STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 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** Based on observations and interviews, the facility failed to ensure resident rooms were maintained in good repair, clean and homelike on 2 of 3 resident care units.Findings include: On 8/19/25 & 8/21/24, following was observations were made on the first-floor unit in the following rooms:room [ROOM NUMBER]: The closet doors were missing and there was a scuffed metal frame around the doorway that appeared altered or broken with bent metal, chipped paint and cracked plaster along the wall. There was large discoloration located on two tiles visible from the hallway in the resident's closet that appeared to be water stains that were dark brown and spanned across two ceiling tiles. room [ROOM NUMBER]: The bathroom had one wet white blanket placed on the floor under the bathroom sink. There was water visible on the floor and wall. The surveyor turned the hot water faucet to the on position, water began to pour out of the bottom of the sink on to the floor and was observed spraying out from under the faucet handle on to the wall and floor. The surveyor turned on the cold-water faucet and no water came out of the faucet. There was no cold water accessible in the bathroom. -The ceiling in the bathroom has two large dark brown water stains that spanned across eight ceiling tiles. The tiles were discolored and appeared to be sagging from the ceiling. -The baseboard located in the bathroom was peeling off the wall and had light and dark brown discoloring throughout the baseboard. During an interview 8/19/25 at 8:31 A.M., Resident #28 said the bathroom sink started leaking over a week ago and said water was all over the floor and pouring out from under the sink. Resident #28 said there is no cold water and said staff have been bringing water from another room to provide care and wash their hands. Resident #28 said he/she notified the nursing staff and the maintenance director, but it has not been fixed. During an observation on 8/21/25 at 8:06 A.M., the surveyor observed one wet white blanket placed on the floor under the bathroom sink. There was water visible on the floor and wall. The surveyor turned the hot water faucet to the on position, water began to pour out of the bottom of the sink on to the floor and was observed spraying out from under the faucet handle on to the wall and floor. The surveyor turned on the cold-water faucet and no water came out of the faucet. There was no cold water accessible in the bathroom.During an interview on 8/21/25 at 8:08 A.M., Resident #28 said no one has been in to fix the sink and said the staff get frustrated because they can't wash their hands or get water for when he/she needs to be cleaned or changed.During an interview on 8/21/25 at 8:13 A.M., Certified Nursing Assistant (CNA) #1 said Resident #28's sink has been leaking for a while and said water pours out so staff placed a blanket under the since to catch the water. CNA #1 said staff bring in water from other rooms to provide care. CNA #1 said staff report issues to maintenance using the TELS system (online reporting system for maintenance issues) and said she did not report the issue but said she was told it was reported last week. During an interview on 8/21/25 at 8:20 A.M., Maintenance Staff #1 said he was not aware of water leaking in Resident #28's room and said he had been helping with issues because the maintenance director left last week. Maintenance Staff #1 reviewed the TELS system with the surveyor and said there were no reports of the leaking sink in the TELS system. During an interview on 8/21/25 at 8:47 A.M., Nurse #1 said she was not aware of the sink being broken and said (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did notice there was a wet blanket on the floor in the bathroom this morning. Nurse #1 said she does not have access to the TELS system and said she would expect the leak to be reported. During an interview on 8/21/25 at 8:52 A.M., Unit Manger #1 said she was not aware of the leak in Resident #28's room and said she would expect staff to notify here right away and report it into the TELS system so it can be addressed. Unit Manager # 1 said everyone has access to the TELS reporting system. During an interview on 8/21/25 at 9:38 A.M., the Administrator said the leak should have been reported to maintenance when it first happened and again if staff noticed it was still leaking and if unable to access water in the room and said it should have been addressed.room [ROOM NUMBER]: The window had one large rip in the screen roughly the size of a softball. room [ROOM NUMBER]: The window had one large rip on the bottom of the screen approximately 10inches x 10inches. On 8/19/25 & 8/21/24, following was observations were made on the second-floor unit in the following rooms:room [ROOM NUMBER]: The wall located under the window had a large hole with cracked plaster that extended from the shelf under the window to the baseboard and was approximately 24inches x 18inches.