Review of the care plan titled Skin Integrity, indicated to apply heel protectors to both feet when in bed. Further review indicated to place hand rolls in bilateral hands as ordered. On 1/20/26 at 8:25 A.M., the surveyor observed Resident #9 in bed. The surveyor also observed Resident #9 to have a contracted left hand without a hand roll in place. The surveyor did not observe the hand roll to be in bed or elsewhere in the room. The surveyor also observed Resident #9 to have a contracted right hand with a hand roll. The surveyor then observed an orthotic carrot (a soft carrot shaped orthotic used to prevent further contracture of a hand) on the Resident's nightstand indicating A.M. care had not been provided yet. The surveyor observed Resident #9 in bed without foam boots on and the heels directly on the mattress. The surveyor then observed foam boots on a wheelchair in the bathroom. On 1/20/26 at 1:50 P.M., the surveyor observed Resident #9 in bed without foam boots on and with heels directly on the mattress. The surveyor observed foam boots on a wheelchair in the bathroom. During an interview on 1/21/26 at 7:27 A.M., the Director of Nursing said that staff should follow physician orders and the care plan. During an interview on 1/21/26 at 8:15 A.M., Unit Manager #1 said that both the care plan and physician orders should be followed.

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	225767	A. Building B. Wing	01/21/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record reviews and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for two Residents (#68, #7) out of a total sample of 19 Residents. Specifically,For Resident #68, the facility failed to accurately reconcile medication orders on admission to the facility. 2. For Resident #7, the facility failed to change a dressing as ordered.Findings include: 1. Resident #68 was admitted to the facility in January 2025 with diagnoses that included hyperlipidemia, weakness and cognitive communication deficits. There is no Minimum Data Set completed at this time for Resident #68. Review of admission paperwork from the referring hospital, dated 1/13/26, indicated in part, the following: Start taking these medications: Rosuvastatin (Crestor, a statin medication used to lower bad cholesterol (LDL) and triglycerides while increasing good cholesterol (HDL), and it is commonly prescribed to prevent cardiovascular diseases) 20 mg (milligrams) by mouth at bedtime. -Key information for Outpatient Providers: Recommend repeat lipid profile in three months to monitor response to Crestor. -Hospital Course: Lipid Panel shows a very high LDL of 217, cholesterol 302, triglycerides 164, HDL up to 250. It appears that he/she was probably not on a statin prior to current admission. -Neurology consult recommended the following: high intensity statin for LDL above 70. Review of the Physician's admission history and physical progress note, dated 1/13/26, upon admission to the facility indicated the following: -Reason for Appointment: rehab admit H+P (history and physical) -Treatment: Pure hypercholesterolemia, Continue (Rosuvastatin) Crestor tablet 20 mg once daily. Review of active and discontinued physician's orders failed to indicate Rosuvastatin was added to the Resident's medication regime on admission to the facility. Review of the medical record failed to indicate that any medications recommended by the referring hospital had been discontinued or changed at the time of admission to the facility. During an interview on 1/21/26 at 10:34 A.M., Nurse #1 said that any changes made from the medication list from the hospital or page one form on admission should have a specific order to change or discontinue it. Nurse #1 reviewed the medical record with the surveyor and said there was no order to discontinue the Rosuvastatin. Nurse #1 said he is not sure if the Resident is supposed to be on it or not. During an interview on 1/21/26 ay 10:36 A.M., Unit Manager #2 said he is not sure what happened with the Rosuvastatin. He said the Physician must have decided not to continue the medication on (continued on next page)

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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	admission if it was not entered into the electronic medical record as an order. He said when a medication is discontinued there should be an order and a progress note to document the changes in medications. During an interview on 1/21/26 at 12:00 P.M., the Director of Nurses said that when a resident is admitted , the nurse will review all admission orders over the phone with the physician. Any changes to the admission orders need to be written on an order form and should be documented in the nurses note as well. During an interview on 1/21/26 at 1:36 P.M., Physician #1 said that he is the attending physician for the Resident. He said that he is seeing the Resident in person today for the first time since admission. He said that he had not instructed for any medications to be stopped or not initiated on admission to the facility, and that today, a new order was written to initiate the Rosuvastatin as recommended by the acute care hospital because it should not have been stopped. 2. Resident #7 was admitted to the facility in March 2025 with diagnoses including dementia, depression and malnutrition. Review of the Minimum Data Set assessment, dated 12/12/25, indicated that Resident #7 is severely cognitively impaired, scoring a 5 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #7 is totally dependent on staff for all activities of daily living. Review of the physician's orders dated January 2026 indicated the following order: Starting 1/16/26, Optifoam (a type of dressing) every three days to LUE (left upper extremity) skin tear; cleanse with NS (normal saline), pat dry, apply Steri strips (leave on until they fall off on their own), cover with Optifoam Q(every) 3 days until healed. On 1/20/26 at 7:45 A.M., the surveyor observed Resident #7 lying in bed with a dressing on the left arm dated 1/16/26. On 1/21/26 at 7:25 A.M., the surveyor and Unit Manager #2 observed Resident #7 lying in bed with a dressing on the left arm dated 1/16/26. During an interview on 1/21/26 at 7:25 A.M., Unit Manager #2 said that the dressing should have been changed as ordered. During an interview on 1/21/26 at 7:27 A.M., the Director of Nursing said that the nurses are to follow physician orders.