STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225510	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prescott House	140 Prescott Street North Andover, MA 01845

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was alert, oriented and able to make his/her needs known, the facility failed to ensure he/she was treated in a dignified and respectful manner, when a staff member told Resident #1 that his/her rang the call bell too much, then intentionally took Resident #1's call bell and placed it out of his/her reach to prevent him/her from using it.Findings include:Review of Facility Policy titled Call System, Residents, dated September 2022, indicated that residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized work station.Review of Facility Policy titled Resident Rights, dated February 2021, indicated employees shall treat all residents with kindness, respect and dignity. The Policy indicated a resident's right to a dignified existence, and self determination.Review of Resident #1's admission Record indicated his/her diagnoses included Dementia, Scoliosis, Congestive Heart Failure, and Adjustment Disorder with mixed anxiety and depressed mood.Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 06/30/25, indicated he/she had intact cognitive functioning and was dependent on others for bed mobility, bathing, personal hygiene and transfers.Review of Resident #1's Care Plan, reviewed and renewed with his/her June 2025 MDS, indicated he/she was at risk for decreased ability to perform activities of daily living. Care Plan interventions included that the call bell to be within reach when in bed.During an interview on 11/25/25 at 10:30 A.M., Resident #1 said while lying in bed he/she pushes the call bell button if he/she needed help. Resident #1 said one day (exact date unknown) when he/she rang the call bell, CNA #1, who was in the room, quickly put her hand on his/her hand squeezing it, pulled the call bell cord hard out of his/her hand and said to him/her you're not going to start this today. Resident #1 said CNA #1 moved the call bell cord out of his/her reach, took it off the bed and put it behind him/her. Resident #1 said CNA #2 had entered the room, stood by the foot of his/her bed and witnessed the incident. During an interview on 11/25/25 at 12:00 P.M., CNA #2 said in the morning on 09/06/25 she entered Resident #1's room and stood at the foot of Resident #1's bed while CNA #1 was with his/her roommate. CNA #2 said CNA #1 complained that Resident #1 always rang the call bell. CNA #2 said she noticed that Resident #1's call bell light was turned off, and that Resident #1 still held the call bell cord button in his/her hand. CNA #2 said she asked Resident #1 if she could help him/her. CNA #2 said when Resident #1 responded by crying out, CNA #1 pulled back the privacy curtain that was between the two residents' beds and yanked the call bell cord held in Resident #1's fist, forcefully out of his/her grip. CNA #2 said CNA #1 stated Resident #1 called too much. CNA #2 said CNA #1 threw the call bell cord to the floor between the two beds out of Resident #1's reach. CNA #2 said she gave Resident #1 back the call bell and provided his/her morning care. CNA #2 said she reported the incident a day or two later to the Unit Manager.During an interview on 12/02/25 at 1:30 P.M., CNA #1 said on 09/06/25 she entered Resident #1's room and told him/her that her assigned CNA was busy, but would come to assist him/her, and then she turned off his/her the call bell from sounding on the wall. CNA #1 said she pulled the privacy curtain and proceeded to assist Resident #1's roommate. CNA #1 said she knew the assigned CNA was coming and did not want Resident #1 to ring the call bell again. CNA #1 said prior to CNA #2's arrival, she (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225510	A. Building B. Wing	11/25/2025

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Prescott House	140 Prescott Street North Andover, MA 01845