-The interior wall located near the bed had chipped pain, scuff marks, and cracked areas that extend down the wall with exposed plaster near the call bell panel. -The bathroom sink had scuff marks, chipped laminate that was peeling off the wood located around the bathroom sink. room [ROOM NUMBER]: The window screen is ripped. During an interview on 8/19/25 at 7:48 A.M., Resident #67 said our screen is torn, they are all ripped so we couldn't open the windows because we are worried birds will fly in and said it has been this way since he/she was admitted this past January. The roommate Resident #20 interjected and said it has been ripped since at least October 2024, the roommate said both residents told the staff it's broken, and they keep saying it will be fixed but it hasn't gotten fixed. During an interview on 8/21/25 at 8:25 A.M., Maintenance Staff #1 said he is helping out with issues in the building because the maintenance director left last week and said he would expect staff to report building concerns and leaks in the TELS system so it can be tracked. During an interview on 8/21/225 at 8:39 A.M. the Director of Nursing said staff should report issues into the TELS system so things can be fixed and monitored. During an interview on 8/21/25 at 8:41A.M., the Administrator said she expects issues identified within the building to be reported by staff in the TELS system so it can be addressed and tracked. The Administrator said residents do not open windows and said she was aware of the ripped screens, but they were not fixed because residents should not be opening the windows. The Administrator said when it rains there are leaks in the building and said she identified issues last October that needed to be addressed but has not followed up on the issues and said she could not locate any information related to the areas identified. Throughout the survey the facility was unable to provide documentation that the areas of concern were being addressed. Review of the TELS system work orders failed to indicate concerns were documented or identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record reviews, the facility failed to accurately document in the medical record for four Residents (#12, #67, #95, and #96) out of 24 total sampled residents. Specifically,1.) For Resident #12, the facility failed to ensure nursing documented weekly blood sugar checks and administration of hydrocodone-acetaminophen (a narcotic pain medication).2.) For Resident #67, the facility failed to ensure nursing accurately documented that seizure pads were not applied to bilateral side rails when in bed.3.) For Resident #95, the facility failed to ensure dressing changes were accurately documented. 4.) For Resident #96, the facility failed to ensure dressing changes were accurately documented.Findings include:Review of the facility policy titled Charting and Documentation, dated July 2017, indicated but was not limited to: -The following information is to be documented in the resident medical record: Medications administered; Treatments or services performed. -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: the date and time the procedure/treatment was provided, whether the resident refused the procedure/treatment. 1.) Resident #12 was admitted to the facility in June 2018 with diagnoses including diabetes and osteoarthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/29/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 8/19/25 at 2:33 P.M., Resident #12 said the nurses always check his/her blood sugars as ordered. Review of Resident #12's active physician's orders indicated: -Weekly Blood Sugar Checks, in the morning every Wed (Wednesday), initiated 4/17/24. -Hydrocodone-Acetaminophen Tablet 5-325 mg (milligram), give 1 tablet by mouth three times a day for pain, initiated 5/17/22. Review of Resident #12's Medication Administration Record (MAR), dated August 2025, indicated: -Weekly Blood Sugar Checks, in the morning every Wed (Wednesday), failed to indicate it was implemented as ordered at 6:00 A.M. on 8/6/25 and 6:00 A.M. on 