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	01/23/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview, record review and observation, the facility failed to ensure one Resident (#175) was able to dine in a dignified manner. Findings include: Review of the facility policy Dignity dated as revised February 2021, indicated, but was not limited to: - Provided with a dignified dining experience. Resident #175 was admitted to the facility in January 2025 and had active diagnoses which included chronic kidney disease, heart disease, muscle wasting and atrophy, difficulty walking, lack of coordination and dysphagia. As of the date of survey, a Minimum Data Set assessment had not yet been completed for Resident #175, including a Brief Interview for Mental Status exam. Resident #175's Activity of Daily Living care plan dated 1/17/25, indicated he/she required staff assistance with setup or clean-up assistance. Resident #175's Admission Functional Abilities and Goals assessment dated [DATE], indicated he/she required setup or clean-up assistance with meals. On 1/21/25 at 8:00 A.M., the surveyor observed a staff person enter Resident #175's room and place his/her meal tray, which contained pancakes, juice and coffee, on the over bed table. The staff person offered to open the lids covering the food, and Resident #175 was agreeable. The staff person removed the lid from a juice cup, then left the bedroom. Resident #175 then picked up a creamer with his/her right hand and opened the lid with his/her teeth. Resident #175 then picked up a pancake with both hands, brought it to his/her mouth, and took bites from it. Resident #175 said she does not have the use of two of his/her fingers on the left hand and so was unable to open lids or cut up his/her food. Resident #175 said today was the first day since admission to the facility that a staff person was nice and offered to open the lids, and that no one has offered to cut up his/her food. Resident #175 said staff have until now just dropped the meal trays off on his/her table and left without offering any assistance. Resident #175 said she has not asked staff for help because he/she was unsure if this was a service provided. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/25 at 12:22 P.M., Unit Manager #2 said staff are supposed to offer to cut up Resident #175's meals. Unit Manager #2 said there is a new meal distribution system in place involving more staff but unfortunately some staff are still learning about individual resident's assistance needs. During an interview with Resident #175 on 1/22/25 at 12:24 P.M., he/she said a staff person cut up his/her lunch meal and that this was the first time this had happened since admission.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview, observation and record review, the facility failed to ensure a home-like environment on the A Unit. Findings include: On 1/21/25 at approximately 8:30 A.M., the surveyor observed a sample of bedrooms located on the A Unit. - room [ROOM NUMBER]: bed D, bed frame side rail has approximately 12 inches of chipped enamel. - room [ROOM NUMBER]: window shade is missing its draw chain, unable to raise or lower the blind. - room [ROOM NUMBER]: unpainted, unsanded plaster on bedroom wall next to bathroom measuring approximately 13 x 6. - room [ROOM NUMBER]: window shade is missing its draw chain, unable to raise or lower the blind. - room [ROOM NUMBER]: wired wall receptacle for television control is dangling from the wall, wires and wall cavity exposed. Review of the Maintenance Log on 1/23/25 indicated the above items in need of repair were not documented. During an interview with the Consulting Maintenance Director on 1/23/25 at 1:30 P.M., he said the blinds, unpainted wall plaster, chipped bed frame paint, and loose television control were not documented in the log book.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record reviews, observations and interviews, the facility failed to ensure resident centered care plans were developed and/or implemented for three Residents (#12, #91 and #13) out of a total sample of 24 residents. Specifically, 1. For Resident #12, the facility failed to a. develop a comprehensive resident centered care plan for a pacemaker and b. failed to implement the Resident's fall intervention of non skid strips on the floor next to his/her bed. 2. For Resident #91, the facility failed to implement a right hand splint and arm wedge as per the plan of care. 3. For Resident #13, the facility failed to implement a right hand roll as per the plan of care. Findings include: Review of the facility policy titled Comprehensive Person-Centered Care Plans, dated March 2022, indicated The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Review of the facility policy titled Care of a Resident with Pacemaker, dated December 2015, indicated The purpose of this procedure is to provide information about and guidance for the care of a resident with a pacemaker. The pacemaker battery will be monitored remotely through the telephone or an internet connection. The resident's cardiologist will provide instructions on how and when to do this. For each resident with a pacemaker, document the following in the medical record: a. The name, address and telephone number of the cardiologist; g. paced rate. When the resident's pacemaker is monitored by the physician, document the date and results of the pacemaker surveillance, including: a. [NAME] the resident's pacemaker was monitored (phone, office, internet); b. Type of heart rhythm; c. Functioning of the leads; d. Frequency of utilization; and e. Battery life. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1a. Resident #12 was admitted to the facility in July 2023 with diagnoses that included dementia, presence of a cardiac pacemaker, adult failure to thrive, and cognitive communication deficit. Review of Resident #12's most recent Minimum Data Set (MDS) assessment, dated 12/5/24, indicated he/she scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Review of Resident #12's physician order, dated 9/18/23, indicated Pacemaker check as ordered. Review of Resident #12's pacemaker care plan dated 9/13/23, indicated Pacemaker checks as ordered. The resident's Pacemaker information: was left blank. During an interview on 1/22/25 12:22 P.M., Unit Manager #1 said there should be a comprehensive pacemaker care plan in place so the nurses know how to monitor the pacemaker. Unit Manager #1 said she is not sure how the Residents' pacemaker is being monitored because there is not a monitoring device in his/her room. The Unit Manager said the Resident has not been followed by cardiology. During an interview on 1/22/25 at 12:58 P.M., the Director of Nurses (DON) said she expect a Resident who has a pacemaker to have a complete and comprehensive care plan in place with the paced rate and how the pacemaker is to be monitored. 1b. On 1/21/25 at 12:33 P.M., the surveyor observed Resident #12 in bed, non skid strips were not in place on the floor next to bed. On 1/22/25 at 8:00 A.M. and 12:13 P.M., the surveyor observed Resident #12 in bed, non skid strips were not in place on the floor next to bed. Review of Resident #12's fall care plan, dated 9/30/24, indicated non skid strips to floor- Next to bed. Review of Resident #12's active Certified Nurse Aide (CNA) Kardex (from indicating the Resident needs to staff), dated 1/21/25, indicated non skid strips to floor- Next to bed. During an interview on 1/22/25 at 12:15 P.M., Certified Nurse Aide (CNA) #1 said she has taken care of the Resident multiple times and he/she is a fall risk. CNA #1 said the Resident does not have non skid strips on the floor next to the bed. During an interview on 1/22/25 12:22 P.M., Unit Manager #1 said the Resident is a fall risk and should have non skid strips on his/her floor next to bed if the care plan says they should be there. During an interview on 1/22/25 at 12:58 P.M., the Director of Nurses (DON) said if a resident is care planned to have non skid strips on the floor next to the bed then they should be in place. 45343 2. Review of the facility policy titled Orthotics and Assistive Devices, dated February 2022, indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An assistive device is any piece of equipment that assists a resident coping with the effects of his or her disability/limited range of motion due to medical condition. These devices are intended to assist residents maneuver or perform other daily functions of daily life or prevent further complications. - If resident refuses notify nurse/provider and update care plan. - The reason for the use of the joint stabilization device is documented in the medical record. Resident #91 was admitted to the facility in August 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, right wrist contracture, right hand contracture, right shoulder contracture, and right elbow contracture. Review of Resident #91's most recent Minimum Data Set (MDS) assessment, dated 11/21/24, indicated Resident #91 had a Brief Interview for Mental Status (BIMS) exam score of 8 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated Resident #91 substantial/maximal to dependent assistance with functional daily activities and upper extremity range of motion (ROM) impairment on one side. On 1/21/25 at 8:15 A.M., the surveyor observed Resident #91 was observed laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. On 1/21/25 at 12:33 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/21/25 at 4:32 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room On 1/22/25 at 6:55 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room On 1/22/25 at 7:59 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/22/25 at 10:16 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/22/25 at 12:39 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 6:47 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. Review of Resident #91's physician order indicated the following order initiated on 11/26/24: - Right flex hand splint to be worn up to 4-6 hrs (hours), daily, as tolerated. Put on in morning, take off in evening. Regular skin checks for any redness, irritation, indication of pain., every day shift. - Right 90-degree elbow wedge cushion to be worn up to 4-6 hrs, nightly, as tolerated. Regular skin checks for any redness, irritation, indication of pain. every evening shift Review of Resident #91's physical mobility care plan interventions indicated the following: - Maintain usage of wrist/elbow braces to prevent contractures, date initiated, 11/25/2024. Review of Resident #91's medical record failed to indicate he/she refused to wear his/her right hand splint or arm wedge. During an interview on 1/23/25 at 8:54 A.M., Unit Manager #1 said Resident #91 has a hand splint and the splint schedule should be followed per the doctor's order and documented if the resident refuses. Unit Manager #1 was not aware that Resident #91 right hand splint and wedge were not on the past two days. During an interview on 1/23/25 9:07 A.M., The Director of Nursing said a splint schedule should be followed as ordered by the physician. The Director of Nursing said if a resident refuses to wear the splint it should be documented in the medical record. 