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review and interview, the facility failed to ensure professional standards of practice for Foley catheter care for one Resident (#48) out of a total sample of 19 residents. Specifically for Resident #48, the facility failed to ensure they obtained physician's orders for the correct indwelling catheter size.Findings include:Resident #48 was admitted to the facility in June of 2024 with diagnoses that included hypertensive chronic kidney disease, retention of urine, adult failure to thrive, and chronic pain. Review of Resident #48's most recent Minimum Data Set (MDS) assessment, dated 12/23/25, indicated he/she scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Further review of the MDS indicated he/she had an indwelling catheter. On 1/20/25 at 7:57 A.M., the surveyor observed Resident #48 in bed with a foley catheter. Review of Resident #48's physician order dated 1/10/26, indicated Catheter: Change foley bag every 1 month. Notes: change foley catheter every month. Review of Resident #48's nursing progress note, dated 11/17/25, indicated Foley cath noted out; re-inserted per order with good result. [sic] Further review of the nursing notes failed to indicate a nursing note was written on 1/10/26 about the catheter change. Review of Resident #48's most recent hospice note dated 1/15/26, failed to indicate that the resident has a foley catheter. During an interview on 1/21/26 at 9:02 A.M., Nurse #1 said Resident #48 has had a foley catheter for some time for urinary retention. Nurse #1 reviewed the medical record with the surveyor and said there is nothing here that says what size the foley catheter should be. Nurse #1 said it is important to know the size, so all the nurses change the catheter the same way and as some residents need a bigger or smaller size depending on anatomy. During an interview on 1/21/26 at 9:03 A.M., Unit Manager #2 said the care plan only reflects that the Resident has a catheter but nothing about the details of it. Unit Manager #2 said the order should have the size of the foley catheter, so all nursing staff change the catheter appropriately. Unit Manager #2 said the order should not read to change the catheter bag and should read to change the catheter only. During an interview on 1/21/26 at 9:09 A.M., the Assistant Director of Nurses (ADON) said a resident with a foley catheter change order should have the size of the catheter, and that information should also be included in the care plan, so all are aware and change the catheter appropriately. During an interview on 1/21/26 at 8:14 A.M., the Director of Nurses said the catheter size does not need to be included in the order.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview, the facility failed to accurately document in the medical record for two Residents (#7 and #9) out of a total sample of 19 residents. Specifically:For Resident #7 the facility documented that a treatment was completed when it was not.For Resident #9 the facility documented that foam booties and hand rolls were in place as ordered when they were not.Findings include:Review of the facility policy titled Documentation, dated 5/21, indicated that a medical record is maintained on each resident to provide a permanent, accurate and legible record of the care given. Further review indicated that only facts are to be documented. 1. Resident #7 was admitted to the facility in March 2025 with diagnoses including dementia, depression and malnutrition. Review of the Minimum Data Set assessment, dated 12/12/25, indicated that Resident #7 had severe cognitive impairment, scoring a 5 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #7 is totally dependent on staff for all activities of daily living. On 1/20/26 at 7:45 A.M., the surveyor observed Resident #7 lying in bed with a dressing on the left arm dated 1/16/26. On 1/21/26 at 7:25 A.M., the surveyor and Unit Manager #2 observed Resident #7 lying in bed with a dressing on the left arm dated 1/16/26. Review of the Treatment Administration Record dated January 2026 indicated that the nurse signed that the treatment was completed on 1/19/26. During an interview on 1/21/26 at 7:25 A.M., Unit Manager #2 said that the dressing should have been changed as ordered. Unit Manager #2 then said that if the dressing had not been changed the nurse should not have documented that it was. During an interview on 1/21/26 at 7:27 A.M., the Director of Nursing (DON) said that the nurses are to follow physician orders. The DON then said that nurses should not document that a treatment was completed when it was not.2. Resident #9 was admitted to the facility in August 2025 with diagnoses including Parkinson's disease, dementia and depression. Review of the physician's orders dated January 2026 indicated an order for foam boots to bilateral feet when in bed. Further review indicated the following order: Following A.M., care, place carrot to right hand as tolerated. During P.M. care, remove carrot to right hand and place hand rolls in both hands. Review of the care plan titled Skin Integrity, indicated to apply heel protectors to both feet when in bed. Further review indicated to place hand rolls in bilateral hands as ordered. On 1/20/26 at 8:25 A.M., the surveyor observed Resident #9 in bed. The surveyor also observed Resident #9 to have a contracted left hand without a hand roll in place. The surveyor did not observe the hand roll in the bed or elsewhere in the room. The surveyor also observed Resident #9 to have a contracted right hand with a hand roll. The surveyor then observed an orthotic carrot (a soft carrot shaped orthotic used to prevent further contracture of a hand) on the Resident's nightstand indicating A.M. care had not been provided yet and the left-hand roll should still be in place. The surveyor observed Resident #9 in bed without foam boots on and the heels directly on the mattress. The surveyor then observed foam boots on a wheelchair in the bathroom. On 1/20/26 at 1:50 P.M., the surveyor observed Resident #9 in bed without foam boots on and with heels directly on the mattress. The surveyor observed foam boots on a wheelchair in the bathroom. The surveyor then observed the carrot was in the left hand and the right hand had nothing in it. Review of the Treatment Administration Record (TAR), dated January 2026, indicated that on 1/20/26, the nurse documented on the 7:00 A.M.-3:00 P.M. and the 3:00 P.M.-11:00 P.M. shifts that the foam boots were in place when they were not. Further review indicated that the 3:00 P.M.-11:00 P.M. nurse on 1/19/26 and the 7:00 A.M.-3:00 P.M nurse documented that the hand rolls and carrot were in place as ordered when one hand roll was not. During an interview on 1/21/26 at 7:27 A.M., the Director of Nursing (DON) said that staff should follow physician orders and the care plan. The DON then said that nurses should not document in the medical record that a treatment was completed when it was not. During an interview on 1/21/26 at 8:15 A.M., Unit Manager #1 said that both the care plan and physician orders should be followed. UM #1 then said that nurses should not document a treatment has been completed when it has not.