8/13/25. -Hydrocodone-Acetaminophen Tablet 5-325 MG, failed to indicate it was administered as ordered at 6:00 A.M. on 8/6/25 and 6:00 A.M. on 8/13/25. Review of Resident #12's nursing progress note, dated 8/6/25 through 8/19/25, failed to indicate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #12's blood sugar was checked as ordered or any rationale for why it was not checked as ordered on 8/6/15 or 8/13/25. Review of these progress notes also failed to indicate the hydrocodone-acetaminophen 5-325 mg tablet was administered or rationale for why it was not documented as administered. During an interview on 8/20/25 at 9:53 A.M., Nurse #3 said he was the nurse responsible for Resident #12 on 8/6/25 at 6:00 A.M. and 8/13/25 at 6:00 A.M. Nurse #3 said he checked Resident #12's blood sugars on 8/6/25 and 8/13/25 but forgot to document it. Nurse #3 reviewed the controlled substance log with the surveyor which indicated a hydrocodone-acetaminophen 5-325 mg tablet was removed from controlled substance box on 8/6/25 at 6:00 A.M. and on 8/13/25 at 6:00 A.M. by Nurse #3 for Resident #12. Nurse #3 said he should have documented the blood sugar results and hydrocodone-acetaminophen administration in the medical record but did not. During an interview on 8/20/25 at 10:47 A.M., the Director of Nursing (DON) said Nurse #3 should have documented the weekly blood sugar check and the administration of the hydrocodone-acetaminophen tablet in the medical record before he left for the day on 8/6/25 and 8/13/25 but did not. 2.) Resident #67 was admitted to the facility in January 2025 with diagnoses including a seizure disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/24/25, indicated Resident #67 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. On 8/19/25 at 7:48 A.M., the surveyor observed Resident #67 in bed without any seizure pads on his/her bilateral side rails. There were seizure pads against the wall across the room. Resident #67 said he/she always refuses the seizure pads on his/her side rails because he/she hates them. On 8/19/25 at 11:02 A.M., 8/20/25 at 6:45 A.M., and 8/21/25 at 6:46 A.M., the surveyor observed Resident #67 in bed without any seizure pads on his/her bilateral side rails. There were seizure pads against the wall across the room. Review of Resident #67's physician's order, initiated 4/2/25, indicated: -Seizure pads to side rails when in bed, every shift for seizure precautions. Review of Resident #67's Treatment Administration Record (TAR), dated August 2025, indicated the order for seizure pads to side rails when in bed was documented as implemented on: -8/18/25 on night shift (11:00 P.M. - 7:00 A.M) -8/19/25 on day shift (7:00 A.M. - 3:00 P.M.) and night shift (11:00 P.M. - 7:00 A.M) -8/20/25 on day shift and night shift (11:00 P.M. - 7:00 A.M) During an interview on at 8/21/25 at 6:54 A.M., Certified Nurse Assistant (CNA) #2 said she works night shift and that Resident #67 should have seizure pads on his/her side rails when in bed. CNA #2 said Resident #67 did not have his/her seizure pads on his/her side rails during her shift because (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he/she always refuses them. CNA #2 said the nurses were aware that the Resident always refuses. During an interview on 8/21/25 at 7:20 A.M., Nurse #4 said she works day shift and that Resident #67 should have seizure pads on his/her side rails when in bed. Nurse #4 said Resident #67 often refuses seizure pads, but when she reapproaches, he/she often will accept them. Nurse #4 said nurses should not document the order for seizure pads to side rails when in bed as implemented if the Resident refused and should instead document the refusal in the medical record. During an interview on 8/21/25 at 7:37 A.M., Nurse #5 said she works night shift and that Resident #67 should have seizure pads on his/her side rails when in bed. Nurse #5 said Resident #67 doesn't use his/her seizure pads because he/she doesn't like them. Nurse #5 said she knew the seizure pads were not implemented on the night shift of 8/18/25 and 8/20/25 but she documented them as implemented, even though they weren't, because the Resident needs them. Review of Resident #67's nursing progress notes, dated 8/19/25 to 8/21/25, failed to indicate the any seizure pad refusal by the Resident. During an interview on 8/21/25 at 11:28 A.M., the Director of Nursing (DON) said Resident #67 should have had seizure pads on his/her side rails when in bed as ordered by the physician. The DON said if Resident #67 refused the seizure pads to his/her side rails when in bed the nurses should have documented it as refused or not implemented instead of as implemented. 