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	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0773 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report lab results to the provider timely for one Resident (#82) out of a total of 24 sampled residents. Specifically, the facility failed to notify the on call provider of Resident #82's urine culture which indicated he/she had a urinary tract infection on 1/4/26. Subsequently, antibiotic treatment was not initiated, and Resident was hospitalized and diagnosed with sepsis, (a life threatening illness that develops when an existing infection triggers an extreme immune system response in your body) secondary to a urinary tract infection on 1/6/26; approximately two days after the lab results were completed. Findings include:Review of the policy titled Test Results dated April 2007 indicated: 1. Results of laboratory, radiological and diagnostic tests shall be reported in writing to the resident's attending physician or the facility. 2. Should the test results be provided to the facility, the attending physician shall promptly be notified of the results. 3. The director of nursing services or charge nurse receiving the test results shall be responsible for notifying the physician of such test results. Review of the policy titled Change in a Resident's Condition or Status, dated as revised February 2021 indicated: The nurse will notify the resident's attending physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or implementing standard disease related clinical interventions. Resident #82 was admitted to the facility in January 2025 with diagnoses including type two diabetes, hypertensive heart disease without heart failure and bilateral osteoarthritis of the hip. Review of the Minimum Data Set assessment (MDS) dated [DATE], indicated Resident #82 is moderately cognitively impaired as evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). Review of Resident #82's Urinary Care Plan indicated:Focus: Resident is incontinent. At risk for UTI, 2/1/25Goal: Resident will not suffer UTI this review.Interventions: Laboratory tests as ordered. Monitor labs as available. Review of the nurse progress note dated 12/30/25 indicated: New orders obtained for a urine spec for UA/CS (urinalysis with culture and sensitivity) and STAT hematology labs, for weakness, confusion. Labs were drawn this afternoon and are currently pending. The lab technician informed this writer that she will not be available to pick the urine up this evening and will tomorrow if it is obtained, recommendations from lab tech is to use the first morning urine, if possible, since she is unable to retrieve the sample until 12/31/2025. will notify the oncoming nurse during shift report. Resident #82 has been observed this morning walking with staff back from the bathroom; however, sample was not obtained at this time. Review of Resident #82's lab report indicated his/her urine was obtained on 1/1/26 and the results of urine culture indicated an infection as the culture grew greater than 100,000 CFU (colony forming unit) Escherichia coli (a group of bacteria that normally lives in the digestive tract often referred to as E. coli). The lab report indicated the results were reported and available for review on 1/4/26, (a Sunday). The clinical record failed to indicate the lab results were reviewed by nursing staff or reported to the provider on 1/4/26 or 1/5/26. Review of the nurse progress note dated 1/6/25, indicated: At approx. 12:00PM upon returning from (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 0773 Level of Harm - Actual harm Residents Affected - Few	the hairdresser back to the c-unit he/she was found to have shaking chills and vomiting. The NP (Nurse Practitioner) as notified and came onto the unit to assess him/her; he/she reported to the NP that he/she felt unwell and would like to be seen in the ER. He/she was transferred to [the hospital]. Review of the Nurse Practitioner note dated 1/6/26, indicated: Seen today per staff request he/she appeared to be in his/her usual state of health this morning, went downstairs to the hairdresser, upon return to floor was found to have shaking chills, dry heaving, states he/she feels generally unwell and would like to be seen in the ER. On 12/23 seen by this NP with fever and general malaise in the setting of Covid-19 infection, CXR (chest x-ray) negative, no hypoxia or other respiratory concerns. On 12/30 nursing reported ongoing weakness and confusion. UACS and labs ordered. BMP CBC unremarkable. On review today it appears UACS was sent on 1/2 with culture resulting on Sunday 1/4 showing greater than 100,000 E. coli, result not reported