3. Resident #13 was admitted to the facility in November 2022 with diagnoses including quadriplegia, C5-C7 central cord syndrome and right-hand contracture. Review of Resident #13's most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated Resident #13 had a Brief Interview for Mental Status (BIMS) exam score of 9 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated Resident #13 is dependent with functional daily activities and upper extremity range of motion (ROM) impairments on both sides. On 1/21/25 at 7:50 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/22/25 at 8:00 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/2/25 at 10:16 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/22/25 at 12:14 P.M., the surveyor observed Resident #13 laying in his/her recliner chair. Resident #13 was not wearing his/her right-hand roll. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 8:31 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. Review of Resident #13's physician order indicated the following order initiated on 8/12/24: - Right hand roll to be worn up to 6-8 hrs (hours), daily, as tolerated. Put on in morning, take off in evening. Regular skin checks for any redness, irritation, indication of pain. Review of Resident #13's skin integrity care plan interventions indicated the following: - The resident needs assistance to apply hand roll, date initiated, 8/12/2024. Review of Resident #13's medical record failed to indicate he/she refused to wear his/her right hand roll. During an interview on 1/23/25 at 8:54 A.M., Unit Manager #1 said Resident #13 has a hand roll, but he/she does not like to wear it all the time. Unit Manager #1 said a hand roll order should be followed per the doctor's order and documented if the resident refuses. Unit Manager #1 was not aware that Resident #13 right hand roll was not on the past two days. During an interview on 1/23/25 9:07 A.M., The Director of Nursing said a hand roll order should be followed as ordered by the physician. The Director of Nursing said if a resident refuses to wear the hand roll it should be documented in the medical record.

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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. 15016 Based on record review, interview and observation, the facility failed to follow physician's orders for two Residents (#175 and #68) of 24 sampled residents. Specifically: 1. For Resident #175, the facility failed to change a soiled wound dressing for three days. 2. For Resident #68, the facility failed to change oxygen tubing for approximately three weeks because staff did not obtain a physician's treatment order for the procedure. Findings include: Review of the facility policy titled Dressing, Dry/Clean dated as revised September 2013, indicated, but was not limited to: - Review the physician's order. - Label tape or dressing with date, time and initials. - Document the wound appearance, including wound bed, edges, presence of drainage. - How the resident tolerated the wound change procedure. 1. Resident #175 was admitted to the facility in January 2025 and had active diagnoses which included chronic kidney disease, muscle wasting and atrophy, difficulty walking, and lack of coordination. As of the date of survey, a Minimum Data Set assessment had not yet been completed for Resident #175. Review of Resident #175's physician orders dated 1/19/25, indicated: - Ulcer in left great toe - wash with normal saline apply dry protective dressing daily, every day shift. Review of Resident #175's Treatment Administration Record (TAR) on 1/21/25 indicated staff changed the toe dressing on 1/19/25, 1/20/25 and 1/21/25. Review of Resident #175's care plan dated 1/20/25, indicated he/she had an ulcer on the left great toe and was at-risk for pain. The care plan did not reference dressing changes, or other interventions to address the wound. Review of Resident #175's nursing progress note dated 1/19/25, indicated: - No new changes noted to skin integrity. Resident has treatable wounds present. Dressing(s) changed as per treatment orders. No notable changes to wound(s) observed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's progress note dated 1/20/25, indicated lesion of the left toe - dressing in place with mild serosanguinous drainage. Review of Resident #175's nursing progress notes dated 1/20/25 and 1/21/25, indicated there was no reference to the ulcer on the Resident's toe, an assessment of the wound, as required by facility policy. The notes did not indicate the Resident was offered or declined a dressing change on these days. On 1/21/25 at 8:50 A.M., the surveyor observed Resident #175's left great toe dressing. The dressing was dated 1/19/25. There was no staff initial on the dressing. The dressing had areas of black color from what appeared to be dirt. During an interview with Resident #175 on 1/21/25 at 8:50 A.M., he/she said he/she fell at home and injured his/her toe. The Resident said a nurse at the facility dressed the wound a few days ago, but staff seemed to have forgotten about the wound. On 1/22/25 at approximately 7:10 A.M., the surveyor observed Resident #175 lying in bed. The Resident had the same dressing covering the toe ulcer, dated 1/19/25. On 1/23/25 at approximately 9:25 A.M., the surveyor observed the Wound Physician had removed the toe dressing and was examining the wound. During an interview with Nurse #1 on 1/23/25 at 9:30 A.M., the surveyor informed her that the surveyor observed Resident #175's left great toe dressing on 1/21/25 and 1/22/25, dated 1/19/25. The surveyor said the physician's order required that it be changed daily but no dressing changes had occurred over the past three days. Nurse #1 said she thought the dressing was to be changed as needed. The surveyor told Nurse #1 that she and another nurse documented in the TAR they had changed the dressing on 1/20/25 and 1/21/25, but that this was not possible because the dressing was dated 1/19/25. Nurse #1 said she did not understand how this error occurred. During an interview with the Director of Nursing (DON) on 1/23/25 at approximately 10:00 A.M., the surveyor informed her of the observation of Resident #175's dressing on 1/21/25 and 1/22/25, yet the dressing was dated 1/19/25 and the TAR indicated dressing changes occurred on 1/20/25 and 1/21/25. The DON said it was nursing staff's responsibility to follow the physician's treatment orders, the facility's wound dressing policy and to document accurately in the clinical record. 