STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Northwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Varnum Avenue Lowell, MA 01854	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and interview the facility failed to obtain informed consent for the administration of psychotropic medication for two Residents (#80 and #98) out of a total sample of 30 residents. Findings include: The facility policy titled Psychotropic Medication Informed Consent-Massachusetts Only, dated February 2016, indicated the following: -Prior to administering psychotropic medication , the facility shall obtain the informed consent of the resident, the resident's health care proxy or the resident's guardian. 1. Resident #80 was admitted to the facility June 2024 and has diagnoses that include Alzheimer's disease and Major Depressive Disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/12/24, indicated that on the Brief Interview for Mental Status exam Resident #80 scored a 0 out of a possible 15, indicating severely impaired cognition. Review of the record indicated the following: -A Health Care Proxy was on file however the Physician had not yet invoked the HCP. -A consent for the psychotropic medication Trazadone, dose range 0-600 mg (milligrams), signed by Resident #80's designated Health Care Proxy (HCP) on 6/05/24. Review of the clinical record failed to indicate Resident #80 consented to the administration of Trazadone or had deferred to his/her HCP to sign for him/her. During an interview on 8/29/24 at 8:18 A.M., Nurse #6 said the following: -If a Resident is their own person and their HCP has not been invoked by the Physician then they should sign their own consents, including consents for psychotropic medication. During an interview on 8/29/24 at 9:37 A.M., with the Director of Nursing (DON) 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: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #80's HCP is not activated until the Physician completes the HCP activation form and writes an order to invoke the HCP. -Until the HCP is activated a Resident should sign their own consents. 45343 2. Resident #98 was admitted to the facility in April 2023 with diagnoses including metabolic encephalopathy, bipolar disorder, and Post Traumatic Stress Disorder (PTSD). Review of the most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had severe cognitive impairments. Further review of the MDS indicated he/she required substantial/maximal to dependent assistance from staff for activities of daily living (ADLs). Review of Resident #98's physician orders, dated 3/5/24, indicated: Lorazepam Oral Concentrate 2 MG/ML, Give 1 ml by mouth every 6 hours as needed for anxiety. Review of Resident #98's physician order, dated 3/27/24, indicated: Mirtazapine Oral Tablet 45 MG, Give 0.5 tablet by mouth in the evening related to major depressive disorder recurrent, unspecified. Review of Resident #98's August Medication Administration Record (MAR) indicated his/her Mirtazapine was administered daily from 8/1/24 to 8/28/24. Review of Resident #98's March Medication Administration Record (MAR) indicated his/her Lorazepam was administered on 3/6/24 and 3/9/24. Review of Resident #98's medical record failed to indicate that a psychotropic consent was obtained for Lorazepam and Mirtazapine. During an interview on 8/28/24 at 10:07 A.M., Nurse #10 said psychotropic medication consents are obtained on admission and yearly. During an interview on 8/28/24 at 10:36 A.M., the Director of Nursing said psychotropic consents should be signed on admission, annually and if a new psychotropic medication is started.

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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. 49880 Based on observation, record review and interview, the facility failed to notify a physician or provider of a Continuous Positive Airway Pressure (CPAP) machine that was not functioning and was unable to be implemented as per the Resident's plan of care for one Resident (#26) out of a total sample of 30 residents. Findings Include: Review of facility policy titled Condition: Significant Change, dated April 2025, indicated the following: -Staff will communicate with the physician, resident/ patient, and family regarding changes in condition to provide timely communication of resident/ patient status change which is essential to quality care management. -This notification should be documented in the clinical record. Resident #26 was admitted to the facility in May 2023 with diagnoses that include chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia and obstructive sleep apnea. Review of Resident #26's most recent Minimum Data Set (MDS) Assessment, dated 5/22/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS also indicated that the Resident uses non- invasive ventilation and oxygen therapy. On 8/26/24 at 9:48 A.M., Resident #26 was observed sitting up in his/her wheelchair utilizing oxygen. Resident #26 said that he/she was tired and has been waking up often at night because his/her CPAP machine was not functioning. He/she said it was last functioning on 8/18/24. He/she said he/she has been waking up and not feeling well rested, and at times falling asleep in his/her wheelchair. The CPAP machine was observed with an error code, System fault, refer to user guide, Error 006. Resident #26 said he/she was waiting for the facility to get a replacement CPAP machine. On 8/26/24 at 2:33 P.M., the surveyor observed Resident #26's CPAP machine with the error code, System fault, refer to user guide, Error 006. The surveyor asked the Resident if he/she was managing the process to obtain a new CPAP machine or if the facility staff were facilitating it. He/she said that the facility was supposed to be ordering a new CPAP machine, and that the Assistant Director of Nurses (ADON) said she was working on it. On 8/27/24 at 8:36 A.M., Resident #26 was up in his/her wheelchair eating breakfast. He/she said they did not have their CPAP machine last night and had a restless night sleep without it. He/she said no one has followed up with him/her yet about the new machine and said, my sleep is suffering without it. The error code remains on the CPAP machine. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 10:19 A.M., Resident #26 is in his/her room. The error message remains on the CPAP machine and Resident #26 said he/she has not yet been provided a new CPAP machine. Review of Resident #26's active care plan indicated that he/she has a diagnosis of COPD with interventions that included CPAP on at bedtime and off in the morning. Review of Progress notes from 8/14/24 through 8/28/24 failed to indicate that a provider has been notified about the non-functioning CPAP machine. During an interview on 8/27/24 at 12:42 A.M., Nurse #2 said that Resident #26's CPAP machine is not working. She said a physician or Nurse Practitioner should be notified, but did not know if they had. During an interview on 8/27/24 at 2:14 P.M., the ADON said that if the CPAP machine is not functioning and being implemented then a provider should be made aware, and it should be documented in the medical record. She said that the Admissions Director assists in ordering equipment and would be ordering the CPAP machine. During an interview on 8/27/24 at 2:40 P.M., Nurse Practitioner #1 said that she was not aware that Resident #26's CPAP machine had not been functioning for over one week and she would have expected to be notified. Nurse Practitioner #1 said that not utilizing a CPAP machine as ordered could result in respiratory compromise. During an interview on 8/28/24 at 10:26 A.M., the Admissions Director said that when CPAP machines are ordered, they come the next day. She said she was told on 8/22/24 that Resident #26 needed a new CPAP machine but was not notified of the settings of the CPAP machine which are required to order it until 8/26/24. At the time of the interview, the CPAP machine had still not arrived at the facility. During an interview on 8/28/24 at 2:38 P.M., the Director of Nurses said she was aware that the CPAP machine was not functioning. She said that nursing should have notified a physician or Nurse Practitioner and documented that in the medical record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49880 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 three nursing units. Findings include: On 8/27/24 at 8:01 A.M., Nurse #2 prepared medications for a resident on the A unit. Nurse #2 left her medication cart to administer medications and left her computer screen open with the electronic health record visible in the hallway. On 8/27/24 at 8:07 A.M., Nurse #2 prepared medications for a resident on the A unit. Nurse #2 left her medication cart to administer medications and left her computer screen open with the electronic health record visible in the hallway. During an interview on 8/27/24 at 8:09 A.M., Nurse #2 said that she should have locked her computer screen because the resident's protected health information was visible on the screen when she walked away, but she did not. On 8/28/24 at 8:52 A.M., Nurse #7 on the A unit walked away from her medication cart and left the computer screen open with the electronic health record visible and protected health information exposed. During an interview on 8/28/24 at 2:30 P.M., the Director of Nurses said that nurses should close or lock the screens when they walk away from computers to ensure protected health information is not visible.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41105 Based on observation, record review and interviews the facility failed to maintain a homelike environment at the facility. Specifically, the facility failed to provide the resident's access to the only resident bathroom in the facility located on the level of their main dining room and activity room. Findings include: During a Resident Group Meeting on 8/27/24 at 11:00 A.M., the residents in attendance indicated that the only resident bathroom on the main floor, next to the resident dining room has been out of service for 6 months. They said they were told by facility management that the toilet is cracked but that there is no plan to fix it. The residents expressed being upset stating it is very inconvenient and said that they are forced to go back to their units, during meals if they need to use the bathroom. During an interview on 8/28/24 at 10:47 A.M., a family member said the main floor resident bathroom has been broken for a long time with no resolution from facility and the residents who come downstairs for meals and activities are inconvenienced by it and may miss things because they have to go back upstairs. He/she said It really affects their quality of life. During an interview on 8/28/24 at 11:19 A.M., the Maintenance Director said the resident bathroom has been kept out of service for several months but that the toilet is not cracked, that's just what the facility told the residents. He said that the facility has had a drainage issue that has impacted the toilet and that in May the toilet started clogging. At that time he had multiple vendors out to clear and assess the system. The Maintenance Director said that the facility hasn't reopened the bathroom for fear of certain residents re-clogging the toilet but that he had been in the bathroom the previous day and it flushed fine. Review of the service invoices provided by the Maintenance Director indicated the following: 1. A service invoice, dated 5/09/24: Shut down water to toilet in bathroom in hallway*Drained down and removed toilet*Hydro jet sprayed 30'*Removed heavy blockage of paper and wipesReinstalled wall hung toilet with tank toilet*Restored water to toilet. (sic) 2. A service invoice, dated 5/10/24: tested system and placed back in service. Recommend a cleaning in the near future. During an interview on 8/29/24 at 10:41 A.M., the Nursing Home Administrator (NHA) said the facility had a significant flood in the building due to back ups in the plumbing system, including the toilet. He said that the facility will need to do bigger repairs at some point to address the plumbing system but that he is not sure if the Maintenance Director had started getting quotes to initiate that process. The NHA deferred to the Maintenance Director regarding the bathroom's repair status and would not say why the bathroom had not been reopened. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 8/29/24 at 11:25 A.M., the Maintenance Director said he has not started the process of obtaining quotes to fix the bigger problem under the building and that he was in a holding pattern until his Regional Director authorized this. In the meantime, he said that he could have the company flush the system again, open the bathroom back up to the residents, and monitor the situation but that he has been reluctant to do that because he knows the same residents will clog the toilet again.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on record review, interviews, and policy review, the facility failed to ensure a resident-centered personalized care plan was developed and/or implemented for two Residents (#16 and #105) out of a total sample of 30 residents. Specifically: 1. For Resident #16, the facility failed to implement multipodus boots (pressure relieving boots) per his/her physician's order. 