

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  Royal Wood Mill Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797</b></p> <p>Based on record review and interviews, the facility failed to ensure staff implemented abuse policies and procedures for one Resident (#28) out of a total of 20 sampled Residents. Specifically, for Resident #28 staff failed notify facility administration of an accusation that a Certified Nurse's Aide (CNA) wrapped a remote cord around his/her neck.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, undated, indicated that any employee who suspects an alleged violation shall immediately notify the executive director or his/her designee.</p> <p>Resident #28 was admitted to the facility in January 2025 with diagnoses including stroke with left sided hemiplegia/hemiparesis, dementia and depression.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #28 is totally dependent for all activities of daily living and scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment.</p> <p>Review of the progress notes dated 3/23/25 at 21:28 indicated that at around 7:00 P.M. Resident #28 accused CNA #2 of wrapping the call light cord around his/her neck.</p> <p>Review of the progress note dated 3/24/25, at 17:21 indicated that the Director of Nursing (DON) was notified at 4:00 P.M. that Resident #28's spouse reported that Resident #28 said that the evening prior a CNA had wrapped a call light cord around his/her neck.</p> <p>During an interview on 4/7/25 at 11:19 A.M. the Director of Nursing (DON) said that she had not been made aware of the accusation of abuse until the next afternoon on 3/24/25 at around 4:00 P.M. The DON said that the nurse who first heard of the accusation of abuse should have reported it to administration immediately so the facility could report the allegation of abuse to the state agency within the 2 our timeframe and start the investigation of the allegation immediately.</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to report an incident of resident to resident abuse to the state agency for one Resident (#11) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse Policy, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>- The ED (executive director) shall also notify the appropriate state agency in accordance with the state law.</li> <li>- The results of all investigations must be reported immediately to the ED or his/her designee and the appropriate state agency, as required by state law.</li> </ul> <p>Resident #11 was admitted in November 2010 with diagnoses including dementia.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #11 scored a three out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the MDS indicated Resident #11 has verbal and physical behaviors.</p> <p>Review of the incident report, dated 9/29/24, indicated Resident #11 walked into another Resident's room and slapped the Resident on the side of the face.</p> <p>Review of the healthcare facility reporting system failed to indicate that the incident had been reported.</p> <p>During an interview on 4/7/25 at 8:40 A.M., the Director of Nursing said that she should have reported the resident to resident interaction to the state agency.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an injury of unknown origin for one Resident (#18) out of a total sample of 21 residents. Specifically, Resident #18 was found to have a dislocated shoulder and the facility interviewed the staff on the morning shift of the incident, but no other staff that had taken care of Resident #18.</p> <p>Findings include:</p> <p>Review of the policy titled Abuse Policy, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-The facility shall take the following steps to prevent, detect, and report abuse, neglect, injuries of unknown source, and misappropriation of resident property.</li> <li>- Where the circumstances of the alleged violation warrants, the DNS or his/her designee, shall initiate a physical and mental assessment of the resident and document the findings. Factual information only shall be documented, no assumptions.</li> <li>- Interview staff members implicated.</li> <li>- Interview other staff members. Employee should document incident in a written statement.</li> <li>- Interview with resident or resident witnesses. Supervisor to document written statement from resident(s).</li> </ul> <p>Resident #18 was admitted in November 2023 with diagnoses including hypertension.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #18 scored a 1 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment.</p> <p>Review of an incident report, dated 6/20/24, indicated Resident #18 had malpositioning of the right shoulder and pain of a 6/10. An x-ray was completed and it was determined that Resident #18 had a dislocated shoulder.</p> <p>Review of the incident report indicated that two of the certified nursing aides were interviewed regarding the dislocated shoulder on the morning it was discovered.</p> <p>Review of the Resident interview with the social worker indicated that Resident #18 said I fell asleep, and when I woke up my shoulder was in pain.</p> <p>During an interview on 4/8/25 at 1:43 P.M., the Director of Nursing said that when an injury of unknown source occurs, she will typically interview everyone on the shift and would interview staff that were on the schedule days before the event occurred.</p> <p>Review of the incident report failed to indicate that staff were interviewed on any of the shifts from the day or night prior to Resident #18 waking up with pain with a dislocated shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25 at 8:35 A.M., the Director of Nursing said that she should have investigated and interviewed staff from the shift the night prior to the incident.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to update the plan of care after an incident of physical abuse for one Resident (#11) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the policy titled Abuse Policy, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>- The facility shall take the following steps to prevent, detect, and report abuse, neglect, injuries of unknown source, and misappropriation of resident property.</li> <li>- ABUSE: unjustified physical contact, intentional or careless, which is likely to result in physical or psychological harm.</li> <li>- If the suspected perpetrator is another resident, the DNS (director of nursing services) or his/her designee, shall separate the residents so they do not have access to each other until the circumstances of the alleged incident can be determined.</li> <li>- Where the circumstances of the alleged violation warrants, the DNS or his/her designee, shall initiate a physical and mental assessment of the resident and document the findings. Factual information only shall be documented, no assumptions.</li> <li>- The ED (executive director) shall also notify the appropriate state agency in accordance with the state law.</li> <li>- The results of all investigations must be reported immediately to the ED or his/her designee and the appropriate state agency, as required by state law.</li> </ul> <p>Resident #11 was admitted in November 2010 with diagnoses including dementia.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #11 scored a three out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the MDS indicated Resident #11 has verbal and physical behaviors.