2. For Resident #68, the facility failed to change oxygen tubing for approximately three weeks. Resident #68 was admitted to the facility in January 2025 and has active diagnoses which include chronic obstructive pulmonary disorder (COPD), emphysema and chronic respiratory failure with hypoxia. Review of Resident #68's Minimum Data Set assessment indicated he/she was cognitively intact and required the use of continuous oxygen to help with breathing. Review of Resident #68's physician order dated 1/4/25, indicated: - Oxygen 3 liters per minute via nasal cannula, continuous, every shift for COPD. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders did not include a schedule for changing the oxygen tubing. Review of Resident #68's Treatment Administration Record dated through 1/21/25 failed to indicate the Resident's oxygen tubing had been changed since his/her admission to the facility. Review of Resident #68's progress notes did not reference changing his/her oxygen tubing On 1/21/25 at 10:25 A.M., the surveyor observed Resident #68 lying in bed with a nasal cannula under his/her nose. The oxygen concentrator ran at 3 liters per minute. The surveyor observed the tubing was undated and disconnected from the concentrator. The surveyor left the room and informed Nurse #2 that the tubing was undated and disconnected from the concentrator, resulting in the Resident not receiving concentrated oxygen. Nurse #2 then replaced the tubing and attached it to the concentrator. During an interview with Nurse #2 on 1/21/25 at approximately 11:30 A.M., she said she thought oxygen tubing was changed as needed and not weekly. Nurse #2 said there was no recorded date of if, or when, the tubing was last changed. Following the surveyor's conversation with Nurse #2, a new physician's order was entered into Resident #68's clinical record, dated 1/21/25, at 4:45 P.M. (approximately three weeks after the start of oxygen use): - Oxygen Equipment Maintenance every night shift every Sunday, During an interview with the DON on 1/23/25 at 10:00 A.M., she said it was the standard of practice and facility policy to obtain a physician's order for weekly oxygen tubing changes and to document these changes on the TAR.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview, record review and observation, the facility failed to ensure it provided one Resident (#175) with the assistance required for meal setup. Findings include: Resident #175 was admitted to the facility in January 2025 and had active diagnoses which included chronic kidney disease, heart disease, muscle wasting and atrophy, difficulty walking, lack of coordination and dysphagia. As of the date of survey, a Minimum Data Set assessment had not yet been completed for Resident #175, including a Brief Interview for Mental Status exam. Resident #175's Activity of Daily Living care plan dated 1/17/25, indicated he/she required staff assistance with setup or clean-up assistance. Resident #175's Admission Functional Abilities and Goals assessment dated [DATE], indicated he/she required setup or clean-up assistance with meals. Review of Resident #175's Activities of Daily Living care plan dated 1/21/25, indicated he/she has a self-care performance deficit related to activity Intolerance, deconditioning, disease process and spinal stenosis. Interventions included: Required setup and clean-up assistance. On 1/21/25 at 8:00 A.M., the surveyor observed a staff person enter Resident #175's room and place his/her meal tray, which contained pancakes, juice and coffee, on the over bed table. The staff person offered to open the lids covering the food, and Resident #175 was agreeable. The staff person removed the lid from a juice cup, then left the bedroom. Resident #175 then picked up a creamer with his/her right hand and opened the lid with his/her teeth. Resident #175 then picked up a pancake with both hands, brought it to his/her mouth, and took bites from it. Resident #175 said she does not have the use of two of his/her fingers on the left hand and so is unable to open lids or cut up his/her food. Resident #175 said today was the first day since admission to the facility that a staff person was nice and offered to open the lids, and that no one had offered to cut up his/her food. Resident #175 said staff have until now just dropped off the meal trays on his/her table and left without offering any assistance. Resident #175 said she had not asked staff for help because he/she was unsure if this was a service provided. During an interview with Unit Manager #2 on 1/22/25 at 12:22 P.M., she said staff are supposed to offer to cut up Resident #175's meals. Unit Manager #2 said there is a new meal distribution system in place involving more staff but that unfortunately some staff are still learning about individual resident's assistance needs. During an interview with Resident #175 on 1/22/25 at 12:24 P.M., he/she said a staff person cut up his/her lunch meal and that this was the first time this had happened since admission.