2. For Resident #105, the facility failed to develop a care plan for a hearing loss diagnosis. Findings Include: Review of policy titled, Splints/Orthotics/Prosthetics, last revised April 2015, indicated the following: Policy: -Residents will receive splint/orthotic/prosthetic devices as deemed appropriate by the physician and rehabilitation services. Staff will monitor the circulation and skin integrity of residents using these devices at least every shift as part of routine care, or more often as ordered by the physician. -Nursing staff will apply remove the designated splint/orthotic/prosthetic device during scheduled wearing times. -If the resident refuses to wear the device, notify the rehab department, physician and responsible party. Review of the policy titled, Comprehensive Care Plans, undated, indicated the following: Policy: -The facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. Recognizing each resident as an individual, we identify and meet those needs in a resident-centered environment. Care plans are oriented towards preventing avoidable decline in clinical and functional levels maintaining a specific level of function and reflect resident preferences and right to refuse certain services or treatment. -Based on the above the interdisciplinary team develops a comprehensive care plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical, nursing, and physical social needs identified in the RAI (Resident Assessment Instrument) and IDT (Interdisciplinary Team). -The Care Plan is evaluated and revised as needed, but at least quarterly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #16 was admitted to the facility in May 2022 with diagnoses that included cerebral infarction, chronic leg syndrome, and cellulitis of the left toe. Review of Resident #16's most recent Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident #16 scored a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she is cognitively intact. Further review of the MDS indicated Resident #16 requires substantial/maximal to dependent assistance for all self-care activities and is at risk for pressure ulcers. On 8/26/24 at 8:33 A.M., 8/27/24 at 7:24 A.M., and 12:01 P.M., and 8/28/24 6:30 A.M. Resident #16 was observed lying in his/her bed. Resident #16 was not wearing his/her multipodus boots on his/her feet. The mutlipodus boots were observed on Resident #16's windowsill. Review of Resident #16's physician order, dated 3/1/24, indicated Multipodus boots at 6 PM, off at midnight for skin check. Reapply and remove after morning care. On at all times when OOB (out of bed) in w/c (wheelchair). Skin checks every shift as needed. Every shift for preventative maintenance. Review of Resident #16's nursing progress notes for the past 30 days failed to indicate the Resident refused pressure relieving boots to his/her feet. Review of Resident 16's [NAME] Pressure Ulcer Risk Scale, dated 7/18/24, indicated Resident #16 scored a 7.0, indicating the Resident was at high risk for developing pressure ulcers. During an interview on 8/28/24 at 6:37 A.M., Certified Nursing Assistant (CNA) #4 said Resident #16 has booties, but he/she does not wear them at night. CNA #4 said she was not aware if Resident #16 wears them during the day as she works the overnight shift. During an interview on 8/28/24 at 10:36 A.M., Nurse #10 said Resident #16 has booties that he/she wears during the night and are removed during morning care. Nurse #10 said it should be documented if the resident refuses. During an interview on 8/28/24 at 10:45 A.M., the Director of Nursing said she expects the booties to be worn as ordered and documented in the nurse's note if the resident refuses care. 2. Resident #105 was admitted to the facility in January 2024 with diagnoses that included conductive hearing loss, bilaterally and dementia. Review of Resident #105's most recent Minimum Data Set (MDS) assessment, dated 7/10/24, indicated Resident #105 has severe cognitive deficits. Further review of the MDS indicated Resident #105 requires substantial/maximal assistance for self-care activities and has an active diagnosis of conductive hearing loss, bilaterally. During an interview on 8/26/24 at 8:29 A.M., the Surveyor attempted to speak with Resident #105, the Resident did not respond to the questions asked and appeared to have difficulty hearing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review on 8/27/24 at 3:09 A.M., a nursing progress note dated 3/26/24 indicated the following: Resident had 1:1 with therapist. Virtual visit from Health Drive behavioral health. Resident had difficulty with session due to difficulty hearing. Resident is hard of hearing. Unit Manager to request audiology to visit with Health Drive. Resident will benefit from this, will look for alternative means until able to have consult. Review of Resident #105's medical record failed to indicate a care plan was developed for his/her hearing deficits. During an interview on 8/28/24 at 10:03 A.M., Nurse #10 said she was not aware that Resident #105 was hard of hearing and that a care plan should have been put in place with interventions on his/her admission. During an interview on 8/28/24 at 10:39 A.M., the Director of nursing said she would expect a hearing care plan to be developed and implemented on admission.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review, policy review and interviews, the facility failed to provide showers for one Resident (#100) out of a total sample of 30 residents. Findings include: Review of the facility policy titled, Activities of Daily Living, dated April 2015, indicated the following: -A program of activities of daily living (ADL) is provided to residents to maintain or restore maximum functional independence. The ability of each resident to meet the demands of daily living is assessed by a licensed nurse and/or other members of the interdisciplinary team. A program of assistance and instruction in ADL skills is developed and implemented based on the individual evaluation to encourage the highest level of functioning. This process is reviewed minimally quarterly. Resident #100 was admitted to the facility in August 2023 with diagnoses including heart failure and muscle weakness. Review of Resident #100's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she had intact cognition. The MDS also indicated Resident #100 required maximal assistance from staff for showering tasks. During an interview on 8/26/24 at 9:55 A.M., Resident #100 said he/she has not taken a shower in over six months. Resident #100 had greasy looking hair and dry skin on his/her face. Review of Resident #100's activity of daily living care plan last revised on 7/24/24, indicated the following intervention: -shower/bathe self - substantial/maximal assistance. Review of the shower list indicated Resident #100 is scheduled to receive showers on Fridays. Review of the Documentation Survey Report for the months of April, May, June, July, and August 2024 indicated the Resident had not been provided a shower in the last 5 months. During an interview on 8/27/24 at 10:51 A.M., Certified Nursing Assistant (CNA) #2 said all residents are scheduled for weekly showers. During an interview on 8/27/24 at 10:55 A.M., Resident #100 said he/she had only had two showers since being admitted to the facility. Resident #100 said it can be painful to take a shower because water does not feel good on his/her nerves but he/she would still like to have a full shower every once in a while. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 11:01 A.M., CNA #1 said all residents are scheduled for weekly showers. CNA #1 said Resident #100 has a wound on his/her heel but is still able to shower. CNA #1 said she was unaware when Resident #100 last had a shower and if he/she refused it would be documented. During an interview on 8/27/24 at 11:09 A.M., Nurse #2 said Resident #100 is able to take a shower even though he/she has a wound on his/her foot. Nurse #2 said all residents are scheduled for weekly showers and the nursing staff document all refusals of care. During an interview on 8/27/24 at 11:32 A.M., the Director of Nursing said all residents are scheduled for weekly showers and unless the resident refuses, scheduled showers should be provided. Review of Resident #100's medical chart failed to indicate Resident #100 refused showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to 1) ensure a diabetic wound dressing was changed daily for one Resident (#8) and 2) failed to follow a physician's order for monitoring of congestive heart failure for one Resident (#100) out of a total sample of 30 residents. Findings include: 1. Resident #8 was admitted to the facility in July 2021 with diagnoses including diabetes. Review of Resident #8's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #8 required supervision for all functional daily tasks. During an interview on 8/26/24 at 10:09 A.M., Resident #8 was observed lying in bed with both legs raised on pillows. The Resident had dressings on both feet, dated 8/24/24. Both dressings were significantly discolored with a brown substance and there was a spoiled odor in the room. When asked about his/her foot dressings, Resident #8 said neither dressing was changed the day prior and he/she often has to get after the nurses to do the dressing changed. Review of Resident #8's physician orders indicated the following orders: *Right plantar second toe: Cleanse with normal saline apply Methylene blue foam dressing follow by ABD pad (large wound bandage) and kerlix (bandage), every day shift for diabetic wound for 30 days. (initiated 8/14/24) *Right plantar first toe: cleanse with normal saline apply Methylene blue foam dressing follow by ABD pad and kerlix. every day shift for diabetic wound for 30 days. (initiated 8/14/24) *Left plantar first toe: cleanse with normal saline apply Methylene blue foam dressing follow by ABD pad and kerlix. every day shift for diabetic wound for 30 days. (initiated 8/14/24) During an interview on 8/28/24 at 12:48 P.M., the Assistant Director of Nursing (ADON) said all physician orders should be followed as written. The ADON said nurses should write a daily note for all wound changes. During an interview on 8/28/24 at 2:24 P.M., the Director of Nursing said she expects all treatments to be followed. 2. Resident #100 was admitted to the facility in August 2023 with diagnoses including heart failure and muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwood Rehabilitation & Healthcare Center	1010 Varnum Avenue Lowell, MA 01854

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she had intact cognition. The MDS also indicated Resident #100 required maximal assistance from staff for showering tasks. Review of Resident #100's physician orders indicated the following order: -Daily weight. Report weight gain of greater than 3LBs (pounds) in a day and 5 LBs in a week in the morning related to unspecified diastolic (Congestive) heart failure, weigh before breakfast, initiated 8/2/24. Review of Resident #100's weights indicated the following: -On 8/2/24, the Resident weighed 143.8 lbs. -On 8/3/24, the Resident weighed 140.6 lbs, a 3 lb decrease in a day. -On 8/4/24, the Resident weighed 132.8 lbs, an 8 lb decrease in a day. -On 8/5/24, the Resident weighed142.2 lbs, a 10 lb increase in a day. - On 8/10/24, the Resident weighed138.8 lbs. -On 8/11/24, the Resident weighed143 lbs, a 4.4 lb increase in a day. -On 8/13/24, the Resident weighed138 lbs. -On 8/14/24, the Resident weighed144 lbs, a 4 lb increase in a day. -On 8/15/24, the Resident weighed140 lbs., a 4 lb decrease in a day. -On 8/16/24, the Resident weighed143 lbs, a 2 lb increase in a day. - On 8/21/24, the Resident weighed144.2 lbs. -On 8/22/24, the Resident weighed141 lbs, a 3 lb decrease in a day. -On 8/24/24, the Resident weighed142 lbs. -On 8/25/24, the Resident weighed138 lbs, a 4lb decrease in a day. Review of the nursing notes for the month of August 2024 failed to indicate the physician was notified with any of the weight changes meeting the parameters of the physician order. Resident #100's physician notes were not in his/her electronic or paper medical record and the facility was unable to provide this surveyor with the physician notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor attempted to call the physician for an interview and the physician's office told the surveyor that the physician was not available the week of survey. During an interview on 8/28/24 at 8:54 A.M., Nurse #7 said weights are taken as ordered and the nurses are expected to look at the weights and notify the physician as needed. Nurse #7 said if the physician needed to be notified, they would also write a note to document the notification. During an interview on 8/28/24 at 9:56 A.M., the Director of Nursing (DON) said all weights are taken as ordered and nurses are expected to look at the weights to identify any significant changes or need to contact the physician. The DON reviewed Resident #100 weight changes throughout the month of August 2024 and said the physician should have been notified with these weight changes and was unaware if that had occurred.