</p> <p>Review of the care plan for Resident #11 indicates the following:</p> <ul style="list-style-type: none"> <li>- Resident has a behavior problem AEB (as evidenced by): cursing at others, screaming at others, accusatory towards others, verbally intrusive. Grabbing others, kicking others, pushing others, hitting others, physically aggressive toward others, physically intrusive (initiated 11/20/20)</li> <li>- Interventions:</li> </ul> <p>* 1:1 monitoring for safety PRN (as needed) (initiated 4/7/25)</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>* Administer medications as ordered. (initiated 11/20/20)</li> <li>* Anticipate and meet the resident's needs to prevent frustration and behaviors (initiated 11/20/20)</li> <li>* Assist the resident to develop more appropriate methods of coping and interacting. Encourage him/her to express his/her feelings appropriately. (initiated 11/20/20)</li> <li>* Caregivers to provide opportunity for positive interaction and attention. Stop and talk with him/her when passing by (initiated 11/20/20)</li> <li>* Explain all procedures to the resident before starting and allow ample time for him/her to adjust to changes (initiated 11/20/20)</li> <li>* Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (initiated 8/10/23)</li> <li>* Obtain MD ordered lab work when ordered to r/o (rule out) cause of increased confusion/agitation (initiated 9/27/22)</li> <li>* Provide a program of activities that is of interest and accommodates residents status (initiated 2/18/21)</li> </ul> <p>Review of the incident report, dated 9/29/24, indicated Resident #11 had walked into another Resident's room and slapped the other Resident on the side of the face.</p> <p>Review of the care plan failed to indicate that it had been reviewed or updated after the incident of abuse.</p> <p>During an interview on 4/8/25 at 1:40 P.M., the Director of Nursing said that it is facility protocol to update the plan of care after a resident to resident incident, but that she probably missed it and said the care plan should have been updated.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</b></p> <p>Based on observation, record review, the facility failed to provide care in accordance with professional standards of care, and for one Resident (#30) out of a sample of 20 residents, the facility failed to follow physician's orders as indicated. Specifically:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure staff were awake and alert during the 11:00 P.M. - 7:00 A.M. shift.</li> <li>2. The facility failed to ensure the nurse checked medications against the physician's order three times when dispensing a medication.</li> <li>3. For Resident #30, the facility took blood pressures on his/her right arm while the physician's orders indicated not to do so.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's Employee Handbook dated March 2017 indicated:  Hours and Compensation: All employees working a shift of 6 hours or more will be entitled to a paid 15 minute rest break and an un-paid 30 minute meal break. Employees must clock in and out for their allotted meal break.  Code of Conduct: As a company team member, employees are expected to accept certain responsibilities, follow acceptable business principles in matters of conduct, and exhibit a high degree of integrity at all times. This not only involves sincere respect for the rights and feelings of others, but also demands that employees refrain from any behavior that might be harmful to themselves, co-workers, residents, the company or that might be viewed unfavorably by current or potential customers or by the public at large.  Types of behavior and conduct that the company considers inappropriate include, but are not limited to the following: Sleeping or loitering during working hours.  During the Resident Group Interview on 4/7/25 at 11:00 A.M., six participating members reported that staff on the 11:00 P.M. - 7:00 A.M. shift sleep during the night on both the 1st and 2nd floor nursing units. One Resident said that he/she observes staff making beds by placing sheets and blankets over chairs. Another Resident said that they had reported this issue to the Administrative team, and although the incidents have improved, staff are continuing to sleep during the overnight shift.  Review of the grievance dated 3/19/25 indicated: Description of Complaint: Staff sleeping. Resident stated these were concerns he/she had previously had but wanted [Administrator] to know. Summary of findings: Resident attended resident council in February and expressed concerns. DON educated staff. Second resident council meeting residents expressed improvement. Corrective Action: Education to be provided by Administrator. Resident assured Administrator will follow up. Resident agreeable to plan although he/she is discharging. <p>(continued on next page)</p> </li></ol>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Attached to the grievance was an in-service sheet indicating Education topic: Staff are not to sleep on shift. The sheet indicated two nurses and one Certified Nursing Aid (CNA) working the 3:00 P.M. - 11:00 P.M. and one nurse working the 11:00 P.M. - 7:00 A.M. were given the education.</p> <p>Review of the Resident Council Meeting Minutes for January 2025, February 2025 and March 2025 failed to include Resident reported concerns related to staff sleeping on the overnight shift.</p> <p>During an early morning visit on 4/8/25 at 3:00 A.M., the surveyors entered the building and observed the following:</p> <p>Upon entry to the first floor unit a high pitched, loud alarm sounded. The surveyors observed that no staff members responded to the alarm and a surveyor silenced the alarm. The surveyor then observed in the first floor dining room, that all the lights were off and the room was dark. The surveyor then observed CNA#2 with her head down on a rolled up blanket on a table sleeping. The surveyor then observed CNA #3 wrapped up in blankets, sitting in a chair with her feet elevated, sleeping.</p> <p>Upon entry to the second floor unit, no staff was observed at the Nurses station. All the residents were asleep, the surveyor found Nurse #1 and CNA #1 in the dining room sleeping. The dining room was dark, all the lights were turned off. CNA #1 was wrapped in linens and blankets. Nurse #1 was sitting and sleeping in a chair in the corner, she had no linens and blankets covering her. Both CNA #1 and Nurse #1 said they were sleeping because they were on their break.</p> <p>Review of the time cards punches for Nurse #1, CNA #1, CNA #2 and CNA #3 indicated they did not punch out during the 11:00 P.M. - 7:00 A.M., shift at any time for a scheduled break.</p> <p>During an interview on 4/8/25 at 4:19 A.M., the Administrator said that she began her employment at the facility in February 2025. The Administrator said that she believed that concerns related to staff sleeping at night were brought up during the January 2025 Resident Council meeting and were addressed by the Director of Nursing by providing education to staff. The Administrator said that resident's may have brought up the concerns again during the February 2025 Resident Council meeting, but she was not sure. The Administrator said that staff are to punch out when taking their breaks and CNA's should take turns and leave the unit while on break. The Administrator said that nurses are expected to be available 24 hours a day and should not be sleeping while on break. The Administrator said that Nurses and CNA's should not be sleeping on resident units.</p> <p>36797</p> <p>2. Review of the facility policy titled Administering Medications, dated August 2024, failed to indicate that the nurse is to check the medications against the physician's orders.