STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225505	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Wood Mill Center	800 Essex Street Lawrence, MA 01841

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had dementia, was known to wander and put objects in his/her mouth, the Facility failed to ensure that he/she was provided with an adequate level of staff supervision and an environment that was free from safety hazards, when on 03/29/24 nursing staff failed to secure medications delivered from the pharmacy, left them unattended at the Nurses' Station, and Resident #1 gained accessed to and was believed to have ingested multiple Seroquel (antipsychotic) and Risperidone (antipsychotic) tablets. Resident #1 was transferred to the Hospital Emergency Department for evaluation and monitoring, later that evening he/she required intubation and admission to the Hospital Intensive Care Unit. Findings include: The Facility Policy, titled Safety and Supervision of Residents, dated 11/2017, indicated the Facility would maintain an environment as free from accident hazards as possible, and resident safety, supervision, and assistance to prevent accidents were Facility-wide priorities. The Facility Policy, titled Storage of Medications, dated 05/2023, indicated the Facility would store all drugs and biologicals in a safe, secure, and orderly manner. Review of the Facility's Investigation Report, undated, indicated that on 03/29/24, sometime in the early morning, Resident #1 was found with two ripped open cards of medication (Seroquel and Risperidone) that were not secured. The Report indicated that it was unclear whether Resident #1 had ingested any of the medications, and he/she was transferred to the Hospital Emergency Department. Review of the Facility's Pharmacy Delivery Manifest, dated 03/29/24 and signed by Nurse #1 at 01:39 A.M., indicated the pharmacy had delivered five medications, which included: -Seroquel 150 mg (10 tablets) which were prescribed and ordered for Resident #2 and -Risperidone 1 mg (25 tablets) which were prescribed and ordered for Resident #3. Resident #1 was admitted to the Facility in April 2021, diagnoses included neurocognitive disorder, history of alcohol use, dementia, and substance use disorder. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Physician Order Summary Report, dated for March 2024, indicated he/she had physician's orders for the following: -Depakote (anticonvulsant, also used to treat anxiety), 250 mg, by mouth, three times daily, dated 03/28/24. -Lexapro (antidepressant), 5 mg, by mouth, once daily, dated 01/04/23. -Trazodone (antidepressant, also used to treat insomnia), 50 mg, by mouth, at bedtime, dated 03/06/24. -Resident #1 did not have physician's orders for Seroquel or Risperidone. Review of Resident #1's Behavior Care Plan, dated as revised on 03/20/24, indicated he/she had behaviors including intrusive wandering, rummaging, and chewing on his/her clothing. Interventions included staff would anticipate and meet his/her needs whenever possible. Review of Resident #1's Elopement and Wandering Care Plan, dated as revised on 03/11/24, indicated interventions including distracting him/her from wandering by offering pleasant diversions. Review of Resident #1's Nurse Progress Note, dated 03/29/24, indicated he/she was transferred to the Hospital Emergency Department after staff found him/her with pharmacy medication packages ripped open. Review of Resident #1's Hospital Discharge Summary, dated 04/06/24, indicated Resident #1 was admitted to the Hospital Emergency Department on 03/29/24, and was diagnosed with encephalopathy as a result of accidental ingestion and overdose of Seroquel and Risperidone at the Facility, and while in the Hospital Emergency Department, Resident #1's heart rate and blood pressure were elevated, he/she developed respiratory failure, and required intubation, ventilation, sedation, and was admitted to the Intensive Care Unit. The Discharge Summary indicated Resident #1 was extubated three days later on 04/01/24, and was discharged from the Hospital on 04/06/24 to a rehabilitation facility. During a telephone interview on 04/10/24 at 8:42 A.M., Nurse #1 said she was the nurse who worked the 11:00 P.M., (03/28/24) to 07:00 A.M., (03/29/24) shift on the unit where Resident #1 resided. Nurse #1 said Resident #1 was awake, wandering the unit, and had been wandering and standing over near the Nurses' Station throughout the shift. Nurse #1 said there was a pharmacy delivery that arrived at 01:39 A.M., and that there were only a few medications in the package, which were enclosed in a sealed red plastic bag. Nurse #1 said she did not secure the medications in the medication cart or in the units locked medication room, which was located directly behind the Nurses' Station, but said she left them in the red plastic bag on the desk at the Nurses' Station throughout the shift. Nurse #1 said she should have secured the medications, but had not. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse #1 said when she came back to the Nurses' Station at 06:00 A.M., Resident #1 was standing alone, near the Nurses' Station, the red plastic bag with the medications in it was torn open, and that multiple tablets of Risperidone and Seroquel tablets were missing from the medication cards. Nurse #1 said she found some pills on the floor, so she was unsure how many pills Resident #1 had ingested. Nurse #1 said Resident #1 was immediately transferred to the Hospital Emergency Department via 911. During a telephone interview on 04/09/24 at 11:24 A.M., Certified Nurse Aide (CNA) #1 said Resident #1 was known to wander intrusively, rummage through others' belongings, would eat others' food, would take anything that was left unsupervised, and was known to go behind the Nurses' Station and steal food. CNA #1 said that throughout the 11:00 P.M., (03/28/24) to 07:00 A.M., (03/29/24) shift, Resident #1 was wandering the unit and was difficult to redirect. During a telephone interview on 04/12/24 at 09:09 A.M., CNA #2 said Resident #1 was known to wander intrusively, would take things he/she found especially food, and was known to seek food to eat. CNA #2 said that on the 11:00 P.M., (03/28/24) to 07:00 A.M., (03/29/24) shift, Resident #1 was difficult to redirect and she had to help him/her back to bed several times throughout the night. During an interview on 04/09/24 at 07:46 A.M., and throughout the survey, the Director of Nurses (DON) said it was her expectation that nurses would secure all medications in the locked medication carts or locked medication room, but on 03/29/24 Nurse #1 had not done either and as a result, Resident #1, who was known to wander, rummage, eat things that he/she found, and required supervision, gained access to and ingested medications that were not prescribed to him/her, required transfer to the Emergency Department and admission to the Hospital.