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 15016 Based on record review and interview, the facility failed for one Resident (#175) to communicate with the Dialysis Center nurse regarding Resident #175's care, document his/her condition after dialysis treatment, and notify the practitioner of fistula bleeds out of a total sample of 24 residents. Findings include: Review of the facility's policy Hemodialysis Catheters - Access Care of dated as revised February 2023, indicated: - Mild bleeding from the site (post-dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. - The nurse should document in the resident's medical record every shift as follows: 1. Location of the catheter. 2. Condition of the dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of the report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis. Resident #175 was admitted to the facility in January 2025 and had active diagnoses which included dependence on renal dialysis, arteriovenous fistula, chronic kidney disease, muscle wasting and atrophy, and lack of coordination. As of the date of survey, a Minimum Data Set assessment had not yet been completed for Resident #175. Review of Resident #175's physician orders, dated 1/20/25, indicated: - Resident to have dialysis on: Tuesday, Thursday, Saturday. - Right arm with hematoma bleeding - change daily and prn (as needed) until stop bleeding. - Monitor access site for bleeding, redness, tenderness and/or swelling every shift for monitoring. Notify Practitioner of abnormal findings as indicated. If bleeding noted, apply pressure and notify the Practitioner. Review of Resident #175's care plan dated 1/20/25, indicated he/she needs dialysis related to renal failure. Interventions included: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor/document/report PRN for signs and symptoms of bleeding, hemorrhage, bacteremia, or septic shock. Review of Resident #175's nursing progress notes dated 1/19/25, 1/20/25 and 1/21/25 indicated there was no reference to the location of the catheter or condition of the dressing (interventions if needed), as required by facility policy. Review of Resident #175's Treatment Administration Record (TAR) dated 1/19/25, 1/20/25 and 1/21/25, indicated on these days the Resident's fistula site bled, and staff changed the dressing. Review of Resident #175's progress note dated 1/19/25 and 1/20/25 and 1/21/25, indicated there was no reference to staff informing the Practitioner that the Resident's fistula site was bleeding, as required by the order. Resident #175's nursing progress notes dated 1/21/25 indicated he/she went to the Dialysis Center for treatment. After returning to the facility, the nursing progress notes did not document (as required by facility policy): - Location of the catheter. - Condition of the dressing. - Any report from the dialysis nurse post-dialysis. - Observations post-dialysis. Review of Resident #175's Dialysis Center Communication Book on 1/23/25, indicated it consisted of blank communication forms. There was no reference to the Resident's visit to the Dialysis Center on 1/21/25. There was no report from the dialysis nurse post-dialysis, observations post-dialysis, the location of the catheter, or condition of the fistula dressing. On 1/21/25, 1/22/25 and 1/23/25, the surveyor observed Resident #175's covered fistula, located on the right arm. On each of these days, the fistula was covered with a 4 x 4 dry sterile dressing. The dressings were undated and not initialed by staff. During an interview with Resident #175 on 1/21/25 at 8:50 A.M., he/she said the fistula site often bleeds following dialysis. A 4 x 4 dry sterile dressing covered the fistula, and it was undated and not initialed by staff. On 1/22/25 and 1/23/25, during the morning, the surveyor observed a 4 x 4 dry sterile dressing covering Resident #175's fistula, and it was undated and not initialed by staff. During an interview with Nurse #1 on 1/23/25 at 9:30 A.M., she said she had changed Resident #175's fistula dressing on 1/21/25 because of bleeding after his/her return from the Dialysis Center on 1/21/25. Nurse #1 said she did not recall if she notified the Practitioner that the site had been bleeding or that she applied a dressing. Nurse #1 said she did not know if the Dialysis Center had communicated with the facility regarding the Resident's status post-dialysis visit on 1/21/25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Unit Manager #2 on 1/23/25 at 9:32 A.M., she reviewed Resident #175's Dialysis Center Communication Book and determined the book did not contain any information about the Resident's visit to the Center on 1/21/25. Unit Manager #2 said that the book did not contain communication from the Center it was nursing staff's responsibility to call the Center to obtain the required information. During an interview with the Director of Nursing (DON) on 1/23/25 at approximately 10:00 A.M., she said it was nursing staff's responsibility to obtain the required information from the Dialysis Center, per facility policy, and follow the physician's treatment orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45343 Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for three Residents (#91, #13 and #175), out of a total sample of 24 residents. Specifically: 1 For Resident #91, the nurses documented in the Treatment Administration Record (TAR) the Resident was wearing his/her right hand splint and arm wedge, when he/she was not; 2. For Resident #13, the nurses documented in the TAR the Resident was wearing his/her right hand roll, when he/she was not; 3. For Resident #175, nursing staff documented they changed a dressing when they did not. Findings Include: Review of the facility policy titled Charting and Documentation, dated July 2022, indicated the following: Policy Statement: - All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between interdisciplinary team regarding the resident's condition and the response to care. Policy Interpretation and Implementation: - Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. - Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided. e. whether the resident refused the procedure/treatment. 