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During medication pass on 4/7/25, at 8:48 A.M., Nurse #3 told the surveyor that her medication cart computer was broken. Nurse #3 then said that she was stationing her medication cart near the nurse's station because she was using the computer at the nurse's station to pass medications. The surveyor then observed Nurse #3 read from the computer at the nurse's station. Nurse #3 then returned to the medication cart where she dispensed four medications into a medication cup from memory. The surveyor then observed Unit Manager (UM) #1 print out a list of 3 more medications and hand the list to Nurse #3. Nurse #3 dispensed the medications from the list. UM #1 then told Nurse #3 that she could not print out the remaining medications scheduled to be dispensed, wrote them out on a piece of paper and handed the hand written list to Nurse #3. Nurse #3 did not check the hand written note against the physician's orders in the computer for accuracy. Nurse #3 then dispensed the medications from the hand written list that UM #1 had written and administered all of the medications to the resident.</p> <p>During an interview on 4/7/25, at 9:03 A.M., Nurse #3 said that she is supposed to triple check each medication against the physician's order before administering the medications to the resident. Nurse #3 then said that she did not triple check medications while dispensing the medications. Nurse #3 also said that she depended upon UM #1 to accurately write down the scheduled medications and should not have.</p> <p>During an interview on 4/7/25 at 11:19 A.M. the Director of Nursing (DON) said that if a nurse's medication cart computer is not working then she is to print out the Medication Administration Record (MAR) for each resident before preparing the medications. The DON then said that it is the standard of practice for a nurse to check each medication 3 times against the physician's order during the dispensing of the medications to ensure accuracy.</p> <p>43807</p> <p>3. Resident #30 was admitted to the facility in December 2024 with diagnoses including end stage renal disease, dependence on renal dialysis and an arteriovenous fistula.</p> <p>A review of the facility policy titled 'Hemodialysis Access Care' dated 5/2023 indicated the following:</p> <p>-Care of AVFs (Arterio-Venous Fistula):</p> <p>-To prevent infection and/or clotting, do not use the access arm to take blood pressure.</p> <p>A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment.</p> <p>A review of Resident #30's April 2025 physician's orders indicated the following:</p> <p>-No blood pressure on right arm every shift. Start date, 12/9/24.</p> <p>A review of Resident #30's vitals: blood pressure indicated the following:</p> <p>-4/4/25, 9:35 P.M., 150/54 mmHg (millimeters of mercury) (Sitting r/arm).</p> <p>-2/7/25, 5:15 A.M., 134/68 mmHg (millimeters of mercury) (Lying r/arm).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-2/6/25, 2:08 P.M., 150/78 mmHg (millimeters of mercury) (Sitting r/arm).</p> <p>-1/17/25 10:46 P.M., 110/60 mmHg (millimeters of mercury) (Lying r/arm).</p> <p>-1/6/25-6:54 A.M., 130/70mmHg (millimeters of mercury) (Lying r/arm).</p> <p>-1/5/25-2:45 P.M., 134/67 mmHg (millimeters of mercury) (Lying r/arm).</p> <p>-1/4/25-12:50 A.M., 116/56 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/3/25-1:43 P.M., 110/53 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/2/25- 5:50 P.M., 113/57 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/1/25- 8:45 P.M., 100/50 mm/Hg (millimeters of mercury) (Sitting r/arm).</p> <p>During an interview and medical record review on 4/7/25 at 12:47 P.M., the Director of Nurses and Unit Manager #1 said the Nurses should follow the physician's orders and not take blood pressure on Resident #30's right arm.</p> <p>Ref F842</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36876</p> <p>Based on record review and interview, the facility failed to follow a physician's order for air mattress settings for three Residents (#49, #17 and #268) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the policy titled Prevention of Pressure Ulcers/Injuries, dated May 2023, indicated the following:</p> <ul style="list-style-type: none"> <li>- Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.</li> </ul> <p>Review of the facility policy titled Support Surface Guidelines, dated October 2023, indicated the following:</p> <ul style="list-style-type: none"> <li>- Any individual at risk for developing pressure ulcers may be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed.</li> <li>- Support surfaces alone are not effective in preventing pressure ulcers, but studies indicate that the use of appropriate support surfaces with interventions such as turning, repositioning and moisture management can assist in reducing pressure ulcer development.</li> <li>- Support surfaces are modifiable. Individual resident needs differ.</li> </ul> <p>A review of the operator's manual titled 'Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System, item #14026' indicated the following:</p> <p>-Indications-The Med Aire Melody Alternating Pressure and Low Air Loss Mattress Replacement System, item #14026 is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program.</p> <p>1. Resident #49 was admitted to the facility in January 2022 with diagnoses including Parkinson's disease, dementia and chronic kidney disorder.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #49 is severely cognitively impaired evidenced by a score of four out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #49 requires assistance with bathing and dressing.</p> <p>Review of the Support Surface Guidelines policy, dated October 2023 indicated: Use of a pressure ulcer risk scale such as the [NAME] or Braden Scale to help determine need for and appropriate type of pressure relieving devices. Refer to bed selection algorithm for support surface selection.</p> <p>On 4/6/25 at 7:49 A.M., the surveyor observed Resident #49 asleep in bed. Resident #49 was on an air mattress set at 200 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #49's most recent weight obtained on 4/1/25 indicated he/she weighed 122 lbs.</p> <p>Review of the physicians orders indicated: Air Mattress - Pressure set per residents most recent weight; +/- 10 lbs. Document weight. Check placement and function every shift, initiated 1/28/25.</p> <p>Review of Resident #49's care plans indicated:</p> <p>Focus: Resident has potential for developing pressure ulcers r/t (related to) bowel and bladder incontinence, revised 1/23/23.</p> <p>Interventions: The resident requires pressure reducing devices on bed and wheelchair.</p> <p>Review of Resident #49's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 1/17/25 indicated he/she was at risk for developing pressure ulcers.</p> <p>On 4/7/25 at 7:28 A.M., the surveyor observed Resident #49 asleep in bed. The air mattress was set at 200 lbs.</p> <p>On 4/7/25 at 8:27 A.M., Unit Manager #1 was observed seated next to Resident #49 assisting him/her with the breakfast meal. Resident #49 was laying in bed and the air mattress was set to 200 lbs. Unit Manager #1 said that the air mattress should be set to Resident #49's weight.</p> <p>During an interview on 4/8/25 at 7:38 A.M., the Director of Nursing said that the expectation is for staff to set air mattresses at the correct setting.</p> <p>41019</p> <p>2. Resident #17 was admitted in April 2013 with diagnoses including dementia.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #17 did not participate in the Brief Interview for Mental Status exam, but was moderately cognitively impaired. Review of the MDS indicated Resident #17 is dependent for all activities of daily living and mobility.