3. Resident #95 was admitted to the facility in August 2024 with diagnoses including skin tears to the right forearm, skin cancer, and gout. Review of the Minimum Data Set assessment indicated it was not due. Review of the physician's note dated 8/13/25, indicated that resident #95 is alert and oriented to person, place and time. Review of the physician's orders, dated August 2025, indicated the following order: Right forearm skin tears; cleanse with wound cleanser, dry, apply xeroform (a petroleum impregnated gauze) and cover with DPD (dry protective dressing) every day shift. On 8/19/25 at approximately 8:10 A.M., the surveyor observed Resident #95 in bed with two dressings on the right upper arm, both dated 8/17/25. During an interview on 8/19/25 at approximately 8:10 A.M., Resident #95 said that the nurse didn't change the dressing yesterday. Review of the Treatment Administration Record (TAR) dated August 2025, indicted that on 8/18/25, the nurse documented that the dressings to the right forearm were changed as ordered. During an interview on 8/19/25 at 3:30 P.M., Nurse #2 said that he changed the dressing to the right forearm as ordered today. Nurse #2 then said that he did see that the date on the old dressing was dated 8/17/25. Nurse #2 then said that the nurse should have changed the dressing on 8/18/25 as the dressing is ordered to be changed daily. Nurse #2 then said that if the nurse did not change the dressing, then the medical record should not indicate that the dressing had been changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/19/25 at 4:09 P.M., the Director of Nursing (DON) said that dressing changes should be completed according to physician's orders. The DON then said that the medical record should accurately reflect the care provided to the Resident. 4. Resident #96 was admitted to the facility in August 2025 with diagnoses including heart disease, liver disease and cancer. Review of the Minimum Data Set assessment indicated it was not due at the time of survey. Review of the progress note dated 8/16/25, indicated that Resident #96 is alert and oriented to person, place and time. Review of the progress note dated 8/14/25, indicated that Resident #96 received a recent treatment to the right side of the face for skin cancer. Review of the physician's orders dated August 2025 indicated the following order: Right ear lesion and right temple: Iodosorb (an antibacterial gel) and DPD (dry protective dressing), change daily and PRN (as needed) every day shift. On 8/19/25 at 7:40 A.M., the surveyor observed Resident #96 in bed with a dressing dated 8/17/25 on the right temple area. Review of the Treatment Administration Record (TAR) dated August 2025, indicted that on 8/18/25, the nurse documented that the dressings to the right temple were changed as ordered. During an interview on 8/19/25 at 3:02 P.M., Nurse #2 said that the dressing should have been changed daily. Nurse #2 then said that he didn't notice the date on the old dressing before he removed it. Nurse #2 then said that if the nurse did not change the dressing, then the medical record should not indicate that the dressing had been changed. During an interview on 8/19/25 at 4:09 P.M., the Director of Nursing said that dressing changes should be changed according to physician orders. The DON then said that the medical record should accurately reflect the care provided to the Resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to ensure resident protected health information (PHI) was secure and not visible to others on one of two nursing units. Findings include: Review of the facility policy titled HIPAA (Health Insurance Portability and Accountability Act), dated as revised 7/12/2012, indicated: It is the policy of the facility to limit access of confidential healthcare information to the minimum necessary - need to Know for the purpose of providing patient care. Individuals shall not access information for those in which they are not responsible for the provision of healthcare. On 8/21/25 at 8:01 A.M., the surveyor observed on the first-floor unit medication cart, a computer screen with an electronic health record that was open, and a document labeled Report Sheet, containing printed and handwritten patient information including full name, date of birth , diagnosis. The surveyor was able to read the PHI. The Nurse was not present at the cart, and the surveyor observed a resident and a housekeeping staff member in