to provider therefore has not been started on antibiotic. Will proceed with ER evaluation per patient request, high risk for urosepsis. Blood sugar stable, nursing states unable to obtain vital signs due to shaking chills. Review of the hospital Discharge summary dated [DATE] indicated Resident #82 was admitted to the hospital and diagnosed with sepsis secondary to urinary tract infection. During an interview on 1/21/26 at 8:42 A.M., Unit Manager #2 said that the facility is using a new lab service. Unit Manager #2 said that labs are reviewed by nursing staff or the NP online through the lab portal and the facility is working on having the lab results be automatically uploaded to the clinical record. Unit Manager #2 said on weekends the nursing staff are responsible for reviewing and reporting lab results to the on-call practitioner. Unit Manager #2 said she did not know why Resident #82's urine results were not reported to the provider over the weekend (1/4/26). During an interview on 1/21/26 at 11:05 A.M., Resident #82 said he/she went to the hospital a few weeks ago but was not sure why. During an interview on 1/21/26 at 1:26 P.M., Nurse Practitioner (NP) #1 said that lab results are reviewed by nursing staff or she will log into the system and review the results herself. NP #1 said that the facility is in the process of having lab results be automatically uploaded in the resident electronic record. NP #1 said that on weekends, nursing staff are expected to report results to the on-call provider. NP #1 said that Resident #82's urine results were not reported and should have been. NP #1 said antibiotic treatment should have been implemented when the culture and sensitivity were finalized. NP #1 said she documented that Resident #82 was high risk of urosepsis because he/she had the chills which is an indication of a systemic issue. NP #1 said that delaying antibiotic treatment could contribute to sepsis. During an interview on 1/21/2026 1:38 P.M., the Director of Nursing (DON) said that nursing staff are expected to report results of labs to the on-call provider on the weekends. The DON said that Unit Manager #2 told her that the Resident #82's labs were not reviewed or reported to the NP on 1/4/26. The DON said that Unit Manager #2 worked on 1/5/26 and told her she had missed it when Resident #82's results were reviewed and was hospitalized on [DATE].

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a change in condition for one Resident (#3) out of a total sample of 24 residents. Specifically, the facility failed to notify the physician/nurse practitioner when Resident #3's blood sugar levels went below 70 mg/dL (milligrams per deciliters) as indicated by the plan of care.Findings include:Review of the facility policy titled Change in a Resident's Condition or Status dated and revised February 2021, indicated the following:- The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in resident's physical/emotional/mental condition, specific instruction to notify the physician of changes in the resident's condition.Resident #3 was admitted to the facility in August 2024 with diagnoses including type 1 diabetes mellitus with diabetic neuropathy, atherosclerotic heart disease, and dementia. Review of Resident #3's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident receives insulin due to hypoglycemia. Review of Resident #3's physician's order dated 8/16/24 indicated the following:- May obtain blood glucose as needed if symptoms of hypo/hyperglycemia (low/high blood sugar) present & notify MD as needed Notify practitioner if blood sugar is less than 70 or greater than 400Review of Resident #3's nursing progress note dated 6/1/25 at 10:33 P.M., indicated the following:- 9:15pm resident called and wanted his/her blood sugar checked because it felt low and he/she had trouble getting onto the toilet from his/her w/c. his/her CBS was found to be 56. He/she was alert and able to drink so he/she requested fruit punch, two puddings, and he/she ate a cupcake. upon recheck 35 minutes later his/her CBS was 89 and he/she reported feeling much better.Review of Resident #3's Blood Sugar Vitals log indicated the following:11/11/25 at 8:20 P.M. - 67 mg/dL (milligrams per deciliter, a unit for measuring blood sugar).11/23/25 at 8:35 A.M. - 64 mg/dL12/4/25 at 12:17 P.M. - 61 mg/dL1/4/26 at 7:56 A.M. - 57 mg/dL1/10/26 at 12:12 P.M. - 69 mg/dLReview of Resident #3's care plan dated 7/23/22 indicated the following:- Resident is at risk for complications related to Diabetes Mellitus - insulin dependent-Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.Review of Resident #3's medical record failed to indicate any documentation