1. Resident #91 was admitted to the facility in August 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, right wrist contracture, right hand contracture, right shoulder contracture, and right elbow contracture. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's most recent Minimum Data Set (MDS) assessment, dated 11/21/24, indicated Resident #91 had a Brief Interview for Mental Status (BIMS) exam score of 8 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated Resident #91 substantial/maximal to dependent assistance with functional daily activities and upper extremity range of motion (ROM) impairment on one side. On 1/21/25 at 8:15 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. On 1/21/25 at 12:33 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/21/25 at 4:32 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room On 1/22/25 at 6:55 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room On 1/22/25 at 7:59 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/22/25 at 10:16 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/22/25 at 12:39 P.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. On 1/23/25 at 6:47 A.M., the surveyor observed Resident #91 laying in his/her bed. Resident #91 was not wearing his/her right-hand splint or right upper extremity wedge. Resident #91's hand splint was observed resting on the nightstand and right arm wedge was not visible in the room. Review of Resident #91's physician order indicated the following order initiated on 11/26/24: - Right flex hand splint to be worn up to 4-6 hrs (hours), daily, as tolerated. Put on in morning, take off in evening. Regular skin checks for any redness, irritation, indication of pain., every day shift. - Right 90-degree elbow wedge cushion to be worn up to 4-6 hrs, nightly, as tolerated. Regular skin checks for any redness, irritation, indication of pain. every evening shift Review of Resident #91's Physical Mobility care plan interventions indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Maintain usage of wrist/elbow braces to prevent contractures, date initiated, 11/25/2024. Review of the January 2025 TAR indicated that nursing documented on January 21st and January 22nd, 2025, that Resident #91 was wearing his/her right hand splint and arm wedge, contrary to direct observation that he/she was not. Review of Resident #91's medical record failed to indicate he/she refused to wear his/her right hand splint or arm wedge. During an interview on 1/23/25 at 8:54 A.M., Unit Manager #1 said the nurses should be following physician's orders and should not document in the TAR if a task has not been performed. During an interview on 1/23/25 at 9:07 A.M., the Director of Nursing said she expects the splint and wedge to be worn as ordered by the physician, accurately documented in the medical record, and indicate if the resident refuses. 4. Resident #13 was admitted to the facility in November 2022 with diagnoses including quadriplegia, C5-C7 central cord syndrome and right-hand contracture. Review of Resident #13's most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated Resident #13 had a Brief Interview for Mental Status (BIMS) exam score of 9 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated Resident #13 is dependent with functional daily activities and upper extremity range of motion (ROM) impairments on both sides. On 1/21/25 at 7:50 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/22/25 at 8:00 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/2/25 at 10:16 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. On 1/22/25 at 12:14 P.M., the surveyor observed Resident #13 laying in his/her recliner chair. Resident #13 was not wearing his/her right-hand roll. On 1/23/25 at 8:31 A.M., the surveyor observed Resident #13 seated in his/her wheelchair. Resident #13 was not wearing his/her right-hand roll. Review of Resident #13's physician order indicated the following order initiated on 8/12/24: - Right hand roll to be worn up to 6-8 hrs (hours), daily, as tolerated. Put on in morning, take off in evening. Regular skin checks for any redness, irritation, indication of pain. Review of Resident #13's Skin Integrity care plan interventions indicated the following: - The resident needs assistance to apply hand roll, date initiated, 8/12/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 TAR indicated that nursing documented on January 21st and January 22nd, 2025, that Resident #13 was wearing his/her right hand roll, contrary to direct observation that he/she was not. Review of Resident #13's medical record failed to indicate he/she refused to wear his/her right hand roll. During an interview on 1/23/25 at 8:54 A.M., Unit Manager #1 said the nurses should be following physician's orders and should not document in the TAR if a task has not been performed. During an interview on 1/23/25 at 9:07 A.M., the Director of Nursing said she expects the hand roll to be worn as ordered by the physician, accurately documented in the medical record, and indicate if the resident refuses. 