</p> <p>Review of the most recent wound doctor evaluation, dated 4/2/25, indicated that Resident #17 has an unstageable wound of the left foot.</p> <p>Review of the current physician's orders indicate the following order:</p> <p>-Air mattress- pressure set per resident's most recent weight +/- 10 pounds. Document weight. Check placement and function every shift.</p> <p>Review of Resident #17's weight summary indicated his/her most recent weight, on 4/4/25, was 85 pounds.</p> <p>During an observation on 4/6/25 at 9:37 A.M., Resident #17's air mattress was set to 330 pounds of pressure.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/7/25 at 7:24 A.M., Resident #17 was lying in bed with the air mattress set at 280 pounds of pressure.</p> <p>During an observation on 4/8/24 at 7:54 A.M., Resident #17's air mattress was set to 280 pounds of pressure.</p> <p>During an interview on 4/9/24 at 8:37 A.M., the Director of Nursing said that she would expect staff to follow the physician's orders for air mattress settings.</p> <p>43807</p> <p>3. Resident #268 was admitted to the facility in February 2025 with diagnoses including type 2 diabetes.</p> <p>A review of the Minimum Data Set, dated dated dated [DATE] did not indicate a Brief Interview for Mental Status score.</p> <p>A review of the care plan initiated on 2/24/25 indicated the Resident is not able to make his/her own health care decisions.</p> <p>Further review of the care plan initiated on 2/26/25 indicated that the Resident has actual impairment to skin integrity as evidenced by an undetermined thickness deep tissue injury to the right 4th and 5th toe, an undetermined thickness deep tissue injury to the right lateral heel, an undetermined thickness deep tissue injury to the left great toe, 4th and 5th toes and an undetermined thickness deep tissue injury to the left heel.</p> <p>A review of Resident #268's April 2025 physician's orders indicated the following:</p> <p>-Air Mattress-Pressure set per resident's most recent weight, plus or minus 10 pounds.</p> <p>Document weight. Check placement and function every shift. Order dated, 3/20/25.</p> <p>A review of Resident #268's most recent weight dated 4/6/25 indicated the Resident weighed 169.8 pounds.</p> <p>On 4/6/25 at 9:40 A.M., the surveyor observed the Resident in bed. The air mattress was set at 210.</p> <p>On 4/7/25 at 9:32 A.M., and 12:12 P.M., the surveyor observed the Resident in bed. The air mattress was set at 320.</p> <p>On 4/8/25 at 3:36 A.M., the surveyor observed the Resident in bed. The air mattress was set at 320.</p> <p>During an interview and observation on 4/8/25 at 7:51 A.M., the surveyor and Unit Manager #2 observed the Resident in bed with the air mattress setting at 320. Unit Manager #2 said as per the physician's orders, the air mattress should be set at the Resident's current weight plus or minus 10 pounds. Unit Manager #2 said the air mattress should be set at 180.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/8/25 at 7:53 A.M., the Director of Nurses said the Resident's air mattress should be set as per the physician's orders, the Resident's current weight plus or minus 10 pounds. The DON said the air mattress should be set at 180.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on observations, record review and interview, the facility failed to ensure three residents (#58, #17, and #2) were free from accidents and hazards including elopement and failed to ensure the appropriate interventions were implemented for safety. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #58, the facility to a. prevent an elopement from a secured unit and b. perform a thorough investigation</li> <li>2. For Resident #17, the facility failed to implement a falls intervention</li> <li>3. For Resident #2, the facility failed to apply seizure pads to bilateral side rails as ordered</li> </ol> <p>Findings include:</p> <p>Review of the facility policy titled Resident Elopement and Wandering, dated June 2024, indicates the following:</p> <ul style="list-style-type: none"> <li>- Resident elopement is defined as that situation where a cognitively impaired resident or someone with impaired safety awareness actually leaves the facility premises/property without staff knowledge.</li> <li>- When the resident is located:</li> <li>- Nursing to assess the resident thoroughly and document findings in the medical record/nurses notes</li> <li>- Notify the MD, DON, Nurse Supervisor, Resident's legal representative/family</li> <li>- Investigate causal factors related to the elopement</li> <li>- Update the post elopement evaluation form &amp; incident report</li> <li>- Update care plan</li> <li>- Reporting: the Executive Director or designee shall notify the state agency as required by law</li> </ul> <p>1a. Resident #58 was admitted in November 2023 with diagnoses including frontotemporal neurocognitive disorder and unspecified psychosis.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #58 scored a 7 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment.</p> <p>Review of the current care plan indicates the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident has a behavior problem AEB (as evidenced by): wandering, pacing (initiated 12/7/23)</p> <p>Review of the care plan failed to indicated Resident #58 was at risk for elopement prior to his/her elopement.</p> <p>Review of the elopement assessment, dated 6/4/24, indicated Resident #58 was not an elopement risk.</p> <p>Review of the incident report, dated 7/13/24, indicated Resident #58 had been seen outside of the facility and stated he/she was walking to the store. Resident #58 was returned to the facility and put on 15 minute checks and a wanderguard (a device applied to set off a door alarm if the Resident attempts to exit) was applied to Resident #58.</p> <p>During an interview on 4/7/25 at 8:33 A.M., the Director of Nursing said Resident #58 was on the first floor when it happened and he/she must have walked out the front door because it is unlocked.</p> <p>Review of the census report failed to indicate Resident #58 had been on the first floor since admission.</p> <p>During an interview on 4/7/25 at 10:55 A.M., Nurse #6 said that Resident #58 has been on the second floor since admission and she was at the facility when the elopement occurred, but could not recall how Resident #58 got out of the building. Nurse #6 said that Resident #58 could have gone out of the building with the smoking group and just started walking away when someone was not looking, but she is not sure.</p> <p>1b. Review of the investigation report failed to include witness statements to recount the events that occurred on 7/13/24.</p> <p>During an interview on 4/7/25 at 8:33 A.M., the Director of Nursing said that when a Resident elopes from the facility, they would put the Resident on the second floor because the second floor is a locked and secured unit. The Director of Nursing said that she should have reported it and does not remember if she ever obtained witness statements.</p> <p>2. Review of the policy titled Managing Falls and Fall Risk Policy Statement, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>- The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.</li> <li>- If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approaches remain relevant.</li> <li>- The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.</li> <li>- If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #17 was admitted in April 2013 with diagnoses including dementia.