the area by the computer screen with visible patient information On 8/21/25 at 8:05 A.M., Nurse #1 returned to the medication cart, and said she should not have left the PHI visible and accessible on the medication cart. During an interview on 8/21/25 at 8:41 A.M., the Director of Nursing said nursing should ensure PHI is secure and not visible to those not authorized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure for 1 Resident (#39), out of a total sample of 24 residents that an antianxiety medication administered PRN (as needed) was limited to 14 days, and that the prescriber documented in the clinical record the rationale for continued use and the duration of the use of the PRN antianxiety medication. Specifically, Resident #39 was administered PRN Ativan, (a medication used to treat anxiety signs and symptoms) without a duration for the use of the PRN Ativan. Findings include: Resident #39 was admitted to the facility in December 2023 with diagnoses that include but not limited to cerebral infarction (an occlusion of blood to the brain resulting in a stroke), adjustment disorder with mixed anxiety and depressed mood. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #39 scored a 15 out of 15 on the Brief Interview of Mental Status exam indicating he/she as having intact cognition. Review of Resident #39's clinical record indicated the following physician's order: -Ativan Oral Tablet 0.5 Milligrams (MG) (Lorazepam) give 0.25 mg by mouth every 12 hours as needed for anxiety, order date 7/3/25. Review of the above physician's order failed to indicate a duration for the use of the PRN Ativan. Review of Medication Administration Record (MAR) dated July 2025 indicated the PRN Ativan was not administered to Resident #39. Review of the MAR dated August 2025 indicated the PRN Ativan was administered to Resident #39 on 8/6/25 0848 (8:48 A.M.), 8/7/25 0943 (9:43 A.M.), 8/10/25 0800 (8:00 A.M.), and 2015 (8:15 P.M.) for a total of 4 PRN doses since the initial order of 7/3/25. Review of Resident #39's clinical record indicated the following: -A note dated 7/3/25 written by the Nurse Practitioner (NP) Depression, unspecified depression type Nursing staff reports concerns of patient becoming depressed due to not being able to return home. Will start Ativan 0.25 mg twice daily as needed for anxiety/depression x 14 days. Although the NP note dated 7/3/25 indicated the PRN Ativan was for 14 days. Review of the order indicated it was entered without a stop date of 14 days and continued as PRN without a duration of use and end date. -A note dated 8/14/25 written by the NP, Depression unspecified depression type; Continue on Ativan 0.25 mg twice daily as needed. The NP note dated 8/14/25 indicated to continue with the PRN Ativan, however the order remained open ended and did not indicate the duration for the use of the PRN Ativan. -A note dated 8/6/25 type: Pharmacist note, -Lorazepam (Ativan) 0.25 q12h (every 12 hours) PRN (7/3/25) MD rec (medical doctor recommendation) stop date PRN Lorazepam. During an interview on 8/21/2025 at 9:43 A.M., Nurse #6 said Resident #39 has had an order for PRN Ativan for about a month or two. Nurse #6 said the target symptoms for Resident #39 is mood changes including crying, becoming agitated and frustrated with his/her situation. Nurse #6 said she has given Resident #39 the PRN Ativan. Nurse #6 said an order for psychotropic medication including Ativan should be for 2 weeks then after that it should have an end date. Nurse #6 reviewed Resident #39's order for the PRN Ativan with the surveyor and said the order was entered 7/3/25 and was indefinite. During an interview on 8/21/2025 at 10:10 A.M., Unit Manager #2 said Resident #39 was having increased anxiety related to his/her situation, and was recently started on Ativan as needed, and has responded well to the medication. Unit Manager #2 said we normally start with 14 day order for psychotropic medication and after that the MD or NP will review and see how a resident is doing and determine the duration for use of the PRN medication. Unit Manager #2 said the NP is here often and that the order written did not have a duration date and should have. During an interview on 8/21/2025 at 11:30 A.M., the Director of Nursing said Resident #39 was having increased anxiety and did not initially consent to the PRN Ativan medication and once he/she consented, the medication was used. The DON said the NP should have addressed the pharmacist recommendation to have an end date for the PRN Ativan. The DON then said the order should have a