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F 0686 Level of Harm - 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** 49880 Based on observations, record review and interviews the facility failed to ensure two Residents (#108 and #100) with pressure ulcers receive care consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. Specifically, 1. For Resident #108 the facility failed to: 1a. Implement recommendations from the consultant wound physician and, 1b. Ensure air mattress settings were set according to the plan of care. 2. For Resident #100 the facility failed to implement recommendations from the consultant wound physician. Findings Include: Review of facility policy titled Consultant Services, dated as April 2015, indicated the following: -Policy: [The facility] will identify and facilitate consultant services to meet the resident's needs, to ensure optimum care for each resident/ patient through consultant services. - Procedure: The charge nurse will then notify the attending physician of findings and he/she can then order the specific treatments as outlined by the consultant. Review of facility policy titled Prevention and Management of Pressure Injuries, undated, indicated the following: -Standard: the facility is dedicated to preventing pressure injuries and to developing a preventive plan of care based on individual needs. Residents receive the care and services they need according to established practice guidelines, so that residents who enter the facility without a pressure injury do not develop one unless the individuals clinical condition demonstrates that they were unavoidable. The necessary treatment and services will be provided to promote healing, prevent infection and prevent new pressure injuries from developing. -Policy: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage heeling and/or maintenance of skin integrity. Care plans are developed based on individual resident's goals and decisions for treatment. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. -Protocol -Assessment: 2. The resident is assessed for pressure injury risk factors. -The Resident's skin is observed daily with care (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4. Residents will have a weekly body audit completed by the licensed staff. Review of facility policy titled Pressure Injury/ Non-Pressure Wound Risk Management, undated, indicated the following: -Those residents who score at risk on the Braden or Norton Scale, or those identified to be at risk through comprehensive assessment or who have actual skin impairment are provided with care to address their individual risk factors and goals of treatment. -Procedure: Determine cause of pressure and remove the causative agent if possible. Interventions may include: 2. Provide appropriate pressure redistributing devices to beds and wheelchairs. 3. Heels are extremely vulnerable and must be elevated completely off the bed and /or chair surface. Residents identified at risk will have an order in place to offload heels. 1. Resident #108 was admitted to the facility in May 2024 with diagnoses that include acute metabolic acidosis and protein- calorie malnutrition. Review of Resident #108's most recent Minimum Data Set (MDS) Assessment, dated 6/7/24, indicates a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15, indicating the Resident has moderate cognitive impairment. The MDS further indicates that the resident has no pressure ulcer or injuries but is at risk for developing pressure ulcers or injuries. The MDS indicates that Resident #108 has no diabetic foot ulcers or other open lesions on the foot. Further the MDS indicates that Resident #108 requires substantial/ maximal assistance for activities of daily living (ADLs) On 8/26/24 at 9:22 A.M., Resident #108 was observed lying in bed, an air mattress was in use. Resident #108 said he has a sore on his/her right heel that developed at the facility. His/her heels were directly on the mattress. Review of Weekly skin Audit, dated 6/1/24 indicated the following: -Indicate type of audit: Admission/ Readmission -Are there any skin impairments: No Review of Resident #108's [NAME] Assessment (an assessment tool used to determine risk for development of pressure ulcers), dated 6/1/24 indicated a score of 8, indicating that Resident #108 is at high risk of developing pressure ulcers. Review of the progress notes indicated the following: -A nursing progress note dated 6/30/24 indicated but was not limited to, Pt [patient] has blister on his/her right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A second nursing progress note dated 6/30/24 indicated that the Resident was Noted to have a blister to right heel, area is blanchable. Measures 2.0 centimeters (cm) length, 3.0 cm, zero depth noted, no drainage. An Interim Skin Audit with an effective date of 6/30/24 indicated the following: -Are there pre-existing skin impairments? No. -Are there any new skin impairments? Yes. -If yes, indicate type(s): New suspected pressure ulcer/ deep tissue injury (DTI) indicated as being located on the right heel. A Pressure Injury Evaluation with an effective date of 6/30/24 indicated Resident #108 has an unstageable deep tissue injury (DTI)to the right heel with a date of origin of 6/30/24. Review of Resident #108's active care plan indicated the following: -A care plan dated as initiated on 7/10/24, ten days after the right heel ulcer was noted, which indicated the resident has potential alteration in skin integrity related to decreased/ impaired mobility or function, friction, nutrition, risk assessment, shearing (sic) with interventions including apply heel protectors posey Xlg Rx (extra-large prescribed) (sic) as ordered with skin prep. -A care plan dated as initiated on 8/13/24, forty-four days after the right heel ulcer was noted, which indicated actual alteration in skin integrity related to decreased mobility, DTI unstageable to right heel with interventions that included to follow physician's orders for skin care and treatments. 1a. On 8/26/24 at 9:22 A.M., Resident #108 was observed by the surveyor lying on his/her back in bed, an air mattress was in place, and the Resident's heels were noted to be directly on the mattress. On 8/27/24 at 10:13 A.M., the surveyor observed a nurse and a certified nurse's assistant (CNA) place a pillow under the Resident #108's knees, leaving bilateral heels to fall directly on the mattress. On 8/28/24 at 10:13 A.M., Resident #108 was observed lying in bed with his/her heels directly on the mattress. An off-loading boot was observed in the corner of the room in a chair, not in use. On 8/28/24 at 4:00 P.M., Resident #108 was observed lying in bed, sleeping with bilateral heels directly on the mattress. On 8/29/24 at 6:50 A.M., Resident #108 was observed lying in bed on his/her back with bilateral heels directly on the mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #108's medical record indicated that a consultant wound physician assessed the Resident on 7/9/24 for an initial evaluation. The progress note indicated that the resident presented with wounds on his/her left posterior heel, right posterior heel. Both areas were classified as unstageable DTIs. Recommendations for treatment included skin prep to bilateral heels every shift, off-load wound, float heels in bed: 2 pillows under the ankle; pressure off-loading boot. Review of Resident #108's July 2024 Treatment Administration Record (TAR) indicated that skin prep was initiated to bilateral heels once daily on 6/27/24 and failed to indicate that the frequency was increased to every shift as recommended by the consultant wound physician. The July 2024 TAR also indicated that an order to off load heels every shift was initiated on 6/26/24 but failed to indicate that a pressure off-loading boot was initiated as per the consultant wound physician's recommendations. Review of the consultant wound physician's progress note, dated 7/23/24, indicated that the left heel DTI had resolved, and that the right heel continues to be evaluated as an unstageable DTI. The recommendations for treatment of the right heel were skin prep to right heel every shift (3 times daily), off-load wound, float heels in bed; pressure off-loading boot. Review of Resident #108's July 2024 TAR indicated that skin prep was discontinued on 7/23/24 to bilateral heels, and an order was put into place for skin prep to the right heel daily on 7/24/24. Review of the July 2024 TAR failed to indicate that skin prep had been ordered as recommended every shift (3 times daily) or that a pressure- off loading boot was initiated. Review of the consultant wound physician progress note, dated 8/6/24, indicated that the right heel had a full thickness, stage 3 pressure wound. The wound size was documented as 0.5 cm x 0.5 cm with no measurable depth. Treatment recommendations made included Alginate Calcium, apply once daily for 30 days, cover with a gauze island dressing once daily, off-load wound, float heels in bed: pressure off-loading boot. Review of Resident #108's August 2024 TAR failed to indicate that the recommendations for Alginate Calcium and pressure off-loading boot were put into place. The treatment order for the right heel remained as skin prep once daily. Review of the consultant wound physician progress note, dated 8/13/24, indicated a right heel wound size of 1.0 cm x 1.0 cm with no measurable depth. Treatment recommendations made included hydrocolloid sheet (thin). apply three times per week for 30 days, off-load wound, float heels in bed: pressure off-loading boot. Review of Resident #108's August 2024 TAR indicated that until 8/16/24 the treatment to the right heel was skin prep once daily and that the treatment recommendations for hydrocolloid sheet were not put into place until 8/17/24, four days after the recommendation was made. The August 2024 TAR also failed to indicate that an off-loading boot was put into place. Review of the consultant wound physician progress note, dated 8/20/24 indicated a right heel wound size of 1.0 cm x 1.0 cm x 0.1 cm depth. Recommendations to continue the same treatment were made. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the consultant wound physician progress note, dated 8/30/24, indicated a right heel full thickness stage 3 pressure wound that measured 1.0 cm x 1.0 cm x 0.1 cm depth. Wound progress was documented as not at goal. Recommendations were made to change treatment to Alginate calcium once daily x 30 days, then wrap with gauze (kerlix). Recommendations remain to float heels in bed, pressure off- loading boot. During an interview on 8/27/24 at 12:47 P.M., Nurse #3 said that when recommendations are made from the consultant wound physician, they should be communicated to the Nurse Practitioner and put into place. During an interview on 8/29/24 at 10:46 A.M., the Director of Nurses (DON) said that a nurse from the facility rounds every week with the consultant wound physician, and that nurse is responsible for communicating and implementing those recommendations. The DON said that consultant wound physician recommendations should be implemented within 24 hours and not implementing recommendations could contribute to worsening of a pressure area. During an interview on 8/29/24 at 3:00 P.M., the consultant wound physician said that the facility should elevate heels with the use of an off-loading boot as recommended. He said there have been several times that he has noticed heels are not being off-loaded appropriately. The consultant wound physician said he would expect that his recommendations be put into place. 