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #17 did not participate in the Brief Interview for Mental Status exam, but is moderately cognitively impaired. Review of the MDS indicated Resident #17 is dependent for all activities of daily living and mobility.</p> <p>Review of the falls care plan for Resident #17 indicated the following:</p> <ul style="list-style-type: none"> <li>- Resident is at risk for falls r/t (related to) decreased safety awareness d/t (due to) dementia and psychosis (initiated 11/4/20)</li> <li>* Anticipate and meet the resident's needs (initiated 12/18/22)</li> <li>* Bed and chair alarm in place at all times. Check every shift for functioning and placement (initiated 2/21/23)</li> <li>* Educate the resident/caregivers about safety reminders and what to do if a fall occurs (initiated 11/24/22)</li> <li>* RESOLVED: Encourage the resident not to furniture walk when in room. Educate him/her on the safety risks of doing so (initiated 3/19/22; resolved on 3/20/25)</li> <li>* Encourage the resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility as tolerated (initiated 11/4/20)</li> <li>* Ensure that the resident is wearing the appropriate footwear when in wheelchair and when in bed (initiated 11/18/23)</li> <li>* Ensure the resident's call light is within reach and encourage him/her to use it for assistance as needed (initiated 4/3/23)</li> <li>* Follow facility fall protocol (initiated 11/4/20)</li> <li>* May use geri chair for enhanced comfort/positioning (initiated 3/18/25)</li> <li>* The resident requires total assistance with wheelchair mobility (initiated 11/4/20)</li> <li>* RESOLVED: Physical therapy evaluation (initiated 3/19/22; resolved on 3/24/22)</li> <li>* RESOLVED: Pt evaluate and treat as ordered or PRN (as needed) (initiated 5/24/23; resolved on 3/24/22)</li> <li>* RESOLVED: PT evaluated and treat as ordered or PRN (initiated 2/23/24; resolved 5/20/24)</li> <li>* RESOLVED: PT evaluate and treat as ordered or PRN (initiated 6/2/24; resolved 8/9/24)</li> <li>* RESOLVED: Rehab to screen resident to assess safety of furniture placement in room (initiated 3/19/22; resolved 6/23/22)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Remind resident to call staff for help and do not try to pick things up from the floor (initiated 5/23/23)</p> <p>Review of the fall risk assessment, dated 5/16/24, indicated Resident #17 was at risk for falls.</p> <p>Review of the incident report, dated 6/2/24, indicated Resident #17 fell in the unit dining room on his/her left side and was found face down. The fall was unwitnessed.</p> <p>Review of the care plan indicated that an intervention for PT to evaluate and treat was ordered on 6/2/24.</p> <p>Review of the rehab notes failed to indicate that PT ever evaluated or treated Resident #17.</p> <p>Review of the incident report, dated 6/22/24, indicated Resident #17 fell in his/her room at the bedside.</p> <p>Review of the care plan failed to indicated that it was revised or updated after the fall on 6/22/24.</p> <p>Review of the incident report, dated 12/11/24, indicated Resident #17 was found on the dining room floor face down. The fall was unwitnessed.</p> <p>During an interview on 4/8/24 at 1:41 P.M., the Director of Nursing said that usually the team will discuss falls the next day and will update the plan of care. The Director of Nursing said that rehab should have seen Resident #17 after his/her fall on 6/22/24, but did not. The Director of Nursing said that the rehab department attends the interdisciplinary team meetings and that Resident #17 should have been seen after discussing the fall.</p> <p>43807</p> <p>3. Resident #2 was admitted to the facility in April 2000 with diagnoses including epilepsy and epileptic syndromes with complex and partial seizures.</p> <p>A review of the most recent Minimum Data Set, dated dated [DATE] did not indicate a Brief Interview for Mental Status score because the Resident is rarely/never understood.</p> <p>A review of Resident #2's April 2025 physician's orders indicated the following:</p> <p>-Seizure pads to bilateral side rails. Check placement every shift. Order date, 12/21/22.</p> <p>On 4/7/25 at 7:35 A.M., and 9:40 A.M., the surveyor observed the Resident sleeping in bed with one seizure pad on the left side rail.</p> <p>On 4/8/25 at 3:35 A.M., the surveyor observed the Resident sleeping in bed with one seizure pad on the left side rail.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 4/8/25 at 7:40 A.M., the surveyor and Unit Manager #1 observed the Resident sleeping with one seizure pad on the left side rail. Unit Manager #1 found the other seizure pad on the Resident's dresser. Unit Manger #1 said as per the physician's orders, the Resident should always have two seizure pads on the side rails while in bed.</p> <p>During an interview on 4/8/25 at 7:53 A.M., the Director of Nurses (DON) said physician's orders should always be followed. The DON said Resident # 2 should always have two seizure pads while in bed because of his/her history of seizures.</p> <p>Ref to F842</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36797</p> <p>Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biological's in accordance with State and Federal requirements. Specifically:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure medication and treatment carts were locked while a nurse was not present and failed to ensure medications were not left unattended on top of the medication cart when a nurse was not present.</li> <li>2. The facility failed to ensure medications were not left at the bedside for one Resident (#64) out of a total of 20 sampled Residents.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility policy titled Administering Medications, dated August 2024 indicated that during the administration of medications, the medication cart will be kept closed and locked when out of sight of the nurse. Further review indicated that no medications are to be left on top of the cart and all medications must be inaccessible to residents and other passers by.</li> </ol> <p>Review of the facility policy titled Storage of medications, not dated, indicated that unlocked medication carts are not left unattended.</p> <p>On 4/6/25, at 7:04 A.M., the surveyor observed the first floor medication carts and a treatment cart open and not in view of the nurse. Nurse #5 then left the area without securing the carts, while the oncoming nurse and 2 residents were in the hallway next to the open carts and had full access to them.</p> <p>On 4/7/25, at 9:08 A.M. the surveyor observed Nurse #4 walk away from the medication cart with an entire card of Rosuvastatin on top of the cart.</p> <p>During an interview on 4/07/25, at 9:08 AM Nurse #4 said she should not have left the card of medicine on top of the medication cart</p> <p>On 4/7/25 at 9:40 A.M., the surveyor observed Nurse #3 seated behind the nurses station. Nurse #3's medication cart was in the hallway, out of view and unlocked and unattended. Nurse #3 then entered the medication room and closed door behind her, while her medication cart continued to be unlocked and unsupervised. Nurse #3 exited the medication room and sat at the nurses station to continue her documentation. Unit Manager #1 arrived on the unit and then secured the medication cart.</p> <p>During an interview on 4/7/25 at 9:46 A.M., Nurse #3 said she did not lock the medication cart when she should have.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/7/25, at 10:03 A.M. the surveyor observed Nurse #6 enter a resident's room, on the second floor, to deliver medication. The surveyor observed that Nurse #6 had her back to the medication cart and the medication cart was unlocked. The surveyor also observed that there were two residents standing next to the medication cart, potentially having full access to it.