15016 3. Resident #175 was admitted to the facility in January 2025 and had active diagnoses which included chronic kidney disease, muscle wasting and atrophy, difficulty walking, and lack of coordination. As of the date of survey, a Minimum Data Set assessment had not yet been completed for Resident #175, including a Brief Interview for Mental Status exam. Review of Resident #175's physician orders dated 1/19/25, indicated: - Ulcer in left great toe - wash with normal saline apply dry protective dressing daily, every day shift. Review of Resident #175's nursing progress note dated 1/19/25, indicated: - No new changes noted to skin integrity. Resident has treatable wounds present. Dressing(s) changed as per treatment orders. No notable changes to wound(s) observed. Review of Resident #175's care plan dated 1/20/25, indicated he/she had an ulcer on the left great toe and was at-risk for pain. The care plan did not reference dressing changes, or other interventions to address the wound. Review of the Physician's progress note dated 1/20/25, indicated lesion of the left toe - dressing in place with mild serosanguinous drainage. Review of Resident #175's nursing progress notes dated 1/20/25 and 1/21/25, indicated there was no reference to the ulcer on the Resident's toe. The notes did not indicate the Resident was offered a dressing change on these days. Review of Resident #175's Treatment Administration Record (TAR) on 1/21/25, indicated nursing changed the toe dressing on 1/19/25, 1/20/25 and 1/21/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 at 8:50 A.M., the surveyor observed Resident #175's left great toe dressing. The dressing was dated 1/19/25. There was no staff initial on the dressing. The dressing had areas of black color from what appeared to be dirt. During an interview with Resident #175 on 1/21/25 at 8:50 A.M., he/she said he/she fell at home and injured his/her toe. The Resident said a nurse at the facility dressed the wound a few days ago, but staff seemed to have forgotten about the wound. On 1/22/25 at approximately 7:10 A.M., the surveyor observed Resident #175 lying in bed. The Resident had the same dressing covering the toe ulcer, dated 1/19/25. On 1/23/25 at approximately 9:25 A.M., the surveyor observed the Wound Physician had removed the toe dressing and was examining the wound. During an interview with Nurse #1 on 1/23/25 at 9:30 A.M., the surveyor informed her that the surveyor observed Resident #175's left great toe dressing on 1/21/25 and 1/22/25 and it was dated 1/19/25. The surveyor said the physician's order required that it be changed daily but it appeared no dressing changes had occurred over the past three days. Nurse #1 said she thought the dressing was to be changed as needed. The surveyor told Nurse #1 that she and another nurse documented in the TAR they had changed the dressing on 1/20/25 and 1/21/25, but that this was not possible because the dressing was dated 1/19/25. Nurse #1 said she did not understand how this error occurred. During an interview with the Director of Nursing (DON) on 1/23/25 at approximately 10:00 A.M., the surveyor informed her of the observation of Resident #175's dressing on 1/21/25 and 1/22/25, yet the dressing was dated 1/19/25 and the TAR indicated dressing changes occurred on 1/20/25 and 1/21/25. The DON said it was nursing staff's responsibility to accurately document in the clinical record.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 45984 Based on observation, record review and interview, the facility failed to regularly inspect bed frames and mattress spacing to identify areas of potential entrapment. Specifically, the facility failed to regularly inspect and document findings regarding the seven zones of bed entrapment of Residents' beds for potential areas of entrapment as evidenced by a bed bolster (an object used to fill gaps between the mattress and headboard/footboard of a bed) that did not fit properly. Findings include: According to The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on March 10, 2006 by the U.S. Department of Health and Human Services Food and Drug Administration Center for Devices and Radiological Health, The HBSW (Hospital Bed Safety Workgroup) identified 7 potential entrapment zones for hospital beds. Review of the facility policy titled Bed Safety and Bed Rails, revised and dated August 2022, indicated the following: - Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. - Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. - Bed dimensions are appropriate for the resident's size. - Regardless of mattress type, width, length and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. - Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. The surveyor made the following observations on the same resident's bed: - On 1/21/25 at 9:17 A.M., on the B-unit, a resident was observed sleeping in his/her bed. There was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the length of the mattress and the gap between the space above the bolster to the footboard was about six inches. - On 1/22/25 at 10:25 A.M., on the B-unit, there was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the length of the mattress and the gap between the space above the bolster to the footboard was about six inches. The surveyor was able to put his entire arm between the mattress and the footboard. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility binder titled Bed Inspection indicated that the Maintenance Director completed Bed entrapment measurement tests on nine beds on the A Unit. Review of the nine checks indicated they were incomplete and did not have documentation on all of the entrapment zones. These checks were done on 7/24/24. The facility bed capacity is 126 beds. During an interview on 1/22/25 at 10:15 A.M., the Administrator told the surveyor that the previous Maintenance Director did not complete the yearly bed entrapment rounds. The Administrator continued to say he has a Maintenance Director from another facility completing them today. During an interview on 1/22/25 at 11:17 A.M., the visiting Maintenance Director from a sister facility said bed inspections for entrapment should be done yearly. He said this building's maintenance director never