that the Physician or Nurse Practitioner were notified of blood sugars <70, as per the physician's order.During an interview on 1/21/26 at 8:48 A.M., Unit Manager #2 said all physician's orders should be followed. Unit Manager #2 said the Nurse Practitioner (NP) or physician should be contacted if a Resident is experiencing a change of condition or if specified by a physician's order. The surveyor and Unit Manager #2 reviewed Resident #3's blood sugar values and she said the NP should have been notified of Resident #3's low blood sugar values so she was aware of the situation and could provide updates and monitor as needed. Unit Manager #2 then said staff need to be documenting in the medical record when they contact the NP.During an interview on 1/21/26 at 12:32 P.M., the Director of Nursing (DON) said when staff contact the NP of physician they should be documenting it in the medical record. The surveyor reviewed Resident #3's low blood sugar values and the physician's order and she said the NP should have been notified.During a telephone interview on 1/21/26 at 1:16 P.M., the NP said she does not remember being notified about Resident #3's low blood sugar values and she should have been to provide guidance and so she could follow up with the Resident. The NP said if she was unavailable then staff should be contacting the on-call provider. The NP then said she would expect staff to be documenting when they contact or attempt to contact her or the physician.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to follow the grievance process for one Resident (#4) related to wound care, out of a total sample of 24 residents. Findings include: Review of the facility policy titled Grievance Policy, undated, indicated the following: It is the policy of the facility to follow all regulatory guidance and support that each resident has the right to voice grievances, complaints, and that resolution will be actively pursued in a reasonable amount of time. - The Center must have a grievance officer -- the Grievance officer is the point person responsible for overseeing the grievance process, receiving, and tracking grievances through to their conclusion. - When a resident, representative or other person linked to a resident has a grievance or complaint a staff member should encourage that person to file a written grievance using the facility grievance/complaint report form. The staff member should assist with the completion of the form if necessary. - If the person does not wish to complete the report, the staff member receiving the grievance should ensure the form is filled out and passed along in accordance with the policy. - Receipt of the grievance and/or complaint will be logged by the Grievance officer in the facility grievance log. This log will be utilized for tracking and trending as part of the facility QAPI program. - The Administrator is responsible for overall compliance of the grievance and/or complaint officer. Resident #4 was admitted in March 2024 with diagnoses including type 2 diabetes and venous insufficiency. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #4 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicates Resident #4 has a stage 4 pressure wound. Review of a voicemail message from the facility's Ombudsman on 1/20/26 at 8:16 A.M. indicated the following: Resident #4 has been complaining about his/her wound care that he/she receives in the facility and he/she is pretty reliable. On 1/21/26 at 11:17 A.M., Resident #4 said that he/she has been having concerns with his/her wound care, specifically wound packing (a technique for deep or tunneling wounds, involving tightly stuffing gauze into the cavity to control bleeding, absorb drainage, and promote healing from the inside out, preventing premature closure), and feels like it is not being addressed. Resident #4 said that he/she has told the staff and has expressed his/her concern during the quarterly care meetings. Resident #4 said he/she told the Ombudsman about his/her concerns regarding the wound care as well. Resident #4 said he/she feels like staff is not addressing it and has not been approached to file a grievance. Review of the care conference note, dated 1/14/26, indicated Resident #4 had concerns regarding the timing of his/her wound care and getting back into bed in the afternoon. During an interview on 1/21/26 at 11:35 A.M., Unit Manager #2 said that Resident #4 has expressed his/her concerns regarding the packing of his/her wound and knows Resident #4 has contacted the Ombudsman and Unit Manager #2 said she told the Administrator. Unit Manager #2 said she has shown her nurses how to correctly do the wound care but does not