</p> <p>During an interview on 4/7/25 at 10:11 A.M., Nurse #6 said that she should not have left the medication cart unlocked.</p> <p>On 4/7/25, at 10:16 A.M., the surveyor observed a treatment cart unlocked on first floor.</p> <p>36876</p> <p>2. Resident #64 was admitted to the facility in August 2024 with diagnoses including malignant neoplasm of unspecified kidney and urinary retention.</p> <p>Review of the Minimum Data Set assessment dated [DATE] indicated Resident #64 is cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam.</p> <p>During an interview on 4/6/25 at 9:18 A.M., the surveyor observed Resident #64 in bed and a cup of pills on his/her dresser. Resident #64 said the nurse had given him/her the medications and he/she told her that he/she would take the medications and then he/she went back to sleep.</p> <p>Review of the Medication Administration Record (MAR) for April 2025 on 4/6/25 at 10:17 A.M. indicated nursing had administered the following medications to Resident #64:</p> <p>HydroCHLORothiazide Oral Tablet 25 MG (Hydrochlorothiazide) Give 1 tablet by mouth in the morning for HTN</p> <p>amLODIPine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth in the morning for HTN</p> <p>Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for Constipation</p> <p>Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 0.4 mg by mouth in the morning related to MALIGNANT NEOPLASM OF UNSPECIFIED KIDNEY</p> <p>traMADol HCl Oral Tablet 50 MG (Tramadol HCl)</p> <p>Review of Resident #64's Self Administration of Medications assessment dated [DATE] indicated he/she was not able to administer his/her own medications or store medications at bedside.</p> <p>During an interview on 4/8/25, the Director of Nursing said that medications should not be left at bedside and the nurse should have administered Resident #64's medications.</p>		

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

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36797</p> <p>Based on record review and interview, the facility failed to ensure specialized rehab services were provided in a timely fashion for one Resident (#28) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Specialized Rehabilitative Services, not dated, indicated that the facility provides specialized rehabilitative services by qualified professional personnel.</p> <p>Resident #28 was admitted to the facility in January 2025 with diagnoses including stroke with left sided hemiplegia/hemiparesis, contracture of muscle of left hand and dementia.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #28 is totally dependent for all activities of daily living and scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. Further review indicated range of motion impairment on one side of upper extremity including wrist and hand.</p> <p>On 4/06/25, at 7:59 A.M. the surveyor observed Resident #28 lying in bed. The surveyor observed that Resident #28 had a severely contracted hand and fingers. The surveyor also observed that Resident was without a palm guard/splint on the left wrist/hand. The surveyor was not able to locate a palm guard/hand splint in Resident #28's room.</p> <p>During an interview on 4/06/25, at 7:59 A.M. Resident #28 said that he/she used to have something on his/her hand but has not had one in a long time.</p> <p>Review of the admission documentation received by the facility from the Resident's prior nursing facility indicated that Resident #28 was receiving occupational therapy to address the contracture's of his/her left hand.</p> <p>Review of the occupational therapy discharge note from the prior facility, dated 1/20/25, indicated the following:</p> <p>a. Patient will safely wear least restrictive splinting/orthotic device during daily tasks without skin irritation and complaints of discomfort in order to improve PROM (passive range of motion) for adequate hygiene and inhibit abnormal positions.</p> <p>b. progress and response to treatment: patient made consistent progress throughout plan of treatment with donning of palm guard s/p (status post) PROM to L (left) digits tolerating 8 hrs (hours).</p> <p>c. D/C (discharge) recs (recommendations): Recommend continuation of splinting of L hand and PROM to LUE (left upper extremity) at new LTC (long term care) facility.</p> <p>Review of the progress note, from prior facility, dated 12/30/24, indicated the following:</p> <p>(continued on next page)</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>eMar - Medication Administration Note. Note Text: Apply palm guard to left. hand during AM care post hand hygiene as tolerated. every day shift check for placement, reapply as needed, check skin for integrity. unable to find.</p> <p>On 4/6/25 at 12:32 P.M., the surveyor observed Resident #28 without a palm guard/splint on the left wrist/hand. The surveyor was not able to locate a palm guard/hand splint in Resident #28's room.</p> <p>On 4/7/25, at 12:14 P.M. the surveyor observed Resident #28 lying in bed without a palm guard/splint on the left wrist/hand. The surveyor was not able to locate a palm guard/hand splint in Resident #28's room.</p> <p>Review of the physician's orders dated April 2025 failed to indicate an order for a palm guard/hand splint. Further review failed to indicate an order for rehabilitation therapy.</p> <p>Review of the care plan failed to indicate the use of a palm guard/hand splint.</p> <p>During an interview on 4/07/25, at 2:33 P.M. the Director of Rehab (DOR) said he was not under the impression from nursing that Resident #28 had been receiving therapy at the previous facility so he did not look for and/or read any therapy notes from the previous facility. The DOR said that it is the responsibility of nursing to inform the rehab department when a resident is admitted who needs therapy, as all admissions are not automatically screened for potential therapy needs. The DOR said that Resident #28 should have been at least screened by therapy upon admission as he/she was receiving occupational therapy at his/her previous nursing home.</p> <p>During an interview on 4/08/25, at 8:35 A.M., Resident #28 said that he/she was given the palm guard yesterday and that before yesterday he/she did not have one since coming to the building.</p> <p>During an interview on 4/08/25 at 8:39 A.M., Nurse #7 said that prior to yesterday she had not seen a palm guard/hand splint on Resident #28.</p> <p>During an interview on 4/08/25, at 8:40 A.M., CNA #5 said that she is Resident #28's regular CNA and she has never seen a palm guard/hand splint for Resident #28 prior to today.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</b></p> <p>Based on observation, record review and interview, the facility failed to ensure medical records were complete and accurate for 4 residents, (#40, #30, #2 and #268) out of total of 20 sampled Residents. Specifically:</p> <ol style="list-style-type: none"> <li>1. For Resident #40, the facility failed to accurately document an order and implementation related to oxygen use.</li> <li>2. For Resident #30 the facility inaccurately documented that they took blood pressures on the correct arm.</li> <li>3. For Resident #2, the facility inaccurately documented that they applied both seizure pads in the Resident's bed.</li> <li>4. For Resident #268, the facility inaccurately documented that the air mattress settings were set correctly.