duration for the use of the PRN Ativan and that the NP should have a note regarding the duration of use and the order should not be written without end date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview the facility failed to implement the plan of care for two Residents (#95 and #96) out of a total sample of 24 residents. Specifically: For Resident #95 the facility failed to change a dressing to the forearm as ordered.For Resident #96 the facility failed to change a dressing to the right temple as ordered.Findings include:Review of the facility policy titled Wound Care Policy dated as revised 11/5/24, failed to indicate that physician ordered dressing changes are to be completed as ordered. 1. Resident #95 was admitted to the facility in August 2024 with diagnoses including skin tears to the right forearm, skin cancer, and gout. Review of the Minimum Data Set assessment indicated it was not due. Review of the physician's note dated 8/13/25, indicated that resident #95 is alert and oriented to person, place and time. Review of the physician's orders, dated August 2025, indicated the following order: Right forearm skin tears; cleanse with wound cleanser, dry, apply xeroform (a petroleum impregnated gauze) and cover with DPD (dry protective dressing) every day shift. On 8/19/25 at approximately 8:10 A.M., the surveyor observed Resident #95 in bed with two dressings on the right upper arm, both dated 8/17/25. During an interview on 8/19/25 at approximately 8:10 A.M., Resident #95 said that the nurse didn't change the dressing yesterday. During an interview on 8/19/25 at 3:30 P.M., Nurse #2 said that he changed the dressing to the right forearm as ordered today. Nurse #2 then said that he did see that the date on the old dressing was dated 8/17/25. Nurse #2 then said that the nurse should have changed the dressing on 8/18/25 as the dressing is ordered to be changed daily. During an interview on 8/19/25 at 4:09 P.M., the Director of Nursing said that dressing changes should be completed according to physician's orders. 2. Resident #96 was admitted to the facility in August 2025 with diagnoses including heart disease, liver disease and cancer. Review of the Minimum Data Set assessment indicated it was not due. Review of the progress note dated 8/16/25, indicated that Resident #96 is alert and oriented to person, place and time. Review of the progress note dated 8/14/25, indicated that Resident #96 received a recent treatment to the right side of the face for skin cancer. Review of the physician's orders dated August 2025 indicated the following order: Right ear lesion and right temple: Iodosorb (an antibacterial gel) and DPD (dry protective dressing), change daily and PRN (as needed) every day shift. On 8/19/25 at 7:40 A.M., the surveyor observed Resident #96 in bed with a dressing dated 8/17/25 on the right temple area. During an interview on 8/19/25 at 3:02 P.M., Nurse #2 said that the dressing should have been changed daily. Nurse #2 then said that he didn't notice the date on the old dressing before he removed it. During an interview on 8/19/25 at 4:09 P.M., the Director of Nursing said that dressing changes should be changed according to physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record review, the facility failed to ensure one Resident (#71), out of 24 total sampled residents, received adequate supervision and assistance devices to prevent accidents. Specifically, for Resident #71, who had multiple recent falls, the facility failed to ensure staff implemented fall interventions, including the use of a baby monitor when in bed and ensuring his/her call bell was within reach.Findings include:Review of the facility policy titled Procedure for Falls, undated, indicated:-Update Kardex (a summary of a patient's plan of care), care plan and communicate this information.-If the intervention is not working discontinue and find another solution.Resident #71 was admitted to the facility in November 2024 with diagnoses including dementia.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/31/25, indicated Resident #71 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15. This MDS also indicated Resident #71 had 3 or more falls in the past quarter.Review of Resident #71's nursing and physician progress notes, dated 4/3/25 to 7/26/25, indicated Resident #71 had multiple recent falls including a fall on 4/3/25 resulting in a humerus fracture, 6/25/25 resulting in scalp sutures, 7/21/25 resulting in scalp sutures, and another fall on 7/26/25.Review of Resident #71's active plan of care related to falls, revised 8/8/25, indicated:-Be sure the call light is within reach and encourage Resident #71 to use it for assistance as needed. Needs prompt response to all requests for assistance.