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	03/09/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had dementia, with known behaviors of being intrusive and rummaging, the Facility failed to ensure they provided an environment free from accident hazards, when Resident #1 was able to get a hold of and consumed an object not meant for human consumption.Findings include:The Facility Policy, titled Safety and Supervision of Residents, dated as revised 05/2025, indicated the Facility would strive to provide an environment as free from accident hazards as possible, and resident supervision was a core component of the systems approach to safety.The Facility Policy, titled Meal Supervision and Assistance, dated 01/2025, indicated residents would be provided meals in the location of his/her preference and with adequate supervision and assistance to prevent accidents.Resident #1 was admitted to the Facility in November 2012, diagnoses included stroke, schizophrenia, anxiety, and dementia.Review of Resident #1's Activities of Daily Living (ADLs) Care Plan, dated as initiated 03/27/24 and renewed with his/her Quarterly Assessments on 12/03/25, indicated he/she required supervision when eating.Review of Resident #1's Behavior Care Plan, dated as initiated 11/20/20 and renewed with his/her Quarterly Assessments on 12/03/25, indicated he/she had known behaviors of being intrusive and rummaging.Review of Resident #1's Health Status Note, dated 01/28/26, indicated he/she was found unresponsive, Cardiopulmonary Resuscitation (CPR) was initiated by nursing, and he/she was transferred to the Hospital Emergency Department via 911.Review of the Ambulance Run Report, dated 01/28/26 indicated 911 paramedics continued CPR, applied the LUCAS device (robotic device that performs chest compressions) and that when intubation (tube inserted into the airway) was attempted, a foreign body was removed from Resident #1's airway which appeared to be a piece of plastic wrap with some food product wrapped up inside it. The Report indicated resident suffered sudden cardiac arrest (witnessed by roommate, who reported resident stood up, vomited and fell forward to floor).During an interview on 03/09/26 at 11:16 A.M., Certified Nurse Aide (CNA) #1 said that on 01/28/26 Resident #1 wanted to have lunch in his/her room, so she assisted him/her to eat in his/her room. CNA #1 said Resident #1 was tired that day, became drowsy as he/she ate, said he/she did not want to eat anymore. CNA #1 said she moved his/her food tray which was on his/her tray table out of his/her reach by pushing it across the room. CNA #1 said she removed all covers and any wrappings from the food from the room and left the room to assist another resident. CNA #1 said Resident #1 was not coughing or having any issues swallowing at breakfast or lunch that day and had no problem talking or communicating with her. CNA #1 said Resident #1 was not in any distress when she left his/her room.During an interview on 03/09/26, CNA #2 said that on 01/28/26 at 12:20 P.M., she found Resident #1 lying face down on the floor in his/her room and immediately called to nursing for help.During an interview on 03/09/26 at 2:45 P.M., Nurse #1 said that on 01/28/26 at 12:20 P.M., she heard CNA #2 yell for help because Resident #1 was on the floor. Nurse #1 said Resident #1 was lying face down on the floor and there was vomit under him/her. Nurse #1 said Resident #1 was not breathing, had no pulse, Code Blue was initiated and 911 was called. Nurse #1 said when nursing suctioned Resident #1's airway, a white substance was removed that resembled mashed potatoes. During an interview on 03/09/26 at 12:09 P.M., The Director of Nurses (DON) said the Facility was not (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to identify exactly where the plastic wrap came from, or when or how Resident #1 was able to get it, because he/she was supervised at all times when eating. The DON said Resident #1 should not have been able to get a hold of or ingest plastic wrap, but somehow, he/she had.On 03/09/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 02/01/26, which addressed the area(s) of concern as evidenced by:A. 01/29/26, the Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, and ensure that staff would provide continual supervision for all residents who require assistance with meals to prevent choking incidents.B. 01/29/26, the Director of Nursing/designee audited all resident care plans to identify residents who require supervision for meals due to cognitive impairment to ensure supervision is provided.C. 01/29/26, The DON/Unit Managers provided a list of residents who require assistance/supervision to the nursing staff. This practice will be ongoing and updated.D. 01/29/26, The SDC/designee provided education to all nursing staff that residents requiring supervision and/or assistance with meals due to impaired cognition are not to be left alone and that their tray is to be removed when the meal is finished and staff leaves the room.E. 01/30/26, The Facility leadership conducted a Root Cause Analysis to review the findings of their internal investigation, try to determine the cause of the incident, and prevent similar incidents.F. 01/30/26, The Facility removed plastic wrap from the kitchen and replaced it with other forms of food covering.G. The SDC added the protocol for dining supervision and/or assistance to the new nursing staff orientation and annual education.H. The Facility's Administrator educated dietary staff that going forward, plastic wrap will no longer be used, and that alternative covers will be used when food or beverages need to be covered.I. The Administrator, SDC, DON, and Unit Managers will conduct audits on the units daily for two weeks, weekly for four weeks, and then monthly until substantial compliance is achieved to ensure there is no plastic wrap found on the meal trays, and that food is not left with residents who require supervision due to cognitive impairment.J. Results of audits will be presented to QAPI.K. The DON/designee are responsible for ongoing compliance.