1b. On 8/26/24 at 9:22 A.M., Resident #108 was observed lying in bed on his/her back on an air mattress that was set at 250. On 8/28/24 at 10:13 A.M., and 2:07 P.M., Resident #108 was observed lying in bed on his/her back on an air mattress that was set at 250. On 8/29/24 at 6:50 A.M., Resident #108 was observed sleeping in bed on his/her back on an air mattress that was set at 250. On 8/29/24 at 10:27 A.M., a nurse was in Resident #108's room completing a wound dressing change. The nurse exited the room and the Resident remained in bed, lying on an air mattress that was set on 250. Review of physician's orders failed to indicate an order for an air mattress. Review of Resident #108's active care plan dated as initiated on 8/13/24 indicated that the Resident has a DTI unstageable to right heel with interventions that included specialty air mattress setting 140 (sic). Review of Resident #108's current weight indicated that on 8/1/24 he/she weighed 141.6 pounds. During an interview on 8/29/24 at 10:46 A.M., the Director of Nurses (DON) said there should be a physician's order for the air mattress, and that it should be set at or around the resident's weight. She said the air mattress should be set at around 140. If the mattress is set too high, it could be a safety issue, and would be ineffective as a pressure relieving mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/29/24 at 3:00 P.M., the consultant wound physician said it is inappropriate to over inflate an air mattress, and it becomes more like a regular mattress. Overinflating the mattress has the potential to cause worsening of the wound. 41456 2. Resident #100 was admitted to the facility in August 2023 with diagnoses including heart failure and muscle weakness. Review of Resident #100's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she had intact cognition. The MDS also indicated Resident #100 required maximal assistance from staff for bed mobility tasks. Review of the Wound Evaluation & Summary Management note dated 8/20/24, indicated Resident #100 has a pressure wound to his/her left posterior heel for over 210 days and the wound is not at goal. On 8/26/24 at 9:55 A.M., Resident #100 was observed lying in bed with both heels lying directly on the mattress. During this observation, Resident #100 said he/she has a wound on his/her left heel. On 8/27/24 at 7:10 A.M., Resident #100 was observed lying in bed with both heels lying directly on the mattress. On 8/28/24 at 8:26 A.M., Resident #100 was observed lying in bed with both heels lying directly on the mattress. Review of Resident #100's physician orders indicated the following order: -Offload heels every shift as tolerated, initiated 7/28/24. Review of the Wound physician notes dated 7/23/24, 7/30/24, 8/6/24, 8/13/24 and 8/20/24 -Pressure off-loading boot, Prevalon (a pressure relieving positioning boot), float heels in bed, off-load wound. Review of Resident #100's skin integrity care plan, last revised 7/24/24, indicated the following interventions: -Follow MD (physician) orders for skin care and treatments, -Provide positioning intervention as indicated on impaired functional mobility care plan. During an interview on 8/27/24 at 10:55 A.M., Resident #100 said he/she used to have a boot for his/her left heel but has not had one in months. On 8/28/24 at 8:41 A.M., Resident #100 was observed lying in bed with both heels directly on the mattress and not offloaded from pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/27/24 at 11:01 A.M., Certified Nursing Assistant #1 said Resident #100 has protective socks but does not need to elevate his/her heels while in bed. During an interview on 8/27/24 at 11:09 A.M., Nurse #2 said Resident #100 has a wound on his/her left heel and should be offloaded from pressure at all times when lying in bed. Nurse #2 said the Resident does not have a prevalon boot. During an interview on 8/28/4 at 8:54 A.M., Nurse #7 said Resident #100 has had a wound on his/her left heel for several months and is treated by the wound doctor every week. Nurse #7 said Resident #100 should be offloading his/her heels while in bed and his/her heels should never be directly on the bed. Nurse #7 said Resident #100 does not have a prevalon boot. During an interview on 8/28/24 at 9:56 A.M., the Director of Nursing said nursing is responsible for making sure all recommendations from the wound doctor are transcribed over and followed. The Director of Nursing said all wound recommendations are expected to be followed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review, policy review and interviews, the facility failed to adequately maintain the nutrition and hydration status of three Residents (#66, #86, and #34) out of a total sample of 30 residents. Specifically, the facility failed to 1) identify and implement interventions for a significant weight loss for Resident #66), 2) identify and implement interventions for a significant weight gain for Resident #86 and 3) failed to obtain monthly weights for one Resident (#34) who was identified to have a significant weight loss when the weight was obtained, out of a total sample of 30 residents. Findings include: Review of the facility policy titled Weights, dated August 2015, indicated the following: -The following residents/patients are weighed weekly X4: -Newly admitted residents/patients. -Newly readmitted residents/patients. -Residents/patients with an unanticipated, unplanned weight loss of >5% in one month. -Residents/patients with an MD order for weekly weights. -Other residents/patients at the discretion of the IDT. -Thereafter, residents will be weighed monthly, unless clinically indicated. -All weight loss/gain of 3 pounds or more on a resident weighing 100 pounds or less ad weight loss/gain of 5 pounds or more on a resident weighing 100 pounds or more requires a reweigh for verification. -If a significant weight loss/gain is identified (>5% in 30 days or > 10% in 6 months), the IDT (interdisciplinary team), Dietitian, Physician and family are notified. -All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. 1. Resident #66 was admitted to the facility in October 2023 with diagnoses including diabetes and dysphagia. Review of Resident #66's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 5 out of a possible 15 on the Brief Interview for Mental Status, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #66 requires assistance for all functional daily tasks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #66's weights indicated the following: -On 4/30/24, the Resident weighed 205.0 pounds. -On 5/1/24, a reweight was completed and the Resident weighed 205.0 pounds. -On 6/2/24, the Resident weighed 196.6 pounds, a 4% weight loss. -On 7/3/24, the Resident weighed 173.2 pounds, an additional 11.9% weight loss in 1 month. -On 8/1/24, the Resident weighed 175.0 pounds, a total of 14.63% weight loss in four months. Resident #66 was able to be interviewed, however, could not answer specific questions about his/her weight status. Review of Resident #66's medical record failed to indicate any nutritional interventions were implemented during any of these periods of weight loss. Review of Resident #66's nutritional care plan, last revised 8/13/24, indicated the following interventions: -Monitor/evaluate weight/weight changes. -Notify RD (Registered Dietitian), family and physician of significant weight changes. Review of Resident #66's medical record indicated Resident #66 had been hospitalized several times from October 2023 to March 2024, however, has not been hospitalized since March 2024. The Nurse Practitioner note dated 6/27/24 indicated Resident #66's edema status was stable. Review of Resident #66's medical record failed to indicate a nutritional assessment had been completed since the Resident had a significant weight loss. The record also failed to include any dietary notes since the weight loss had occurred. During an interview on 8/27/24 at 1:58 P.M., the Registered Dietitian (RD) said she works 4 days a week at the facility and she reviews the weekly weight report at least weekly and all residents with significant weight changes are discussed at the weekly facility At Risk meeting. The RD said if a resident were to have a significant weight loss, the interventions provided would be fortified foods, supplements, weight monitoring and then possibly medication if needed. The RD said Resident #66 is receiving hospice services so the decision for nutritional interventions is up to hospice. The RD said Resident #66's significant weight loss was discussed in At Risk meeting but only that weights should be discontinued due to hospice services, and nutritional interventions were not discussed. The RD said she knew of the weight loss and did not implement an intervention because Resident #66 was on hospice. The RD said nutritional interventions should be put in place after a significant weight loss for all residents, regardless of hospice services, and this was missed for Resident #66. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Northwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Varnum Avenue Lowell, MA 01854	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 8:54 A.M., Nurse #7 said the nursing assistants obtain weights and then the nurses enter the weights into the electronic medical record. Nurse #7 said the nurses are expected to look at the previous weights and identify if there had been a significant weight change and notify the physician and dietitian. Nurse #7 said Resident #66 is receiving hospice services but is not actively dying. Nurse #7 said Resident #66 eats well and would be agreeable to supplements or extra foods. During an interview on 8/28/24 at 9:56 A.M., the Director on Nursing (DON) said nurses are expected to monitor weights to identify possible significant weight changes. The DON said if a significant weight loss is identified, a reweight should be obtained within 48 hours, and, if the significant change is confirmed, the physician, dietitian and family should be notified. The DON said the dietitian should also be monitoring weights in order to identify any significant weight changes. The DON said the facility completes At Risk meetings every week and all residents with a significant weight change are discussed. The DON said if a resident were to have a significant weight loss, the dietitian should initiate an intervention immediately. When asked about Resident #66's significant weight loss, the DON said he/she was discussed at the At Risk meeting, however, was unaware if any interventions were initiated. The DON said weight loss/nutritional interventions are still appropriate and can still be initiated for Residents who are receiving hospice services. 2. Resident #86 was admitted to the facility in November 2023 with diagnoses including diabetes. Review of Resident #86's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and the staff had assessed him/her to have moderate cognitive impairment. The MDS also indicated Resident #86 required supervision for self-feeding tasks. Review of Resident #86's weights indicated the following: -On 05/01/2024, the resident weighed 148 lbs. On 08/01/2024, the resident weighed 160.2 pounds which is a 8.24 % gain in three months. Review of Resident #86's nutritional care plan, last revised 8/9/24, indicated the following interventions: -Monitor/evaluate weight/weight changes. -Notify RD (Registered Dietitian), MD (physician) and family of any significant weight changes. Review of Resident #86's communication care plan, last revised 11/6/23, indicated the Resident would need translator services for communication and did not indicate Resident #86 had receptive aphasia (difficulty understanding written and spoken language). Review of the nutritional assessment dated [DATE] indicated Resident #86 had a significant weight gain and a high A1C lab (the level of sugar in your blood). Review of Resident #86's medical record failed to indicate any education was provided to Resident #86 regarding his/her weight gain and increased A1C lab. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 1:58 P.M., the Registered Dietitian (RD) said she works 4 days a week at the facility, and she reviews the weekly weight report at least weekly and all residents with significant weight changes are discussed at the weekly facility At Risk meeting. The RD said she mainly focuses on weight loss, but if a resident were to have a significant weight gain, the nurses would be notified, and education provided to the resident. The RD said Resident #86 is non-verbal and aphasic and would not be able to complete education. The RD said she did not attempt education with the use of a translator. During an interview on 8/28/24 at 9:56 A.M., the Director of Nursing (DON) said nurses are expected to monitor weights to identify possible significant weight changes. The DON said if a significant weight change is identified, a reweight should be obtained within 48 hours, and, if the significant change is confirmed, the physician, dietitian and family should be notified. The DON said the dietitian should also be monitoring weights to identify any significant weight changes. The DON said the facility completes At Risk meetings every week and all residents with a significant weight change, gains, or losses, are discussed. The DON said she would expect interventions to be put in place for weight gains as much as losses, such as education with the resident. The DON said it is concerning for a resident with diabetes to gain weight as it is not healthy. The DON said education should be provided to any resident with a significant weight gain and said she was unaware if Resident #86 had aphasia. The DON said the dietitian should have attempted to educate Resident #86. 41105 3. Resident #34 was admitted to the facility in December 2023 and has diagnoses that include Dysphagia (difficulty chewing and swallowing) and Major Depressive Disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/05/24, indicated that on the Brief Interview for Mental Status exam Resident #34 scored a 10 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #34 requires set-up or clean up assistance with eating. Review of Resident #34's weight report indicated the following weights were obtained: -5/7/24: 122.4 -6/6/24: 119 lbs. -8/25/24: 103 pounds (lbs.) The record failed to indicate that the Resident was weighed in July 2024 or that Resident #34 was reweighed after a significant weight loss of 13.35 % was recorded on 8/25/24. Review of the clinical progress notes and current care plan failed to indicate Resident #34 refused to be weighed. Review of the most recent Diet Nutrition Assessment, dated 6/02/24, indicated: Reports sores in mouth so difficulty chewing. (sic) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current nutrition care plan for Resident #34 indicated: Resident at Risk for Nutritional Decline related to diagnosis of FTT (failure to thrive), potential malnutrition. The care plan indicated the following interventions: -Monitor/evaluate weight/weight changes. -Obtain weights per protocols and record. During an interview on 8/27/24 at 8:09 A.M., Resident #34 said he/she has lost weight but doesn't know why. Resident #34 was unable to recall if he/she had discussed this weight loss with the Physician or Dietitian. During on an interview on 8/27/24 at 1:58 P.M., the Registered Dietitian (RD) said the following: -Resident weights are expected to be obtained monthly and are obtained by the CNAs. -Resident should be reweighed if there is a 5 lb. discrepancy from the previous weight. -She is in the building 26 hours a week and each time runs a weight report. If she notices any residents missing a monthly weight, she lets the CNAs and nurses know that the resident needs to be weighed. -She remembers that Resident #34 didn't get weighed in July and thinks she spoke to a nurse about it but cannot remember if she ever followed up, and had not documented any follow-up. -She does not get notified by nursing if there is a weight loss, nor would she expect to be notified as she identifies the weight loss when she is in the building and addresses the weight loss as needed. During an interview on 8/28/24 at 10:01 A.M., Resident #34's Certified Nursing Assistant (CNA) #5 she said that all residents are weighed at the beginning of the month and if you are working the 1st of the month, day shift, it is your responsibility to get the residents on your assignment weighed. CNA #5 said that if a resident refuses to be weighed, the CNAs will get the nurse and together try to get the resident to agree to be weighed. Once the weight is obtained the CNAs give the weight to the nurse who enters the weight in the computer. The Nurse tells the CNA if a resident has had a weight loss and needs to be reweighed. CNA #5 said that Resident #34 has a good appetite and he/she does not refuse to be weighed. During an interview on 8/28/24 at 10:13 A.M., the Director of Nursing (DON) said that residents are supposed to be weighed monthly and if the resident refused to be weighed it would be documented in the clinical record. The DON said if a significant weight loss is documented it is the expectation that the resident is reweighed to determine accuracy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49880 Based on observation, policy review, record review and interview the facility failed to provide respiratory care consistent with professional standards of practice for two residents (#26 and #30) out of a total sample of 30 residents. Specifically, 1. For Resident #26 the facility failed to ensure physician's orders included settings for a Continuous Passive Airway Pressure (CPAP) machine, and that the CPAP machine was functioning and available for use. 2. For Resident #30 the facility failed to obtain a complete physician's order for oxygen administration that included an oxygen flow rate. Findings Include: 1. Review of Facility Policy titled CPAP/ BiPAP Management, dated as revised April 2015, indicated the following: - Licensed nursing will provide CPAP/ BiPAP to treat sleep apnea or sleep disorders as ordered by the physician. Resident #26 was admitted to the facility in May 2023 with diagnoses that include chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia and obstructive sleep apnea. Review of Resident #26's most recent Minimum Data Set (MDS) Assessment, dated 5/22/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS also indicated that the Resident uses non- invasive ventilation and oxygen therapy. 1a. On 8/26/24 at 9:48 A.M., Resident #26 was observed sitting up in his/her wheelchair. A CPAP machine was observed on his/her bedside table. Review of Resident #26's active physician's orders failed to indicate an order with CPAP settings for Resident #26's CPAP. Review of Resident #26's active care plan failed to indicate settings for his/her CPAP machine. During an interview on 8/27/24 at 2:14 P.M., the Assistant Director of Nurses (ADON) said that CPAP settings should be included in physician's orders, but they were not. During an interview on 8/28/24 at 2:38 A.M., the Director of Nurses said that CPAP orders should include the settings for use and for Resident #26 the orders did not include the settings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. On 8/26/24 at 9:48 A.M., Resident #26 was observed sitting up in his/her wheelchair utilizing oxygen. Resident #26 said that he/she was tired and has been waking up often at night because his/her CPAP machine was not functioning. He/she said it was last functioning on 8/18/24. He/she said he/she has been waking up and not feeling well rested, and at times falling asleep in his/her wheelchair. The CPAP machine was observed with an error code, System fault, refer to user guide, Error 006. Resident #26 said he/she was waiting for the facility to get a replacement CPAP machine. On 8/26/24 at 2:33 P.M., the surveyor observed Resident #26's CPAP machine with the error code, System fault, refer to user guide, Error 006. The surveyor asked the Resident if he/she was managing the process to obtain a new CPAP machine or if the facility staff were facilitating it. He/she said that the facility was supposed to be ordering a new CPAP machine, and that the Assistant Director of Nurses (ADON) said she was working on it. On 8/27/24 at 8:36 A.M., Resident #26 was up in his/her wheelchair eating breakfast. He/she said they did not have their CPAP machine last night and had a restless night sleep without it. He/she said no one has followed up with him/her yet about the new machine and said, my sleep is suffering without it. The error code remains on the CPAP machine. On 8/28/24 at 10:19 A.M., Resident #26 is in his/her room. The error message remains on the CPAP machine and Resident #26 said he/she has not yet been provided a new CPAP machine. Review of Resident #26's progress notes indicated the following: On 8/17/24 a progress note triggered from the Electronic Medication Administration Record (EMAR) indicated that the CPAP machine was not in use. -On 8/22/24 a progress note triggered form the EMAR indicated CPAP broken pt (patient) calling company. -On 8/22/24 a progress note triggered from the EMAR indicated, CPAP machine is not working. -On 8/23/24 a progress note indicated, Pt requesting for new CPAP machine, ADON (Assistant Director of Nurses) aware. - On 8/27/24 a progress note triggered from the EMAR indicated, CPAP not working. Review of Resident #26's active care plan indicated that he/she has a diagnosis of COPD with interventions that included CPAP on at bedtime and off in the morning. During an interview on 8/27/24 at 12:42 A.M., Nurse #2 said that Resident #26's CPAP machine is not working and has not been working for over a week. She did not know the status of obtaining a new CPAP machine. During an interview on 8/28/24 at 2:38 P.M., the Director of Nurses said that she has been aware for about a week that the CPAP machine is not functioning, and it should have been replaced but it had not yet. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of facility policy titled Oxygen Administration Nasal Cannula, dated as revised November 2020, indicated the following: -Policy: to deliver low flow oxygen, per the physician's order (generally 1-6 liters per minute [lpm] and 24%-45% concentration) via nasal cannula. -Set the oxygen liter flow to the prescribed liters flow per minute. Resident #30 was admitted to the facility in April 2024 with diagnoses that include chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pulmonary hypertension, and emphysema. Review of Resident #30's most recent Minimum Data Set Assessment, dated 7/24/24 indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating that Resident #30 has moderate cognitive impairment. The MDS further indicated that oxygen therapy is not utilized. On 8/26/24 at 9:18 A.M., and 2:21 P.M., Resident #30 was observed utilizing oxygen via nasal cannula at 2 liters per minute (lpm). On 8/27/24 at 7:34 A.M., 8:07 A.M., and 12:32 P.M., Resident #30 was observed utilizing oxygen via nasal cannula at 2 lpm. Review of Resident #30's active care plan indicated that Resident #30 has a diagnosis of COPD with interventions that included to administer oxygen and monitor effectiveness by checking saturation as indicated. Review of Resident #30's active physician's orders as of 8/27/24 indicated the following: -Wean oxygen as tolerated to maintain o2 sats [oxygen saturation] over 90% every shift for COPD, dated 4/22/24. Review of Resident #30's physician orders failed to indicate the liter flow for oxygen administration. During an interview on 8/27/24 at 12:44 P.M , Nurse #2 said Resident #30 receives oxygen at 2 lpm. The surveyor and Nurse #2 reviewed active physician's orders for Resident #30 and Nurse #2 said the order is not specific to liter flow and how much oxygen to administer, but that it should be. During an interview on 8/28/24 at 2:37 A.M., the Director of Nurses said that oxygen orders should specify if they are continuous or as needed and should have a specific liter flow or liter flow range to administer and Resident #30's physician's orders did not.