-Baby monitor when in bed, staff in dayroom when patient is out of bed.On 8/19/25 at 7:59 A.M., the surveyor observed Resident #71 in bed without any staff within view of the Resident. There was a call bell on the floor and a hand bell on the windowsill not within reach of the Resident. There was a baby monitor on the roommate's side of the room facing away from Resident #71.On 8/20/25 at 6:54 A.M., the surveyor observed Resident #71 in bed without any staff within view of the Resident. There was a call bell on the floor and a hand bell on the windowsill not within reach of the Resident. There was a baby monitor camera on the roommate's side of the room facing away from Resident #71.On 8/20/25 at 6:57 A.M., the surveyor observed the baby video monitor at the nurse's station which showed video feed of the Resident's bathroom, without any portion of the Resident, who was in bed at the time and without any staff in the room.On 8/20/25 at 8:34 A.M., the surveyor observed Resident #71 in bed without any staff within view of the Resident. There was a call bell on the floor and a hand bell on the windowsill not within reach of the Resident. There was a baby monitor camera on the roommate's side of the room facing away from Resident #71.On 8/21/25 at 6:44 A.M., the surveyor observed Resident #71 in bed without any staff within view of the Resident. There was a call bell on the floor and a hand bell on the windowsill not within reach of the Resident. There was a baby monitor camera on the roommate's side of the room facing away from Resident #71. On 8/21/25 at 6:47 A.M., the surveyor observed the baby video monitor at the nurse's station which was not powered on and had no video feed of the Resident's room. Resident #71 was in bed at this time without any staff in the room.During an interview on 8/20/25 at 12:20 P.M., Unit Manager #2 and Nurse #4 said staff use a baby monitor to supervise Resident #71 in his/her room. Unit Manager #2 and Nurse #4 said there is one baby monitor system used to monitor both Resident #71 and his/her roommate, and it should be directed to capture both Residents when they are in their room.During an interview on 8/21/25 at 6:45 A.M., Certified Nurse Assistant (CNA) #2 said she uses the kardex to obtain specific care instructions for each resident on her assignment. CNA #2 said all interventions listed on the kardex should be implemented, and if they were unable to be implemented the CNA should alert the nurse. CNA #2 and the surveyor reviewed Resident #71's kardex, which indicated the following active interventions: Be sure the call light is within reach and encourage Resident #71 to use it for assistance as needed and Baby monitor when in bed, staff in dayroom when patient is out of bed. CNA #2 said Resident #71 should have a baby monitor always directed at him/her when he/she is in bed when staff is not present in the room. CNA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 said the staff does not give Resident #71 a call bell because he/she would press it a lot of times. CNA #2 and the surveyor went into Resident #71's room and CNA #2 said both the call bell and the hand bell was out of reach because staff does frequent checks instead.During an interview on 8/21/25 at 7:20 A.M., Nurse #4 said CNAs are expected to get resident care information from the kardex. Nurse #4 said all interventions should be implemented. Nurse #4 said if the intervention is refused or ineffective the Nurse should be notified, and it should be documented or the plan of care revised as necessary. Nurse #4 said Resident #71 should have a baby camera directed at him/her when he/she is in his/her room, except when staff is in the room providing care. Nurse #4 said Resident #71 should have a call bell within reach if it is an intervention on his/her care plan or kardex.During an interview on 8/21/25 at 7:37 A.M., Nurse #5 said she does not use the baby monitor for Resident #71 because she felt it was an ineffective intervention and said this was why the baby monitor was not powered on at the time. Nurse #5 said she does frequent checks on the Resident instead. Nurse #5 said Resident #71 should have a call bell within reach if it is an intervention on his/her care plan or kardex and was unaware staff were not giving Resident #71 the call bell. Nurse #5 said if an intervention is ineffective the plan of care should be revised