have a record of the education. During an interview on 1/21/26 at 12:09 P.M., the Social Worker said that Resident #4 had concerns about his/her wound care not being packed correctly by certain nurses and she feels that the staff did address it with him/her. The Social Worker said that the Administrator was in the care meeting and may have filed a grievance, but she is not sure. The Social Worker said that when a resident has a complaint, then a grievance should be filed about it. During an interview on 1/21/26 at 12:21 P.M., the Director of Nursing said she was aware of Resident #4's wound concerns, but the Administrator is the one that handles grievances. During an interview on 1/21/26 at 12:34 P.M., the Administrator said that he will file a grievance if it is a serious concern or something regarding care. The Administrator said that Resident #4 has a lot of concerns and feels like no matter what the facility does, the Resident is not satisfied. The Administrator said that he feels he addressed the concerns by notifying the Unit Manager and he feels that the notes in the electronic medical record (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are accurate in reflecting that they have addressed the wound. When the surveyor asked how the Administrator ensures resolution of a grievance, the Administrator said that even though there is not a paper trail, he ensures they get resolved. The Administrator said he does remember Resident #4 bringing up the wound care concern and feels he appropriately addressed the issue with the Unit Manager. On 1/21/26 at 10:59 A.M., the surveyor observed Nurse #8 fail to correctly apply the appropriate treatment to Resident #4's wound, according to the wound doctor's recommendations made on 1/15/26. See F686.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility to ensure that services provided met professional standards for one Resident (#126), out of 24 total sampled residents. Specifically, the facility failed to obtain and implement a physician's order for Resident #126's Sinemet (carbidopa-levodopa, medication used to treat tremors with Residents who have Parkinson's disease) based on the Resident's home schedule.Findings include: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 prescribers 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. Review of the facility policy titled, Reconciliation of Medication Administration, dated as revised July 2017, indicated the purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission. Review of the Sinemet fact sheet (sinemet.org), dated as 2026, indicated that the timing of Sinemet doses can vary depending on individual factors and the specific needs of each person. There are a few general guidelines to consider:1. Symptom pattern: It is beneficial to take Sinemet at times when you typically experience the most significant Parkinson's symptoms. For example, if you notice that your motor symptoms, such as stiffness or tremors, are more pronounced in the morning, you may consider taking a dose of Sinemet in the morning to help alleviate those symptoms and improve mobility.2. Meal times: Sinemet is typically taken on an empty stomach, as protein-rich foods can interfere with its absorption. Therefore, it is generally recommended to take Sinemet at least 30 minutes before meals or 1-2 hours after meals.3. Consistency: Maintaining a consistent dosing schedule is important to achieve optimal symptom control. Regularly spaced doses help to maintain a steady level of medication in the body and minimize fluctuations in symptom control.4. Nighttime dosing: Some individuals may benefit from a dose of Sinemet taken closer to bedtime if they experience nighttime symptoms or sleep disturbances associated with Parkinson's disease. This can help alleviate those symptoms and improve sleep quality. Resident #126 admitted to the facility in January 2026 with diagnoses including Parkinson's disease without dyskinesia, Alzheimer's disease, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/20/26, indicated Resident #126 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. On 1/20/26 at 8:00 A.M., the surveyor observed Resident #126 in bed, he/she was awake and alert and his/her hands were tremulous. The Resident was unable to participate in an interview. Review of Resident #126's hospital Discharge summary, dated [DATE], indicated: -carbidopa-levodopa 25-100 milligrams (mg) per tablet take 1.5 tablet by mouth 4 times a day. Review of Resident #126's physician's order, dated 1/16/26, indicated:-Carbidopa-Levodopa Oral Tablet 25-100 mg (Carbidopa-Levodopa), give 1.5 tablet by mouth every 6 hours for Parkinson's. Give 30 minutes before