finished them so he was asked to do them. The visiting Maintenance Director said if there is a space between the headboard or footboard of the bed then a bolster that is the same thickness of the mattress should be used and the bolster should be level with the mattress so there are no gaps. The surveyor showed the visiting Maintenance Director photos of the current bolster being used and he said that is the wrong type of bolster being used and it needs to be thicker and higher up to properly fill the gap as a resident can get entrapped in the space. During an interview on 1/22/25 at 2:18 P.M., the Director of Nursing (DON) said bed safety checks for entrapment were not done. The DON said they had a previous Maintenance Director who quit and told the facility they were complete when they were not but she would expect them to still be complete. The surveyor showed the DON the photos of the bed bolster and she said it is the incorrect bolster and needs to be changed as the resident can be entrapped in the spacing with the current bolster.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on policy review, interview and observation, the facility failed to ensure it provided a means for residents to communicate to staff on the A Unit. Findings included: The Facility's policy titled Answering the Call Light dated as revised September 2022, indicated: - The purpose of this procedure (answering the call light) is to ensure timely responses to the resident's requests and needs. - Be sure the call bell is plugged in and functioning at all times. On 1/21/25 at approximately 8:30 A.M., the surveyor observed that the call bell system was broken on the A Unit. The surveyor sampled the call bell system from several bedrooms and noted that the call bell did not sound, either in the hallway of the nursing station, and the call bell board at the nursing station did not illuminate to identify which bedroom requested help. The surveyor observed that in some of the sampled bedrooms the call light button illuminated the light outside the bedroom doorway. The surveyor observed that the call lights in the hallway located on the left wing of the unit, and the end of the hallway of the right wing, were not visible from the nursing station. During the morning of 1/21/25 and the afternoon of 1/22/25, the surveyor observed: - room [ROOM NUMBER]W: No hand bell. The Resident was unaware the call light system was broken. - room [ROOM NUMBER]W: No hand bell. The Resident was unaware call light system was broken. - room [ROOM NUMBER]D and 7W: No hand bells in the bedroom. The Residents said they were unaware the call light system was broken. - room [ROOM NUMBER]D: No hand bell. The Resident was unaware the call light system was broken. - room [ROOM NUMBER]W: Resident lying in bed and a hand bell was located on windowsill, beyond his/her reach. The Resident was aware the call light system was broken. - room [ROOM NUMBER]W: Resident lying in bed and hand bell on windowsill, beyond his/her reach. The Resident was aware call light system was broken. - room [ROOM NUMBER]D: Resident lying in bed and hand bell was located on over bed table, within reach. Resident said light in the hallway outside the bedroom illuminates when the call bed cord button is pushed, but no alarm sounds or light illuminates at the nursing station. The Resident said sometimes staff respond to the hall light, other times he/she needs to call out for help. - room [ROOM NUMBER]D: No hand bell, and the call bell cord was on the floor, beyond the Resident's reach. The Resident was unaware the call light system was broken. (continued on next page)

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	01/23/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER]W: No hand bell, and the call bell cord was on the floor, beyond the Resident's reach. The Resident was aware call light system was broken. During an interview with Unit Manager #2 on 1/22/25 at 11:20 A.M., she said the call light system began to stop functioning in some of the residents' bedrooms in November 2024, and that by mid-December 2024 the system stopped functioning in all the bedrooms. Unit Manager #2 said none of the call bells sounded, but that some of the hallway call lights still activated, but not at the nursing station. Unit Manger #2 said she did not when the call system was to be repaired. Unit Manager #2 said she had instructed staff nurses to distribute hand bells to each of the residents and to place them within reach. The surveyor told Unit Manager #2 that many residents did not have handheld bells, and for those that did these were sometimes out of reach. The surveyor told Unit Manager #2 that many of the residents did not know the call light system was broken, yet were still using the call bell, and complained about the late response time. On 1/22/25 at 11:25 A.M., the surveyor was on the A Unit hallway and heard the Resident in room [ROOM NUMBER]D calling for help, from his/her bed. The surveyor entered the bedroom and observed that room [ROOM NUMBER]D still did not have a hand bell. During an interview with the Administrator on 1/23/25 at 9:36 A.M., he said he was aware the call light system was broken, and that staff should have given each resident a hand bell to ring for assistance. During an interview with the Consulting Maintenance Director on 1/23/25 at 1:30 P.M., he said the building has been without a Maintenance Director for approximately a week, and he was not familiar with required repairs in the building. The surveyor and Consulting Maintenance Director reviewed the Maintenance Log, and it indicated staff documented the A Unit call light system needed repairs in October and December 2024. The Log indicated the call light system had not been repaired.