but it was not.Review of Resident #71's nursing progress note, dated 8/19/25 to 8/21/25, failed to indicate any rationale for call bell not being within reach and for baby monitor not being utilized. During an interview on 8/21/25 at 11:28 A.M., the Director of Nursing (DON) said CNAs and nurses should implement all interventions on the care plan and kardex, document refusal, or revise the plan of care for ineffective interventions. The DON said the baby monitor should have been directed at Resident #71 if unattended in bed and turned on if that was intervention. The DON said Resident #71's call bell should have been within reach if that had been an intervention. The DON further said that if any intervention is not appropriate it should have been documented as to why it was not done and/or plan of care should have been revised if the intervention was ineffective.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 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, interviews, and record review, the facility failed to provide care and maintenance of a peripherally inserted Intravenous catheter (IV), consistent with professional standards of practice for one Resident (#94), out of a total sample of 24 residents. Specifically, for Resident #94, the facility failed to monitor a peripherally inserted Intravenous IV catheter site and failed to develop a plan of care for the IV.Findings include:Resident #94 was admitted to the facility in August 2025 with diagnoses including acute kidney failure, fracture of the right humerus (upper arm) and heart disease. Review of the Minimum Data Set assessment indicated that it was not due. Review of the progress note dated 8/18/25, indicated that resident #94 is alert and oriented x3 (to person, place and time). On 8/19/25, at 8:01 A.M. the surveyors observed Resident #94 with a peripherally inserted intravenous (IV) line in the left antecubital (inner elbow) space. The surveyors also observed a clear dressing over the site without a date. Review of the physician's orders indicated an order dated 8/14/25 to start a peripheral IV line and administer normal saline at 50 milliliters per hour for one liter. Review of the physician's orders dated August 2025 failed to indicate an order to monitor the IV site or how to care for the IV site. Review of the care plan dated 8/17/25, failed to indicate a focus to monitor the IV site or how to care for the IV site. During an interview on 8/19/25 at 3:30 P.M., Nurse #2 said that he was not able to locate an order for the monitoring of or for the care of the IV site in the medical record. Nurse #2 then said that the IV site should be monitored every shift for signs/symptoms of infiltration and infection. During an interview on 8/19/25 at 3:33 P.M., Resident #94 said that the IV was inserted in the facility last week. During an interview on 8/19/25 at 4:09 P.M., the Director of Nursing said that all IV sites should be monitored each shift for signs/symptoms of infiltration and infection. The DON said that the medical record should indicate monitoring of the IV site.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Andover LLC	80 Andover Street Andover, MA 01810

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, the facility failed to ensure nursing staff secured medications in the medication cart prior to leaving the cart unattended on the first-floor unit. Findings include:Review of the facility policy titled Storage of Medications, dated as revised August 2018, indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 8/21/25 at 8:01 A.M., the surveyor observed a medication cart unlocked and unsupervised on the first-floor unit. The surveyor observed one bottle of nystatin powder (antifungal powder to treat skin infections) and one container of clotrimazole ointment (antifungal medication to treat skin infections) on top of the medication cart. The surveyor observed a resident and a housekeeping staff member in the area by the unlocked medication cart. During an interview on 8/21/25 at 9:05 A.M., Nurse #1 she should not have left the mediations on top of the medication cart and said the medication cart should have been locked prior to walking away from the cart when she was in a Residents room. During an interview on 8/21/25 at 8:39 A.M., the Director of Nurses (DON) said she expects nursing staff to lock the medication carts and not to keep medications stored on top of the medication carts when they are not using or accessing the carts. The DON said the medications must be stored and locked appropriately when not in use.