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41105 Based on observations, record review, policy review and interviews, the facility failed to ensure services consistent with professional standards of practice related to Hemodialysis (the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood) were provided for two Residents (#46 and #51) out of a total sample of 30 residents. Specifically, for Residents #46 and #51, the facility failed to ensure that emergency supplies were at the bedside. Findings include: The facility policy titled Hemodialysis, dated April 2015, indicated the following: -Policy: to provide comprehensive care to residents/patients that receive Hemodialysis treatments. -Care of a venous catheter: a non-serrated clamp is to be kept at the bedside for emergencies. -Emergency Care: 2. Accidental dislodgement or removal of catheter -a. Clamp the catheter using non-serrated clamp 1. Resident #46 was admitted to the facility in September 2019 and has diagnoses that include End Stage Renal Disease and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated on the Brief Interview for Mental Status exam Resident #46 scored a 12 out of a possible 15 indicating moderately impaired cognition. The MDS further indicated that Resident #46 received dialysis treatment. Review of the care plans for Resident #46 indicated a care plan Resident requires Hemodialysis End Stage Renal Disease (sic). During an interview on 8/26/24 at 7:49 A.M., Resident #46 said he/she goes to dialysis 3 times a week. Resident #46 said that that there are not any emergency supplies, including a clamp kept in his/her room. With the surveyor, Resident #46 checked his bedside table and room, and verified a clamp was not in the room. During an interview on 8/28/24 at 2:34 P.M., the Director of Nursing (DON) said she expects the dialysis policy to be followed, which includes maintaining an emergency clamp in the room of all residents who receive Dialysis treatment. 49880 2. Resident #51 was admitted to the facility in July 2024 with diagnoses that include end stage renal disease and dependence on renal dialysis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Northwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Varnum Avenue Lowell, MA 01854	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's most recent Minimum Data Set (MDS) Assessment, dated 7/31/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating that the Resident is cognitively intact. the MDS further indicated that the resident received dialysis. On 8/26/24 at 8:53 A.M. Resident #51 was observed laying in bed, a right chest dialysis catheter was observed. The surveyor did not observe any emergency supplies or clamp at the bedside. On 8/27/24 at 8:42 A.M., Resident #51 was observed in his/her room. The surveyor did not observe any emergency supplies or clamp at the bedside. Review of Resident #51's active care plan indicated that the Resident requires hemodialysis Stage 5 CKD [chronic kidney disease] Currently using Rt [right] chest port for Dialysis (sic), with interventions that include, if resident has bleeding, apply firm and steady pressure. During an interview on 8/28/24 at 12:13 P.M., Nurse #7 said that Resident #51 has a left arm fistula that is not currently being used for dialysis, so he/she is receiving dialysis through a central line in his/her chest. Nurse #7 said there is no clamp in Resident #51's room for emergencies, and as far as she knows it is not the policy to keep one. During an interview on 8/28/24 at 2:34 P.M., the Director of Nursing (DON) said that she expects the dialysis policy to be followed, which includes maintaining an emergency clamp in the room of all residents who receive Dialysis treatment.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 41105 Based on record review and interview the facility failed to ensure a Trauma Informed Care Plan, with resident specific interventions and triggers, was developed for one Resident (#75), out of a total sample of 30 residents. Findings include: The facility policy titled Trauma Informed Care, undated, indicated the following: 4. Social Service will screen each resident for a history of trauma upon admission. Documentation regarding the resident's psychosocial well-being including their response to stressful life events/trauma and coping mechanisms will be reflected in the initial Social Service Assessment and/or Social service Progress notes. 5. A trauma informed care plan will be documented in the resident's medical record by social service in conjunction with the IDT Resident #75 was admitted to the facility in August 2024 and has diagnoses that include alcohol-induced pancreatitis, depression and anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/09/24, indicated that on the Brief Interview for Mental Status exam Resident scored a 10 out of 15, indicating moderately impaired cognition. Review of the clinical record indicated the following: -A SUD (Substance Use Disorder) progress note: Processed emotions with Resident #75. PT (patient) has anxiety over next steps after (facility name). Coordinated ice coffee for PT, which helps me with my anxiety. Discussed prayer and meditation as healthy coping skills. -A Social Service Admission Note that included: He/she has a lengthy trauma history but denies have trauma issues (sic). During an interview on 8/29/24 at 9:57 A.M., with Social Worker (#1) and the Director of Social Service they said that Resident #75 has been at the facility several times for care and that during a prior stay had disclosed an unimaginable trauma situation. The Director of Social Service said that one of the biggest triggers of this trauma present when it gets closer to the residents discharge or when discharge is discussed with him/her. She said as soon as you have a discharge date , Resident #75's behaviors increase and if you back off then the behaviors decrease. Review of Resident #75's current care plan failed to indicate a care plan had been developed for Resident #75's known trauma history, with resident specific triggers and interventions. During an interview on 8/29/24 at 12:06 P.M., SW #1 said that Resident #75 should have a trauma care plan in place with resident specific triggers and interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 12:12 P.M., the Director of Social Service said that Resident #75 should have a trauma care plan in place with resident specific triggers and interventions, but that she did not put one in place because the Resident did not disclose this trauma directly to her.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 45343 Based on interviews and record review, the facility failed to ensure that sufficient staffing levels were maintained to safely and adequately meet each resident's personal care needs. Finding Included: Review of the Facility Assessment indicated the following: Staffing Plan: Nursing: Licensed Nurses (LN): RN (Registered Nurse, LPN (Licensed Practical Nurse), LVN (Licensed Vocational Nurse), provided direct care: -Director of Nursing: 1 RN Full time days. -Assistant Director of Nursing: 1 RN full-time days. -2 Unit managers' days: 1 RN, 1 LPN. - Weekend supervisor: 1 RN. -Second Shift Supervisor: Position is open. -12 Nurses for 116 residents first and second shift. -3 Nurses for 116 residents third shift. -8 RN's, 18 LPN's. Direct Care Staff: Certified Nursing Assistants (CNA): -1 CNA per 10 Residents first shift. -1 CNA for 12 Residents second shift. -1 CNA for 20 Residents third shift. -2 Nurses per shift per unit (3) first and second shift and 1 Nurse for third shift each unit (3) -Infection control/wound nurse Staffing Assignments: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225298	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwood Rehabilitation & Healthcare Center	1010 Varnum Avenue Lowell, MA 01854

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On shift software allow staff and scheduler to ensure proper staffing is available at all times. We have a consistent assignment for continuity of care which are rotated every few months so staff can know all residents. Review of the HPPD (hours per patient per day) report provided by the facility indicated 1.90 budgeted hours for Nursing as well as 1.90 budgeted hours for Certified Nursing Assistants. Review of the working schedules and HPPD report for January through March 2024 indicated the facility failed to meet appropriate staffing levels for 23 out of 91 days. Further review of the HPPD report and working schedules for May through July 2024 indicated the facility failed to meet the appropriate staffing levels for 26 out of 92 days. During an interview on 8/29/24 at 10:57 A.M., Corporate Nurse #1 said the facility has new leadership and she was not aware that there were staffing issues. She said the facility will make staffing adjustments as needed and will investigate current staffing levels.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to provide behavioral health services by a) ensuring recommendations from the Psychiatric Nurse Practitioner were implemented and b) psychotropic medications were provided as ordered for one Resident (#80) out of a total sample of 30 residents. Findings include: Review of the facility policy titled, Psychotropic Medication Management, dated April 2015, indicated the following: -Administer medications as directed by the physician and manufacturer. -Monitor target behaviors daily for antipsychotics, antidepressants and anxiolytics using behavior monitoring tool. -Review the care plan with IDT (interdisciplinary team) when a resident is admitted on psychoactive medications, quarterly, annually and as needed for changes in resident status and revise as necessary. -Review should include verification that adequate indications for use of the psychotropic medication exist, the medications are note being used for extended duration, and residents are free from duplicate therapy and being monitored for adverse consequences, per current professional standards of practice and in accordance with Federal and State guidelines. Review of the policy titled, Consultant Services, sated April 2015, indicated the following: -A note should be recorded on the consultation form by any health care consultant who sees the resident/patient at the request of the MD of family. The consultant should document findings and recommendations on this form. -The charge nurse will then notify the attending physician of findings and he/she can then order the specific treatments as outlined by the consultant. Resident #80 was admitted to the facility in June 2024 with diagnoses including Alzheimer's Disease, major depression, unspecified dementia with other behavioral disturbance. Review of Resident #80's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had severe cognitive impairment with a score of 0 out of a possible 15 on the Brief Interview for Mental Status. The MDS also indicated Resident #80 required partial assistance with all functional daily tasks. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Throughout the survey, Resident #80 was observed pacing throughout the C Unit and was unable to be redirected by staff. During the survey period, Resident #80 sustained two falls and was involved in a resident-to-resident altercation. Review of the Documentation Survey Report for the months of June, July and August, indicated Resident #80 displayed behaviors daily, however, did not specify the type of behaviors. Review of the admitting Nurse Practitioner note written on 6/5/24 indicated the following: -Resident #80 was admitted to the facility with a preexisting prescription for Risperidone (an antipsychotic medication) and Trazadone (a mood stabilizer) and the plan was to continue both medications. -Resident #80 was cooperative with exam upon admission. At time of admission, the following orders were initiated for Resident #80: -Psych consult as indicated. -Risperidone 0.25 mg (milligrams) oral tablet, every 24 hours PRN (as needed). -Risperidone 0.25 mg BID (twice a day). -Trazadone 50 mg at bedtime. a. Review of Resident #80's nursing notes, six weeks after admission indicated the following: -6/23/24: Patient had episodes of increased agitation with physical aggression towards staff. Banging on the table and throwing stuff off the nurse's station counter, redirected multiple times and Risperidone utilized as needed with no effect. -6/28/24: Patient is having increased behaviors, agitation, intrusive yelling and aggression. -6/30/24: Resident walked through halls all day and had to be redirected. -7/3/24: resident continue with increased agitation and aggressive behavior towards staff and other residents. Resident not redirectable, PRN risperidone administered in the AM with no effects. -7/3/24: Patient continued to exhibit increased behaviors, with physical aggression towards staff and attempting to hit other residents. New order to increased risperidone. 7/4/24: patient has not slept in days. Increased confusion, restlessness, agitation and aggression towards staff and residents. Patient refusing to take medications. The nurse received doctor ordered to send resident out to ER, nurse complied. 7/4/24: patient returned from (hospital) with recommendations to increase Risperdal to 1 mg (milligram) at HS (night) and .5 mg in am and .5 mg as needed for agitation. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	7/6/24: Resident alert, (he/she) has been up all night and refused to take medication. (He/she Was very aggressive and agitated, going from room to room uncovering residents who are sleeping this shift. (He/she) Was very difficult to redirect. Roommate was very upset and not happy because (he/she) kept going to her, screaming, yelling at her and calling her names. 7/6/24: Resident #80 had hit his/her roommate and was being sent out to the hospital for a psychiatric evaluation. 7/8/24: a psych consult was requested for Resident #80. Review of Resident #80's medical record indicated he/she was first evaluated by the behavioral health team on 7/11/24, six weeks after the Resident's admission, over two weeks after his/her first behaviors presented and over a week after the Resident had been aggressive towards staff and residents. Review of the behavioral health note indicated the following: - Problem: 86 YO (year old) new to this clinician, here for LTC (long term care) as family was no longer able to care for (him/her) at home. (He/she) has a psych hx (history) of dementia with ETOH (alcohol) abuse, MDD (major depressive disorder), agitation, aggression, and psychosis. Seen per staff request for initial assessment and due to significant mood and behavioral disturbance. Staff report resident has been highly irritable, agitated, restless, delusional and aggressive at times since admission and has had to be sent out on multiple occasions. (He/she) Has had multiple evaluations by the crisis team in the ER and they have been upward titrating (his/ her) Risperdal with some benefit. Staff report (he/she) is now being less aggressive but remains highly restless and intrusive and can be difficult to redirect at times. -Plan/recommendations: Remeron (a mood stabilizer), recommend trialing resident on Remeron 7.5 MG (milligrams) PO (by mouth) daily at bedtime to help with mood and appetite. Review of the nursing note from 7/11/24 indicated Resident #80 was seen by the Psychiatric Nurse Practitioner, however, failed to indicate the recommendation for the initiation of Remeron was relayed to the Physician. Review of the Medication Administration Record for July and August 2024 failed to indicate Remeron was initiated. Review of the Physician note dated 7/26/24, failed to indicate the physician was aware of this recommendation. Review of the nursing notes from July and August 2024 indicated the following: -7/15/24: Continues to have increased anxiety and aggression. (He/she) was wandering the hallway at about 7PM, (he/she) slapped a staff's hand who was sitting there documenting. -7/20/24: Resident #80 refused all day time medications. -8/2/24: Resident was observed pulling on another resident's hair by staff .Social worker made aware and working on section 12 (involuntary transportation to hospital for evaluation of mental health). (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Resident #80 returned to the facility the same day, on 8/2/24. Resident #80 was seen by the Psychiatric Nurse Practitioner again on 8/16/24, 2 weeks after the Resident was sectioned 12'd to the hospital for being a danger to self or others. Review of the Psychiatric Nurse Practitioner indicated the following: -Chief complaint: Pt (patient) pacing around unit, agitation, aggression, and refusing medications. Target symptoms: aggression. agitation, anxiety and paranoia. -Clinical assessment: Patient pacing in (his/her) room and unit, patient with agitation, and at times moving fast, restless, having racing thoughts, and refusing medications. Aggressive, poor concentration, poor judgement, aggressive behaviors. No s/sx (signs or symptoms) of SI (Suicide Ideation). Recommending to start Ativan (an anti-anxiety medication) 0.5mg as follows: give 1 tab by mouth twice a day prn for anxiety/agitation. -Plan/recommendation: Notify of any changes or concerns. Continue to monitor. Recommendation to start new medication(s). Recommending start Ativan as follows: 0.5mg as follows: give 1 tab by mouth twice a day prn for anxiety/agitation. Recommending to start Depakote (mood stabilizer) 125 mg twice a day r/t (due to) psychotic disorder with delusions due to known physiological condition. Review of the nursing note on 8/16/24 failed to indicate these recommendations were reported to the physician. Review of the Medication Administration Record for August 2024, failed to indicate Ativan or Depakote were ever initiated. Review of the Physician note dated 8/20/24 failed to indicate the physician was made aware of these recommendations. The surveyor attempted to call the physician and his office said he was unavailable for the week. Review of Resident #80's psychotropic medication care plan, last revised 7/2/24, indicated the following intervention: -investigate/monitor need for psychological/psychiatric support provide services as ordered by the physician. During an interview on 8/29/24 at 9:37 A.M., Nurse Practitioner #1 said all recommendations from behavioral health are sent to her by nursing for her to approve. Nurse Practitioner #1 said she was not aware of the Remeron recommendation in July and approved the recommendation for Ativan and Depakote in August but was never aware the medications had not been given. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/29/24 at 9:45 A.M., Nurse #6 said Resident #80 displays a lot of behaviors. Nurse #6 said behavioral health services are at the facility weekly, however, Resident #80 has only been seen twice since admission. Nurse #6 said she feels Resident #80 would have benefitted from being seen more often. Nurse #6 said recommendations from behavioral health are given to nurse who then sends them over to the physician. Nurse #6 said Resident #80's family was never contacted to sign the consent for use of Remeron which is why the Resident was never started on that medication. Nurse #6 said she was also aware of the recommendation to start Ativan and Depakote, however, never followed up to see if the doctor approved and should start them. During an interview on 8/29/24 at 9:55 A.M., Social Worker #1 and the Director of Social Services both said Resident #80 exhibits behaviors often and his/her behavior is pretty significant. Both said behavioral health is in the building weekly but Resident #80 was only seen once a month because of billing and should have been seen more frequently. During an interview on 8/29/24 at 10:59 A.M., Corporate Nurse #1 said she would expect Resident #80 to have been seen by behavioral services after every resident-to-resident incident and when the Resident presented with increased behaviors. During an interview on 8/29/24 at 10:23 A.M., the Director of Nursing (DON) said behavioral services are in the building at least once a week and residents are seen on an as needed basis. The DON said behavioral health services should evaluate/treat a resident who is experiencing increased behaviors and who are involved in resident-to-resident incidents with each increase of behavior or incident. The DON said Resident #80 should have been seen more regularly by the behavioral health team. The DON said if the Psychiatric Nurse Practitioner makes recommendations, the nurses are expected to notify the physician so they can be implemented if he agrees. The DON was unaware of the recommendations made and that they were never followed through. During an interview on 8/29/24 at 2:14 P.M., the Psychiatric Nurse Practitioner said all recommendations are given to nursing and it is expected that the nursing staff report these recommendations to the physician and follow through with them. The Psychiatric Nurse said she was unaware that the three recommendations made were never followed up with and that Resident #80 should have been seen more frequently due to his/her behaviors/presentation. b. Review of the Medication Administration Report for June, indicated Resident #80 was prescribed the following psychotropic medications: -Trazadone oral tablet, 50mg. Give one tablet at bedtime related to major depressive disorder, initiated on 6/5/24 -Risperidone oral tablet 0.5mg. Give 1 tablet by mouth two times a day related to major depressive disorder, initiated on 6/5/24. --Risperidone oral tablet .25mg. Give one tablet by mouth every 24 hours as needed for anxiety, initiated on 6/5/24 Review of the Medication Administration Report for July, indicated Resident #80 was prescribed the following psychotropic medications: (continued on next page)

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	225298	A. Building B. Wing	08/29/2024

