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	03/25/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide services that meet professional standards of quality as evidenced by failing to implement physician's orders for one Resident (#30), out of a total sample of 23 residents. Specifically, for Resident #30, the facility failed to implement a physician's order to administer Pyridostigmine Bromide (a medication to treat orthostatic hypotension/low blood pressure).Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019 indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #30 was admitted to the facility in March 2026 with diagnoses including hypertension (high blood pressure), orthostatic hypotension (blood pressure drops abnormally when a person moves from lying or sitting to standing), and chronic kidney disease.Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident #30 had moderate cognitive impairment evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15.Review of Resident #30's active physician orders, dated 3/10/26, indicated: Pyridostigmine Bromide Oral Tablet 60mg (milligrams). Give 60mg by mouth four times a day for postural orthostatic. Scheduled for 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.During an interview on 8/24/26 at 8:38 A.M., Resident #30 said he/she has not been receiving his/her Pyridostigmine blood pressure medication daily and said he/she did not receive it this morning and has not had his/her blood pressure taken since yesterday.Review of Resident #30's Electronic Medication Administration Record (EMAR) indicated the medication was not administered and contained the following documentation:3/24/26 8:00 A.M., 9=Other / See Nurse Notes.Review of the Nursing Progress notes dated 3/24/26, indicated the following: Pyridostigmine Bromide Oral Tablet 60mg unavailable from pharm (pharmacy) MD aware N.N.O (no new orders).During an interview and observation on 3/24/26 at 12:21 P.M., the surveyor asked to see Resident #30's Pyridostigmine Bromide medication. Nurse #1 removed the bottle of Pyridostigmine Bromide from the medication cart. The bottle was dated as dispensed 3/10/26 and was open.During an interview on 3/24/26 at 12:24 P.M., Nurse #1 said she did not administer the scheduled 60mg of Pyridostigmine at 8:00 A.M., because the Resident had low blood pressure not because the medication wasn't available and said she must have documented it incorrectly in the EMAR (Electronic Medication Administration Record). The surveyor then asked to see the documented blood pressure and parameters for withholding the blood pressure medication and Nurse # 1 said she has been a nurse for a while and knows that a blood pressure medication shouldn't be given if the blood pressure is too low and said Resident #30's blood pressure was 94/68 at 8:00 A.M. Nurse #1 said there are no parameters in place for holding the medication and she just knows not to give it. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said she spoke to the Medical Director this morning and notified her that Resident #30's blood pressure was low and that the medication was not administered.Review Resident #30's Medical Record indicated the last documented blood pressure was dated 3/23/26 and was 113/74.During an interview on 3/25/26 at 11:16 A.M., the Medical Director said Resident #30 should have been administered the 8:00 A.M., medication and said she was not aware of the medication not being administered yesterday morning due to low blood pressure. The Medical Director said she received a call yesterday afternoon about adding blood pressure parameters and said the Resident's blood pressure must be checked prior to administering the medication and documented in the medical record. The Medical Director said she was not aware of blood pressure parameters not being in place and said staff should have been checking the blood pressure prior to administration. During an interview on 3/25/26 at 12:24 P.M., the Director of Nurses (DON) said Nurse #1 should not have withheld the medication and should have contacted the physician for parameters. The DON said she would expect orders to be in place for monitoring blood pressures with parameters prior to administration and said Nurse #1 should not be withholding a blood pressure medication without notifying the physician and should not document that the medication was not available when it was available for administration.