STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225478	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Meadow View Center	134 North Street North Reading, MA 01864

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to identify and assess the use of pillows and a blanket tucked under a fitted sheet on both sides of the bed, as well as the use of a geri-chair (a reclining chair) directly next to the bed as a potential restraint for one Resident #74 out of a total sample of 20 Residents.Findings include:Review of the facility policy titled Restraint Free Environment Policy, dated and revised May 2025, indicated the following:- It is the policy of this facility that each resident shall attain or maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience that limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints.- A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a physical restraint.- Before a resident is physically restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints.Resident #74 was admitted to the facility in November 2025 with diagnoses including paranoid schizophrenia, bipolar disorder, epilepsy (a brain disorder causing seizures) and dementia. Review of Resident #74's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident was unable to participate in the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review indicated that the Resident does not use restraints. On 1/29/26 at 8:16 A.M., the surveyor entered Resident #74's bedroom, the surveyor observed Resident #74 sleeping on his/her left side in his/her bed. On both sides of the bed, padded side rails were in use. On the right side and left side on the perimeter of the mattress there was a significant hump tucked underneath the fitted sheet running the majority of the length of the mattress after the side rails. The surveyor lifted the sheet revealing pillows and blankets stuffed under the fitted sheet. Additionally, a geri-chair was placed directly next to the right side of Resident #74's bed.During an interview on 1/29/26 at 8:20 A.M. at Resident #74's bedroom doorway, Certified Nursing Assistant (CNA) #1 said Resident #74 is fully dependent on staff for Activities of Daily Living, CNA #1 then said the Resident can often become restless while he/she is in bed and he/she tried to get out of bed on his/her own. The surveyor asked CNA #1 to observe Resident #74 in his/her bed, the surveyor and CNA #1 observed the significant humps tucked under the sheets of the left and right side of Resident #74's bed. CNA #1 said there should not be anything tucked under his/her sheets as it is not allowed. CNA #1 said the night shift staff must have done it.During an interview on 1/29/26 at 8:22 A.M., Unit Manager #1 said Resident #74 is a fall risk as he/she is unpredictable and likes getting out of bed. The surveyor and Unit Manager #1 then observed Resident #74 in bed, and she removed two pillows roughly two-feet long in length from under the fitted sheet on the right side of the Resident's bed as well as a bunched-up blanket from under the fitted sheet on the left side of Resident #74's bed. Unit Manager #1 then proceeded to say it looks like a restraint to me and it was probably the night staff from the previous night. Unit Manager #1 said she has never seen it before, and it is not something staff members should be doing.Review of Resident #74's physician's orders failed to indicate an order for the use of pillows or blankets tucked under (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fitted sheets or any use of a potential restraint.Review of Resident #74's clinical admission assessment dated [DATE] indicated that the Resident does not use a restraint while in the facility.Review of Resident #74's fall risk evaluations dated 11/18/25, 12/29/25 and 1/16/26 indicated that the Resident scored a 15, 16 and 16 respectively indicating that he/she is at risk for falls.Review of Resident #74's care plan for high risk of falls dated and revised 12/2/25 did not indicate the use of pillows or blankets tucked under fitted sheets or the use of a geri-chair being next to the bed to be used as a potential restraint.Review of Resident #74's potential for pressure ulcer development care plan dated and revised 11/20/25 did not indicate the use of pillows or blankets as positioning devices as interventions.Further review of Resident #74's care plans also failed to indicate the use of pillows or blankets tucked under fitted sheets or the use of a geri-chair being next to the bed to be used as a potential restraint.Further review of Resident #74's medical record failed to indicate that a restraint assessment or a device assessment for the use of potential restraints was present.Review of a nursing progress note dated 1/29/26 at 6:25 A.M. written by Nurse #3 who worked the overnight shift prior indicated the following:- Resident was up for most of the night making noises. Slept at 1am and woke up at 4am. This nurse administered neb (nebulizer) per doctor's order, pt (patient) tolerated tx (treatment) well. No signs of sob (shortness of breath)/discomfort noted this shift.During a telephone interview on 1/29/26 at 11:07 A.M., CNA #3said he worked the previous overnight shift, he continued to say he is unfamiliar with Resident #74 and did not stuff pillows or blankets under his/her sheets.During a telephone interview on 1/29/26 at 11:11 A.M., CNA #2 said he worked the previous night on Resident #74's floor. CNA #2 said Resident #74 will need help getting out of bed however when he/she is hyper he/she can get out of bed. CNA #2 said Resident #74 was yelling last night until past midnight. CNA #2 said stuffing pillows or blankets under fitted sheets is not allowed.The surveyor attempted to call Nurse #3 who worked the night prior on 1/29/26 at 11:16 A.M. and on 1/30/26 at 9:12 A.M. but did not receive a response.Telephone interview with CNA #2 and #3 did not provide any indication as to why pillows and a blanket were tucked under Resident #74's fitted sheet or why a geri-chair was directly next to the Resident's bed.During an interview on 1/29/26 at 12:38 P.M., the Director of Nursing (DON) said the facility is a restraint-free facility and we should not be stuffing anything under fitted sheets to prevent residents from getting out of bed.During a follow-up interview on 1/29/26 at 2:00 P.M., Unit Manager #2 said all signs point to the overnight staff who stuffed pillows and blankets underneath Resident #74's sheets and she has never seen anything like that before. Unit Manager #2 then said Resident #74 is schizophrenic and he/she has the ability to roll over and move his/her body and he/she can flip him/herself over from side-to-side in the bed. Unit Manager #2 then said Resident #74 has no problems with his/her skin and currently has no skin issues. Unit Manager #1 said Resident #74 also has epilepsy and has a seizure history, so the facility uses padded side rails for that, not stuffing pillows and blankets under fitted sheets.During an email correspondence with the Director of Nursing on 1/30/26 at 12:15 P.M., the DON said she identified the CNA (CNA #5) who put the pillows and blanket under Resident #74's fitted bedsheet. The surveyor attempted to call CNA #5 on 1/30/26 at 12:39 P.M. and on 2/4/26 at 8:44 A.M., but CNA #5 did not answer and the voicemail box was full not allowing the surveyor to leave a voicemail.