</li> </ol> <p>Findings include:</p> <p>Review of the Charting and Documentation policy, undated, indicated: Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.</p> <ol style="list-style-type: none"> <li>1. Resident #40 was admitted to the facility in January 2025 with diagnoses including acute respiratory failure with hypoxia and type II diabetes.</li> </ol> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #40 is cognitively intact evidenced by a score of 14 out of 15 in the Brief Interview for Mental Status Exam. The MDS also indicated Resident #40 requires assistance with bathing and dressing.</p> <p>Additional review of the MDS indicated Resident #40 was on oxygen therapy.</p> <p>During an interview on 4/6/25 at 7:59 A.M., the surveyor Resident #40 was seated in his/her wheelchair in his/her room not wearing oxygen.</p> <p>Review Resident #40's physicians orders indicated: O2 @ 1-4L /min via nasal cannula continuous to maintain O2 (oxygen) sats (saturations) greater than 90%, initiated 1/14/25.</p> <p>Review of Resident #40's care plans indicated:</p> <p>Focus: The resident requires oxygen therapy r/t (related to) respiratory failure, pulmonary collapse and OSA (obstructive sleep apnea), initiated 1/15/25.</p> <p>Interventions: Oxygen settings: The resident has O2 @ 1-4L/min as ordered. See MAR (Medication Administration Record).</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/6/25 at 11:46 A.M., the surveyor observed Resident #40 asleep in bed, not wearing oxygen.</p> <p>During an interview on 4/6/25 at 1:08 P.M., Resident #40 was observed in his/her room seated in his/her wheelchair, not wearing oxygen. Resident #40 said he/she doesn't wear oxygen and hasn't since being in the facility.</p> <p>During an interview on 4/7/25 at 8:25 A.M., Nurse #3 said that Resident #40 is on oxygen PRN (as needed).</p> <p>On 4/7/25 at 7:33 A.M., the surveyor observed Resident #40 seated in his/her wheelchair in the lobby area, not wearing O2.</p> <p>During an interview on 4/7/25 at 9:52 A.M., Unit Manager #1 said that Resident #40 utilizes oxygen PRN. Unit Manager #1 and the surveyor reviewed Resident #40's physician's orders and Unit Manager #1 said that the order was transcribed in error and it should be PRN.</p> <p>Review of the January 2025, February 2025, March 2025 and April 2025 MAR indicated nursing staff were signing off on all three shifts that Resident #40 was receiving continuous oxygen daily from admission through 4/7/25; after Unit Manager #1 said that the oxygen order was written incorrectly.</p> <p>During an interview on 4/8/25 at 8:36 A.M., The Director of Nursing (DON) said that Resident #40's oxygen order should have been PRN and nurses should be paying attention to the orders and documenting medications/treatments that are implemented.</p> <p>43807</p> <p>2. Resident #30 was admitted to the facility in December 2024 with diagnoses including end stage renal disease, dependence on renal dialysis and an arteriovenous fistula.</p> <p>A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 9 out of a possible 15 indicating moderate cognitive impairment.</p> <p>A review of Resident #30's April 2025 physician's orders indicated the following:</p> <ul style="list-style-type: none"> <li>-No blood pressure on right arm every shift. Start date, 12/9/24.</li> </ul> <p>A review of Resident #30's vitals: blood pressure indicated the following:</p> <ul style="list-style-type: none"> <li>-4/4/25, 9:35 P.M., 150/54 mmHg (millimeters of mercury) (Sitting r/arm).</li> <li>-2/7/25, 5:15 A.M., 134/68 mmHg (millimeters of mercury) (Lying r/arm).</li> <li>-2/6/25, 2:08 P.M., 150/78 mmHg (millimeters of mercury) (Sitting r/arm).</li> <li>-1/17/25 10:46 P.M., 110/60 mmHg (millimeters of mercury) (Lying r/arm).</li> <li>-1/6/25-6:54 A.M., 130/70mmHg (millimeters of mercury) (Lying r/arm).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1/5/25-2:45 P.M., 134/67 mmHg (millimeters of mercury) (Lying r/arm).</p> <p>-1/4/25-12:50 A.M., 116/56 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/3/25-1:43 P.M., 110/53 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/2/25- 5:50 P.M., 113/57 mm/Hg (millimeters of mercury) (Lying r/arm).</p> <p>-1/1/25- 8:45 P.M., 100/50 mm/Hg (millimeters of mercury) (Sitting r/arm).</p> <p>A review of Resident #30's January 2025 Medication Administration Record (MAR) indicated Nurses documented they took the Residents blood pressure on the left arm on 1/17/25 evening shift, 1/6/25 night shift, 1/5/25 day shift, 1/4/25 night shift, 1/3/25 day shift, 1/2/25 evening shift, 1/1/25 evening shift.</p> <p>A review of Resident #30's February 2025 MAR indicated Nurses documented they took the Resident's blood pressure on the left arm on 2/7/25 night shift, 2/6/25 day shift.</p> <p>A review of Resident #30's April 2025 MAR indicated Nurses documented they took the Resident's blood pressure on the left arm on 4/4/25 day shift.</p> <p>During an interview and medical record review on 4/7/25 at 12:47 P.M., the Director of Nurses and Unit Manager #1 said the Nurses document accurately in the medical record. They both said Nurses should not document that they took blood pressures on the left arm when they took blood pressures on the right arm.</p> <p>3. Resident #2 was admitted to the facility in April 2000 with diagnoses including epilepsy and epileptic syndromes with complex and partial seizures.</p> <p>A review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status (BIMS) score because the Resident is rarely/never understood.</p> <p>A review of Resident #2's April physician's orders indicated the following:</p> <p>-Seizure pads to bilateral side rails. Check placement every shift. Order date, 12/21/22.</p> <p>On 4/7/25 at 7:35 A.M., and 9:40 A.M., the surveyor observed the Resident sleeping in bed with one seizure pad on the left side rail.</p> <p>On 4/8/25 at 3:35 A.M., the surveyor observed the Resident sleeping in bed with one seizure pad on the left side rail.</p> <p>A review of Resident # 2's Treatment Administration Record (TAR) indicated that staff had documented on 4/7/25 day shift and 4/8/25 night shift that the Resident had two seizure pads to bilateral side rails while in bed.</p> <p>During an interview 4/8/25 at 7:40 A.M., the Unit Manager #1 said Nurses should document accurately in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/8/25 at 7:53 A.M., the Director of Nurses said Nurses should document accurately in the medical record. The DON said Nurses should not document that the Resident has both seizure pads in bed when they only have one.</p> <p>4. Resident #268 was admitted to the facility in February 2025 with diagnoses including type 2 diabetes.</p> <p>A review of the Minimum Data Set, dated dated dated [DATE]/5/25 did not indicate a Brief Interview for Mental Status score.</p> <p>Review of the care plan initiated on 2/24/25 indicated the Resident is not able to make their own health care decisions.</p> <p>Review of the care plan initiated on 2/26/25 indicated that the Resident has actual impairment to skin integrity as evidenced by a deep tissue injury to right 4th and 5th toe, deep tissue injury to the right lateral heel, deep tissue injury to the left great toe, 4th and 5th toes and a deep tissue injury to the left heel.</p> <p>Review of Resident #268's April 2025 physician's orders indicated the following:</p> <p>-Air Mattress-Pressure set per resident's most recent weight, plus or minus 10 pounds.</p> <p>Document weight. Check placement and function every shift. Order dated, 3/20/25.</p> <p>Review of Resident #268's most recent weight dated 4/6/25 indicated the Resident weighed 169.8 pounds.