meals or 1 hour after meals. Further review of the order indicated the medication was scheduled to be administered at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. During an interview on 1/20/26 at 1:09 P.M., the Family Member (Health Care Agent (HCA), which was active) said that Resident #126 takes Sinemet at home. The HCA said that he administers Resident #126 his/her Sinemet four times a day, every four hours starting when he/she is wakes up usually around 9:00 A.M., at home and the facility should do the same. The HCA said that the medication helps with Resident #126's tremors. The HCA said that Resident #126 does not take Sinemet at midnight. During an interview on 1/20/26 at 3:47 P.M., Nurse #1 said she completed the second medication check for Resident #126's admission physician's medication orders. Nurse #1 said on the day Resident #126 was admitted to the facility it (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a very busy shift and there were four admissions that day and Nurse #1 said that the Admissions Director did the first transcription for the admission medications from the hospital discharge summary. Nurse #1 reviewed the Sinemet order and she said that Sinemet is not usually given at midnight (12:00 A.M). During an interview on 1/20/26 at 3:54 P.M., the admission Director (a licensed nurse) said that she transcribed the admission physician's orders for Resident #126's Sinemet based on the hospital discharge summary. The Admissions Director said although she was a nurse she had not transcribed physician's orders into the electronic health record in a long time. The Admissions Director said that she was not sure why she put in the Sinemet order for every six hours, when the recommendation was for four times a day, and said she was not sure why there was additional information to administer the medication around meals. The Admissions Director said that the Director of Nursing (DON) was supposed to be the second check to ensure she transcribed all the medications correctly. During an interview on 1/20/26 at 3:59 P.M., the DON said she didn't review Resident #126's admission orders that were transcribed by the Admissions Director, the DON said that Nurse #1 was supposed to review the orders to ensure accuracy of the transcribed physician's orders. The DON said that Sinemet is used for Parkinson's related tremors and the medication times should be individualized to the resident's regime. The DON said that Resident #126 should not receive Sinemet at midnight. During an interview on 1/21/26 at 7:46 A.M. Nurse #2 said she routinely works the overnight shift, and she said Resident #126 receives Sinemet at midnight. Nurse #2 said she questioned the timing of the Sinemet order to herself, and she did not ask a provider for clarification because Sinemet is not normally given at during the middle of the night. During an interview on 1/21/26 at 8:29 A.M., Unit Manager #1 said that the order from the hospital discharge summary was for four times daily and she said that nursing could have transcribed the order for Sinemet as every six hours. Unit Manager #1 said that Resident #126 takes Sinemet for Parkinson's related tremors and the timing for Sinemet administration is individually scheduled according to the Resident's home schedule. During an interview on 1/21/26 at 1:26 P.M., the Nurse Practitioner said that Resident #126 takes Sinemet for his/her Parkinson's and tremors. The Nurse Practitioner said that nursing should have obtained and transcribed Resident #126's Sinemet order from the hospital discharge summary and based on Resident #126's home time schedule.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to accurately transcribe wound recommendations and perform wound care appropriately for one Resident (#4) out of a total sample of 24 residents. Findings include: Review of the facility policy titled Dressings, Dry/Clean, dated September 2013, indicated the following: Verify that there is a physician's order for this procedure.Review the resident's care plan, current orders, and diagnoses to determine if there are special treatment needs. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage.Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). Resident #4 was admitted in March 2024 with diagnoses including type 2 diabetes and venous insufficiency. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #4 scored a 15 out of 15 of the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicates Resident #4 has a stage 4 pressure wound. Review of the care plan for Resident #4 indicated the following: Focus: The resident has pressure ulcer on coccyx (initiated 3/1/24)Interventions: Administer treatments as ordered and monitor for effectiveness (initiated 3/1/24) Review of the current physician's orders indicated the following order:wound care: COCCYX: Cleanse the wound with Full Strength Dakin's solution (an antiseptic used for wound cleaning) moistened gauze, (pack the wound depth and tunnel/s adequately with IODOFORM PACKING), maintain packing in one piece, apply Zinc Barrier Cream to peri wound area, cover with superabsorbent Silicone border foam dressingReview of the wound follow up progress note, dated 1/15/26, indicated the following: Wound Measurements: 0.6 centimeters (cm) length, 0.5 cm width, and 2.4 cm depth. The wound has a tunnel measurement of 2-5 o'clock: 2.9 cm. Instruction: Offer/provide prompt perineal care with incontinence, Cleanse the wound with Full Strength Dakin's solution moistened gauze, allow for Dakin's soak for 1-2 minutes, pack the wound depth and tunnel/s adequately with Iodoform rope/packing. May reinforce with clean gauze, cover with superabsorbent Silicone border dressing daily, as needed (PRN). Turn, reposition, offload every 2 hours PRN and as tolerated. Monitor for changes. Review of the physician's orders failed to indicate that the recommendations for the Dakin's soak were transcribed to the current physician's orders. During an interview on 1/20/26 at 12:36 P.M. and 1/21/26 at 11:17 A.M., Resident #4 said that he/she has had a wound for 3 years now and some of the staff don't pack the wound correctly or with enough Iodoform packing. Resident #4 said that it is certain staff members who do not pack it correctly and he/she can tell which nurses do not perform the wound care correctly. Resident #4 said that he/she has told staff including the Social Worker, Unit Manager, Ombudsman, and Administrator about his/her concerns regarding his/her coccyx wound treatment. On 1/21/26 at 10:59 A.M., the surveyor observed Nurse #8 complete Resident #4's coccyx wound dressing. Nurse #8 cleansed the exterior of Resident #4's coccyx wound with Dakin's solution (not the wound bed). Nurse #8 did not apply any Dakin's solution to the wound bed according to the wound provider's recommendation. After Nurse #8 cleansed the exterior of the coccyx wound Nurse #8 immediately began to pack Resident #4's coccyx wound. Nurse #8 did not apply any zinc cream to the peri wound. During an interview on 1/21/26 at 11:03 A.M., Nurse #8 said that she routinely cares for Resident #4 coccyx wound. Nurse #8 said that she does not insert Dakin's moistened gauze into the wound bed and she does not apply zinc cream to the peri-wound. Nurse #8 said that she put the dressing on Resident #4's coccyx and then puts the zinc cream around his/her rectum. During an interview on 1/21/26 at 11:32 A.M., Unit Manger #2 said that the wound doctor provides a spreadsheet with recommendations for each wound after their visit. Unit Manager #2 said that the wound doctor was in the facility on 1/15/26 and showed the surveyor a spreadsheet with the recommendation to apply the Dakin's solution to Resident #4's wound and let it sit for 1-2 minutes. Unit Manager #2 said that Nurse #8 should have taken a clean piece of gauze and (continued on next page)

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	225510	A. Building B. Wing	01/21/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moistened the gauze with the Dakin's solution, and then Nurse #8 should have filled the wound bed with the Dakin's moistened gauze and let the wound soak for 1-2 minutes according to the wound providers recommendations. Unit Manager #2 said that the purpose for the Dakin's solution soak is to help prevent infection and to help remove old dead tissue and drainage from the wound to promote healing. During an interview on 1/21/26 at 12:21 P.M., the Director of Nursing said she would expect the wound doctor's recommendations to be transcribed correctly to the orders and nurses should be following the orders. The Director of Nursing said that the wound bed should have been cleaned as recommended.