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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 0761 Level of Harm - Actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was known to wander, rummage, and eat food he/she found, the Facility failed to ensure that medications were kept locked up (secured) or under direct supervision of nursing staff, when on 03/29/24, Nurse #1 left a medication package delivered from the Pharmacy unattended on the desk at the Nurses' Station, and as a result, Resident #1 was later found with the opened package and was believed to have ingested multiple Seroquel (antipsychotic) and Risperidone (antipsychotic) tablets. Resident #1 was transferred to the Hospital Emergency Department for evaluation and monitoring, and later required intubation and admission to the Hospital Intensive Care Unit. Findings include: The Facility Policy, titled Storage of Medications, dated 05/2023, indicated the Facility would store all drugs and biologicals in a safe, secure, and orderly manner. Review of the Facility's Investigation Report, undated, indicated that on 03/29/24, sometime in the early morning, Resident #1 was found with two ripped open cards of medication (Seroquel and Risperidone) that were not secured. The Report indicated it was unclear whether Resident #1 ingested any of the medications, and he/she was transferred to the Hospital Emergency Department. Review of the Facility's Pharmacy Delivery Manifest, dated 03/29/24 and signed by Nurse #1 at 01:39 A.M., indicated the pharmacy had delivered five medications, which included: -Seroquel 150 mg (10 tablets) which were prescribed and ordered for Resident #2 and -Risperidone 1 mg (25 tablets) which were prescribed and ordered for Resident #3. Resident #1 was admitted to the Facility in April 2021, diagnoses included neurocognitive disorder, history of alcohol use, dementia, and substance use disorder. Review of Resident #1's Physician Order Summary Report, dated for March 2024, indicated he/she had physician's orders for the following: -Depakote (anticonvulsant, also used to treat anxiety), 250 mg, by mouth, three times daily, dated 03/28/24. -Lexapro (antidepressant), 5 mg, by mouth, once daily, dated 01/04/23. -Trazodone (antidepressant, also used to treat insomnia), 50 mg, by mouth, at bedtime, dated 03/06/24. -Resident #1 did not have physician's orders for Seroquel or Risperidone. (continued on next page)

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F 0761 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Nurse Progress Note, dated 03/29/24, indicated he/she was transferred to the Hospital Emergency Department after staff found pharmacy packages ripped open. Review of Resident #1's Hospital Discharge Summary, dated 04/06/24, indicated Resident #1 was admitted to the Hospital Emergency Department on 03/29/24, was diagnosed with encephalopathy as a result of accidental ingestion and overdose of Seroquel and Risperidone at the Facility, and while in the Hospital Emergency Department, Resident #1's heart rate and blood pressure were elevated, he/she developed respiratory failure, and required intubation, ventilation, sedation, and was admitted to the Intensive Care Unit. The Discharge Summary indicated Resident #1 was extubated three days later on 04/01/24, and was discharged from the Hospital on 04/06/24 to a rehabilitation facility. During a telephone interview on 04/10/24 at 8:42 A.M., Nurse #1 said she was the nurse who worked the 11:00 P.M., (03/28/24) to 07:00 A.M., (03/29/24) shift on the unit where Resident #1 resided. Nurse #1 said Resident #1 was awake, wandering the unit, and had been wandering and standing over near the Nurses' Station throughout the shift. Nurse #1 said there was a pharmacy delivery that arrived at 01:39 A.M., and that there were only a few medications in the package, which were enclosed in a sealed red plastic bag. Nurse #1 said she did not secure the medications in the medication cart or the units locked medication room, which was located directly behind the Nurses' Station, but said she left them in the red plastic bag on the desk at the Nurses' Station throughout the shift. Nurse #1 said she should have secured the medications. Nurse #1 said when she came back to the Nurses' Station at 06:00 A.M., Resident #1 was standing alone, near the Nurses' Station, the red plastic bag with the medications in it was torn open, and multiple tablets of Risperidone and Seroquel were missing from those medication cards. Nurse #1 said she saw that there were some pills on the floor so she picked them up, so she was unsure how many of the pills Resident #1 may have ingested. Nurse #1 said she called poison control, notified the physician, and that Resident #1 was immediately transferred to the Hospital Emergency Department via 911 for evaluation and monitoring. During a telephone interview on 04/09/24 at 11:24 A.M., Certified Nurse Aide (CNA) #1 said Resident #1 was known to wander intrusively, rummage through others' belongings, and to eat others' food, would take anything that was left unsupervised, and was known to go behind the Nurses' Station and steal food. During an interview on 04/09/24 at 07:46 A.M., and throughout the survey, the Director of Nurses (DON) said it was facility policy and her expectation that nurses secure all medications in the locked medication carts or locked medication room, but on 03/29/24 Nurse #1 had not done either, and as a result, Resident #1 had accessed and ingested medications that were not prescribed to him/her and required transfer to the Emergency Department and admission to the Hospital.