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwrapped the call bell cord from Resident #1's side rail, put it on the ground (floor) out of his/her reach and proceeded to care for the roommate. During an interview on 09/08/25 at 8:30 A.M., Unit Manager #1 said on 09/08/25, CNA #2 approached her to report that CNA #1 had pulled the call bell cord away from Resident #1 and tossed it out of his/her reach. Unit Manager #1 said she immediately reported the incident to the Director of Nurses. During an interview on 11/25/25 at 2:50 P.M., the Director of Nurses (DON) said she was informed of the incident by Unit Manager #1 in the morning on 09/08/25. The DON said upon interviewing CNA #1 on 09/08/25, CNA #1 stated that Resident #1 had his/her call light turned on, she wanted it to stop sounding, so she pulled it away from his/her reach. The DON said CNA #1's employment was terminated.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was dependent on staff for assistance with care, the facility failed to ensure staff consistently implemented and followed their abuse policy related to the reporting of abuse allegations, when in the morning on 09/06/25, although Certified Nurse Aide (CNA) #2 witnessed CNA #1 forcefully remove that call bell cord out of Resident $#1's hand and intentionally place it out of his/her reach, CNA #2 did not immediately report the incident as required, but waited two days to report it. Findings include:Review of Facility Policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated September 2022, indicated if abuse is suspected, the suspicion must be reported immediately to the administrator.Review of Resident #1's admission Record indicated his/her diagnoses included Dementia, Scoliosis, Congestive Heart Failure, and Adjustment Disorder with mixed anxiety and depressed mood.Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 06/30/25, indicated he/she had intact cognitive functioning and was dependent on others for bed mobility, bathing, personal hygiene and transfers.Review of Resident #1's Care Plan, reviewed and renewed with his/her June 2025 MDS, indicated he/she was at risk for decreased ability to perform activities of daily living. Care Plan interventions included that the call bell to be within reach when in bed.During an interview on 11/25/25 at 10:30 A.M., Resident #1 said one day (exact date unknown) when he/she rang the call bell while lying in bed, CNA #1, who was in the room, quickly put her hand on his/her hand squeezing it, pulled the call cord hard out of his/her hand and said you're not going to start this today. Resident #1 said CNA #1 moved the call bell cord out of his/her reach, off the bed and put it behind him/her. Resident #1 said CNA #2 had entered the room, stood by the foot of his/her bed and witnessed the incident. During an interview on 11/25/25 at 12:00 P.M., CNA #2 said in the morning on 09/06/25 she stood at the foot of Resident #1's bed while CNA #1 was with his/her roommate. CNA #2 said CNA #1 complained that Resident #1 always rang the call bell. CNA #2 said she noticed that Resident #1's call light was turned off, and that Resident #1 still held the call bell cord button in his/her hand. CNA #2 said she asked Resident #1 if she could help him/her. CNA #2 said when Resident #1 responded by crying out, CNA #1 pulled back the privacy curtain that was between the two Residents beds and yanked the call bell cord held in Resident #1's fist, forcefully out of his/her grip. CNA #2 said CNA #1 stated Resident #1 called too much. CNA #2 said CNA #1 threw the call bell cord onto the floor between the two beds out of Resident #1's reach. CNA #2 said she did not immediately report the incident but waited and reported the incident a day or two later to Unit Manager #1. CNA #2 said she waited to report the incident to Unit Manager #1 because she was unsure if other nurses (working on the unit that day) would respond to the incident appropriately during the shift. During an interview on 12/02/25 at 1:30 P.M., CNA #1 said on 09/06/25 prior to CNA #2's arrival to assist Resident #1, she unwrapped the call bell cord from Resident #1's side rail and put it on the ground (floor) out of his/her reach and proceeded to care for his/her roommate. During an interview on 09/08/25 at 8:30 A.M., Unit Manager #1 said in the morning on 09/08/25, CNA #2 approached her in tears to report that CNA #1 had pulled the call bell cord away from Resident #1 and tossed it out of his/her reach. Unit Manager #1 said she immediately reported the incident to the Director of Nurses. Unit Manager #1 said while investigating the incident it was determined that the incident occurred on 09/06/25, when both CNA #1 and CNA #2 were assigned to Resident #1's Unit. Unit Manager #1 said the nurses who were scheduled to work on the Unit (on 09/06/25) told her they were unaware that an incident occurred. During an interview on 11/25/25 at 2:50 P.M., the Director of Nurses (DON) said on 09/08/25 Unit Manager #1 informed her that CNA #1 pulled Resident #1's call bell cord out of Resident #1's hand on 09/06/25. The DON said neither herself nor the Administrator had been made aware of the incident prior to being notified of it by Unit Manager #1 (on 09/08/25). The DON said staff members were expected to immediately report allegations of abuse and not wait until two days later.