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure professional standards of practice for the care of an indwelling Foley urinary catheter (a flexible tube inserted through the urethra into the bladder to drain urine) for one Resident (#30) out of a total sample of 24 residents. Specifically, the facility failed to ensure nursing inserted the correct balloon size in accordance with physician's orders.Findings include:Review of the facility policy titled Indwelling (Foley) Catheter Insertion, Male Resident, dated and revised August 2022, indicated the following:- Preparation: Verify there is a physician's order for this procedure, review the resident's care plan to assess for any special needs of the resident- Equipment and Supplies: The catheter size is specified in the order.Resident #30 was admitted to the facility in August 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of the right elbow and neuromuscular dysfunction of bladder. Review of Resident #30's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has an indwelling urinary catheter and does not reject care. Review of Resident #30's physician's order dated 8/30/25, indicated the following:- Foley catheter size #16fr (French) with 10cc (cubic centimeters) Balloon- Foley catheter care every day and evening shift for maintenance provide catheter care as neededReview of Resident #30's indwelling foley catheter care plan dated 11/30/23, indicated the following intervention: Catheter: Resident #30 has 16f 10cc (balloon size) Foley Catheter.Review of Resident #30's Kardex (a care card indicating the type of care a resident needs) indicated the following under the Bladder/Bowel section: Resident #30 has 16f 10cc Foley Catheter.During an observation on 1/21/26 at 7:32 A.M., the surveyor observed Resident #30's foley catheter as having a 16 French sized tubing with a 30 cc balloon.During an interview on 1/21/26 at 11:40 A.M., Nurse #7 said Resident #30 either uses a 16 or 18 French sized catheter tubing with a 5 cc balloon. The surveyor disclosed to Nurse #7 that Resident #30 is currently using a 30cc balloon and Nurse #7 said she was not even aware they had balloon that big in the facility and he/she should not be using that big of a balloon as it can cause pressure on the bladder and she missed it when doing catheter care. The surveyor and Nurse #7 then observed Resident #30's catheter together and she confirmed he/she currently had a 30 cc balloon foley catheter.During an interview on 1/21/26 at 11:50 A.M., Unit Manager #2 said Resident #30 should not be using a 30 cc balloon for his/her foley catheter. Unit Manager #2 said the last time she changed Resident #30's catheter was in November 2025 and she is not sure who changed it since then or how long the Resident has been using a 30 cc balloon. Unit Manager #2 said Resident #30 has not been out to urology and all catheter care is done in the facility.Review of the facility's Central Supply room on 1/21/26 at 11:58 A.M., indicated there were foley catheters with 30 cc balloon available for use.During an interview on 1/21/26 at 12:32 P.M., the Director of Nursing (DON) said physician's orders should be followed and Resident #30 should not be using a 30 cc balloon for his/her foley catheter as it could cause some irritation.During a telephone interview on 1/21/26 at 1:20 P.M., the Nurse Practitioner (NP) said Resident #30's physician's orders should be followed, and she had no knowledge of a 30 cc balloon being used for his/her foley catheter. The NP then said Resident #30 has not gone out to Urology recently.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, record review, and interview the facility failed to provide care and maintenance of a peripherally inserted central catheter (PICC), consistent with professional standards of practice for one Resident (#22), out of a total sample of 24 residents. Specifically, for Resident #22, the facility failed to apply a PICC line dressing that did not have gauze obstructing the insertion site. Findings include:Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated as revised March 2022, indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. 3. Change the dressing if it becomes damp, loosened or visibly soiled and:a. at least every 7 days for a transparent semi-permeable membrane (TSM) dressing; orb. at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured). Resident #22 was admitted to the facility in October 2025 with diagnoses including osteomyelitis and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/4/26, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #22 required IV antibiotics. Review of Resident #22's physician's orders, dated 12/29/25, indicated:-Change PICC:(Right arm): change transparent dressing, extension set and cap on admission, weekly, and as needed. every day shift and as needed for dressing change every day shift every Tuesday for IV maintenance date and label dressing and as needed for maintenance change as needed for leakage, infiltration, etc. date and label dressing.