</p> <p>On 4/6/25 at 9:40 A.M., the surveyor observed the Resident in bed. The air mattress was set at 210.</p> <p>On 4/7/25 at 9:32 A.M., 12:12 P.M., the surveyor observed the Resident in bed. The air mattress was set at 320.</p> <p>On 4/8/25 at 3:36 A.M., the surveyor observed the Resident in bed. The air mattress was set to 320.</p> <p>A review of Resident # 268's Treatment Administration Record indicated that Nurses documented on 4/6/25 day shift, 4/7/25 day shift and 4/8/25 night shift that the air mattress was set per the Resident's weight plus or minus 10 pounds.</p> <p>During an interview on 4/8/25 at 7:51 A.M., the Unit Manager #2 said the Nurses should document accurately in the medical record.</p> <p>During an interview on 4/8/25 at 7:53 A.M., the Director of Nurses said the Nurses should document accurately in the medical record.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797</b></p> <p>Based on observation, policy review and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure that nursing performed hand hygiene (HH) and changed a wound dressing in accordance of professional standards to prevent infection.</li> <li>2. Ensure the nurse did not touch medications while dispensing.</li> <li>3. Ensure personal protective equipment (PPE) was readily available to staff when needed.</li> <li>4. For Resident #40, the facility failed to implement contact precautions after he/she developed symptoms and tested positive for Clostridioides difficile (C-Diff; a bacterium that causes an infection of the colon, the longest part of the large intestine).</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility policy titled Dry, Clean Dressings, dated October 2023 indicated that hand hygiene is to be performed before and after glove changes.</li> </ol> <p>Resident #28 was admitted to the facility in January 2025 with diagnoses including stroke with left sided hemiplegia/hemiparesis, dementia and depression.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #28 is totally dependent for all activities of daily living and scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment.</p> <p>During a dressing change on 4/7/25, at 12:14 P.M., the surveyor observed the following:</p> <p>Nurse #4 donned gloves and gathered supplies from the treatment cart. Nurse #4 then doffed gloves and donned gloves without performing hand hygiene (HH) potentially contaminating the new gloves. Nurse #4 then poured saline onto gauze and cleaned the pressure ulcer with potentially contaminated gloves. Nurse #4 then doffed her gloves, went to the treatment cart to obtain skin prep and donned new gloves without performing HH potentially contaminating them. Nurse #4 then opened and applied skin prep to the skin surrounding the wound with potentially contaminated gloves on. Nurse #4 then doffed her gloves and donned new gloves without performing HH. Nurse #4 then continued the the wound treatment. Nurse #4 then doffed her gloves and donned new gloves without performing HH two more times during the application of the wound treatment.</p> <p>During an interview on 4/7/25, at 12:25 P.M., Nurse #4 said that she was supposed to perform HH before and after glove changes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/7/25, at 1:48 P.M., the Director of Nursing said that HH is to be performed before donning and after doffing gloves.</p> <p>2. During medication pass on 4/7/25, at 7:30 A.M. the surveyor observed Nurse #8 to open an acidophilus capsule with her bare hands potentially contaminating the medication.</p> <p>During an interview on 4/7/25 at 7:45 A.M. Nurse #8 said that she thought because she sanitized her hands it was ok to touch the pills.</p> <p>During an interview on 4/8/25, at 7:42 A.M. the Director of Nursing said that it is never okay to touch medication with bare hands.</p> <p>3. On 4/6/25, at 7:04 A.M. the surveyor observed outside of room [ROOM NUMBER], a precaution sign for enhanced barrier precautions. The surveyor also observed that there was no PPE cart in the area for PPE to be readily available to staff when needed.</p> <p>During an interview on 4/08/25, at 7:42 A.M. the Director of Nursing said that it is the expectation that a PPE cart is positioned outside of a resident's room who is on enhanced barrier precautions so that PPE is readily available to the staff when needed.</p> <p>36876</p> <p>4. Resident #40 was admitted to the facility in January 2025 with diagnoses including acute respiratory failure with hypoxia and type II diabetes.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #40 is cognitively intact evidenced by a score of 14 out of 15 in the Brief Interview for Mental Status Exam. The MDS also indicated Resident #40 requires assistance with bathing and dressing.</p> <p>Review of the Clostridium Difficile (C-Diff) policy, undated, indicated: 9. Residents with diarrhea associated with C. difficile (i.e. residents who are colonized and symptomatic) are placed on Contact Precautions. 10. Residents with diarrhea and suspected C. difficile are placed on contact precautions while awaiting laboratory results.</p> <p>Review of the Nurse Progress Notes indicated:</p> <p>3/28/2025: Resident reports having diarrhea for days. During 3-11 shift aide reports loose stool x1 will continue to monitor.</p> <p>3/30/2025: No report of loose stools during shift. Sample picked up from lab. Awaiting further results</p> <p>4/4/2025: Resident tested positive for C-Diff. [Physician] ordered Vancomycin 125 mg every 6 hrs for 6 weeks.</p> <p>Review of the physicians orders indicated: All staff must adhere to contact precautions (gown and gloves) every shift for precautions, initiated 4/6/2025; 48 hours after Resident #40 tested positive for C-Diff.</p> <p>(continued on next page)</p>

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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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observations on 4/6/25 at 7:15 A.M., the surveyor observed Resident #40's room. There were no precaution signs or PPE cart indicating he/she was on precautions.</p> <p>During an interview on 4/6/25 at 7:59 A.M. Resident #40 said that he/she had been ill with C-Diff since last week. During the interview, the surveyor observed Unit Manager #1 place a precaution cart outside of Resident #40's room which included personal protective equipment.</p> <p>During an observation on 4/6/25 at approximately 10:00 A.M., the surveyor observed a sign had been posted outside of Resident #40's room indicating: Contact Precautions; Everyone must clean their hands with alcohol-based hand cleaner or soap and water before entering the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry if providing direct care or coming in contact with resident, resident clothing, bedding, etc. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one resident. Use dedicated or disposable equipment. Clean and disinfect re-usable equipment before use on another person.</p> <p>During an interview on 4/7/25 at 9:52 A.M., Unit Manager #1 said that residents should be placed on contact precautions for C-Diff when symptoms start and when the lab results come back positive. Unit Manager #1 said she did not work on Friday, (4/4/25), when Resident #40's results came back positive. Unit Manager #1 said she put the precaution cart in place, hung the sign and input orders for contact precautions for Resident #40 on 4/6/25; 48 hours after Resident #40 had a confirmed case of C-Diff.</p> <p>During an interview on 4/8/25 at 7:40 A.M., the Director of Nursing (DON) said that residents should be placed on contact precautions when there is suspicion of C-Diff and a lab pending.</p>		