-Monitor IV site- PICC and location: Right arm for signs/symptoms of infection and/or infiltration every shift for maintenance monitor IV site each shift, notify practitioner and document if swelling, redness, drainage and/or infiltration noted. Review of Resident #22's physician's orders, dated 12/30/25, indicated:-Meropenem Intravenous Solution Reconstituted 1 GM (Meropenem), Use 1 gram intravenously every 8 hours for osteomyelitis until 2/5/26. Review of Resident #22's Skilled Care Nursing Documentation note, dated 1/18/26, indicated:-Resident receives IV therapy, PICC line dressing changed no signs and symptoms of infection noted. On 1/20/26 at 7:41 A.M., and on 1/21/26 at 8:56 A.M., the surveyor observed Resident #22's PICC line inserted in his/her right arm, the dressing was dated 1/18/26 and there was a gauze dressing obstructing the insertion site. During an interview on 1/21/26 at 8:33 A.M., Unit Manager #1 said that PICC line dressings are to be changed every 7 days and there should be no gauze obstructing the insertion site and nursing should be able to see the insertion site every shift. During an interview on 1/21/26 at 8:39 A.M., Nurse #4 said that PICC line changes require a sterile technique. Nurse #4 said that he will put the gauze over the insertion site during dressing changes if it is available in the kit. During an interview on 1/21/26 at 8:44 A.M., the Staff Development Coordinator (SDC) said that PICC line dressing changes should be completed according to policy. The SDC said that gauze dressing obstructing the PICC line dressing site should be changed every 2 days. During an interview on 1/21/26 at 8:50 A.M. the Director of Nursing said that nursing should not apply gauze underneath the transparent dressing during the PICC line dressing changes. On 1/21/26 at 8:56 A.M., the surveyor and the Director of Nursing observed Resident #22's PICC line dressing dated as 1/18/26 (3 days prior), the DON said that there should not be gauze under the transparent dressing, and she said that the insertion site could not be visualized.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to accurately document in the electronic medical record for one Residents (#30), out of a total sample of 24 residents. Specifically, the facility documented that Resident #30 was wearing an orthotic elbow edge cushion when he/she was not.Findings include:Resident #30 was admitted to the facility in August 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of the right elbow and neuromuscular dysfunction of bladder. Review of Resident #30's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has upper extremity impairment on one side.The surveyor made the following observations:- On 1/20/26 at 8:04 A.M., Resident #30 was sleeping in his/her bed, his/her right arm was visible and was bent very closely to his/her body with no orthotic observed.- On 1/21/26 at 6:39 A.M., Resident #30 was sleeping in his/her bed, his/her right arm was visible and was bent very closely to his/her body with no orthotic observed.Review of Resident #30's physician's order dated 10/17/26 indicated the following: Right 90 degree elbow wedge cushion to be worn, nightly, as tolerated every evening shift.Review of Resident #30's care plan dated 11/25/24 indicated the following:- Resident #30 has limited physical mobility r/t (related to) CVA with right sided hemiplegia- Maintain usage of wrist/elbow braces to prevent contracturesReview of Resident #30's January 2026 Treatment Administration Record (TAR) indicated that staff documented that Resident #30 was wearing the Right 90 degree elbow wedge cushion on 1/20/26 and 1/21/26 despite the surveyors observations of the Resident not wearing it.During an interview on 1/21/26 at 10:26 A.M., Nurse #7 said Resident #30 only wears a wrist splint when he/she goes into his/her wheelchair and does not use any other orthotic devices.During an interview on 1/21/26 at 10:29 A.M., Certified Nursing Assistant (CNA) #1 said Resident #30 is supposed to wear a splint under his/her arm but he/she refuses. CNA #1 said she will tell therapy that he/she has been refusing whenever they check in with the staff.During an interview on 1/21/26 at 11:02 A.M., the Occupational Therapist (OT) and Director of Rehabilitation (DOR) said Resident #30 has a cushion for his/her elbow but he/she takes it off because he/she does not like it. At 11:34 A.M., the OT and DOR said they found Resident #30's cushion in his/her bedside table drawer, the OT and DOR said staff should be documenting if Resident #30 is refusing to wear the cushion or that he/she takes it off.During an interview on 1/21/26 at 11:50 A.M., Unit Manager #2 said she would expect staff to be accurately documenting the medical record. During an interview on 1/21/26 at 12:32 P.M., the Director of Nursing said she expects staff to documenting in the medical record accurately and if Resident #30 is not wearing his/her cushion they should not be documenting that he/she is.