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-Risperidone oral tablet 0.5 mg. Give 1 tablet two times a day related to major depressive disorder, initiated on 6/5/24 and discontinued on 7/4/24. -Risperidone oral tablet. Give .5mg by mouth three times a day related to Alzheimer's Disease, initiated, and discontinued on 7/4/24. -Risperidone oral tablet 0.5 mg by mouth one time a day related to Alzheimer's Disease, initiated on 7/5/24 and discontinued on 7/8/24. -Risperidone oral tablet 1 mg. Give 1 tablet by mouth in the evening related to unspecified dementia, initiated on 7/5/24 and discontinued on 7/16/24. -Risperidone oral tablet 0.5 mg. Give 1 tablet by mouth at bedtime for increased behavior, initiated 7/15/24 and discontinued 7/24/24. -Risperidone oral tablet 1 mg. Give 1 mg by mouth one time a day for increased behavior, initiated 7/16/24 and discontinued 7/24/24. -Risperidone oral tablet 0.5 mg. Give 1 tablet at bedtime for increased behavior, initiated on 7/24/24 -Risperidone oral tablet 1 mg. Give 1mg by mouth one time a day for increased behavior, initiated 7/25/24. -Risperidone oral tablet 0.25mg. Give one tablet by mouth every 24 hours as needed for anxiety, initiated on 6/5/24 and discontinued on 7/5/24. -Risperidone oral tablet 0.5mg. Give one tablet by mouth every 8 hours as needed for behaviors related to unspecified dementia, initiated 7/5/24. -Risperidone oral tablet. Give 0.5mg by mouth every 8 hours as needed for increased agitation related to major depressive disorder, initiated 7/3/24 and discontinued 7/9/24. -Trazadone 50 mg. Give 1 tablet by mouth at bedtime related to major depressive disorder, initiated 6/5/24 and discontinued on 7/4/24. -Trazadone 50 mg. Give 1 tablet by mouth at bedtime related to major depressive disorder, initiated on 7/25/24. -Trazadone 50 mg. Give 1 tablet by mouth in the afternoon related to major depressive disorder, initiated on 7/23/24. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of the Psychiatric Nurse Practitioner and Physician notes failed to indicate a recommendation to stop Resident #80's Trazadone on 7/4/24, and he/she was without the mood stabilizer for 20 days. Throughout this time period, there were several nursing notes indicating Resident #80 had increased anxiety and agitation and had several occasions of refusing his/her medications. In addition, there was no indication for a recommendation to start the second dose of Trazadone on 7/25/24 when the medication was reintroduced on 7/23/24. Further review indicated that Resident #80's went 6 days (from 7/9/24 to 7/14/24) with only a one-time dose of the antipsychotic Risperidone, with no indication of that dose reduction being recommended by the Physician or nurse Practitioner. On 7/15/24, after 6 days without the second dose of antipsychotic medication, Resident #80 was physically aggressive towards a staff member. Review of the Medication Administration Report for August, indicated Resident #80 was prescribed the following psychotropic medications: -Risperidone oral tablet 0.5 mg. Give one tablet by mouth at bedtime for increased behavior, initiated on 7/24/24 and discontinued on 8/6/24. -Risperidone oral tablet 1 mg. Give 1 mg by mouth one time a day for increased behavior, initiated on 7/25/24 and discontinued on 8/6/24. -Trazadone 50 mg. Give 1 tablet by mouth at bedtime related to major depressive disorder, initiated 7/25/24 and discontinued 8/20/24. -Trazadone 50 mg. Give 1 tablet by mouth in the afternoon related to major depressive disorder, initiated 7/23/24 and discontinued 8/20/24. -Trazadone 50 mg. Give 1 tablet by mouth three times a day for increased agitation related to dementia, initiated on 8/20/24. -Trazadone 50 mg. Give 1 tablet by mouth every 8 hours as needed for increased agitation, initiated on 8/20/24 and discontinued on 8/21/24. -Trazadone 50 mg. Give 1 tablet by mouth every 8 hours as needed for increased agitation for 14 days, initiated on 8/21/24. Review of the Psychiatric Nurse Practitioner and Physician notes failed to indicate a recommendation to stop Resident #80's Risperidone on 8/6/24 and he/she has been without the antipsychotic medication since, a total of 23 days. Review of the physician note dated 8/20/24 indicated the following: -The patient does have a history of dementia with behavioral disturbance. The patient is currntly on Risperdal 1 mg p.o.q.a.m. (by mouth every morning) and .5mg p.o.h.s.p.r.n. (by mouth every day as needed), although this was scheduled through 8/6/24. It is unclear if this has been continued. Review of Resident #80's psychotropic medication care plan, last revised 7/2/24, indicated the following intervention: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-Administer medication as prescribed by the physician. Review of Resident #80's behavioral care plan, last revised 7/19/24, indicated the following intervention: -Administer medications as ordered and monitor for effectiveness. Document resident's medication effects and notify MD/NP if behavior escalates. The surveyor attempted to call the physician and his office said he was unavailable for the week. During an interview on 8/29/24 at 9:37 A.M., Nurse Practitioner #1 said she was unaware Resident #80's Trazadone and Risperidone had been stopped and did not know why that would have happened. Nurse Practitioner said all medication changes should be approved by the physician. During a follow-up interview on 8/29/24 at 1:07 P.M., Nurse Practitioner #1 said the side effects of stopping an antipsychotic abruptly without tapering would be increased behaviors which Resident #80 has been exhibiting. Nurse Practitioner said the abrupt stopping without authorization from the medical team can be harmful to the Resident. During an interview on 8/29/24 at 9:45 A.M., Nurse #6 said she was aware there was a period Resident #80 was not on any psychotropic medication and was unsure of the reason. During an interview on 8/29/24 at 10:23 A.M., the Director of Nursing (DON) said she was unaware of both the Trazadone and Risperidone being discontinued and could not explain how or why this occurred. The DON said there are possible side effects of stopping psychotropic medications without a taper, which would include instability, shakes, increased agitation and confusion, and general symptoms of withdrawal. During an interview on 8/29/24 at 10:59 A.M., Corporate Nurse #1 said she would expect Resident #80 to have been seen by behavioral services after every resident-to-resident incident and when the Resident presented with increased behaviors. Corporate Nurse #1 said she would expect the interdisciplinary team to discuss every incident, including a medication review and the stopping of Resident #80's Risperidone and Trazadone should have been caught by the team. Corporate Nurse #1 said stopping antipsychotic medications abruptly would create increased symptoms. Corporate Nurse #1 said the facility had recently completed education on psychotropic medications and she believes a nurse put an end date on all psychotropic medications without speaking with the doctor. Corporate Nurse #1 said the facility went through all the medication orders to ensure this end date was deleted, however the end date of Resident #80's Risperidone must have been missed. During an interview on 8/29/24 at 2:14 P.M., the Psychiatric Nurse Practitioner said she was unaware that Resident #80's medication had been stopped and said this could have caused harm to the Resident causing increased behaviors, instability and a fast increasing of symptoms.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49880 Based on observations, record review, policy review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when 1 out of 2 nurses observed made 5 errors out of 26 opportunities, resulting in a medication error rate of 19.23%. Those errors impacted one Resident (#86), out of four residents observed. Specifically, for Resident #86, Nurse #4 failed to administer his/her medications within the one-hour time frame. Findings Include: Review of facility policy titled Medication Administration- Oral, dated June 2015 indicated the following: Procedure: 1. Verify Medication order on Medication Administration Record (MAR). Check against physician order. 9. Verify that the medication is being administered at the proper time, in the prescribed dose, & by the correct route. On 8/27/24 at 10:12 A.M., the surveyor observed Nurse #4 prepare and administer morning medications to Resident #86 including the following: -Metformin 500 milligrams (mg), 2 tablets -Metoprolol 25 mg, 1 tablet -Methocarbamol 500 mg, 1 tablet -Lantus insulin 12 units -Colace 100 mg, 1 capsule Review of Resident #86's physician's orders indicated the following: -Metformin 500 mg give 2 tablets two times daily (1000 mg BID) for diabetes with breakfast and dinner at 8 A. M. and 5 P.M., dated 11/2/23. Administered at 10:12 A.M., 2 hours and 12 minutes after the scheduled time and not with breakfast. -Metoprolol Tartrate 25 mg, give one tablet by mouth twice daily for hypertension at 8 A.M. and 5 P.M., dated 5/20/24. Administered at 10:12 A.M., 2 hours and 2 minutes after the scheduled time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Methocarbamol 500 mg one tablet twice daily at 8 A.M. and 7 P.M., dated 11/20/24. Administered at 10:12 AM., 2 hours and 12 minutes after the scheduled time. -Lantus subcutaneous solution 100 unit/ml (insulin glargine) inject 12 units subcutaneously in the morning at 8 A.M. and Lantus subcutaneous solution 100 unit/ ml (insulin glargine) inject 10 units subcutaneously at bedtime at 7 P.M. for diabetes, dated 5/2/24. Administered at 10:12 A.M., 2 hours and 12 minutes after the scheduled time. -Colace 100 mg twice daily for constipation at 8 A.M. and 5 P.M, dated 11/2/23. Administered at 10:12 A.M., 2 hours and 12 minutes after the scheduled time. During an interview on 8/27/24 at 10:17 A.M., Nurse #4 said that medications should be given within one hour before or after the scheduled time. She said she did not administer medications within the appropriate time frame. Nurse #4 also said that Metformin should have been given to Resident #86 with breakfast as ordered but it was not. During an interview on 8/28/24 at 2:32 P.M., the Director of Nurses (DON) said that nurses have one hour before and after the scheduled administration time to administer medications. The DON further said that physician orders that specify to administer with meals should be given with meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Northwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Varnum Avenue Lowell, MA 01854	

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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. 49880 Based on observations, interviews, and policy review, the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, 1. The facility failed to ensure medications were labeled and stored according to manufacturer's guidelines in two of four medication carts. 2. The facility failed to ensure that unlicensed personnel were supervised while in the medication room. Findings Include: Review of facility policy titled Medication Storage room/ Medication Cart Policy, dated February 2018, indicated the following: -The facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet applicable Federal, State and Local Laws, rules, and regulations. -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. -Storage for other medications will be limited to a locked medication room. 1. On 8/27/24 at 7:45 A.M., the surveyor observed the following in the A wing medication cart #1: - An opened and undated Symbicort inhaler with instructions to discard the inhaler three months after opening. - An opened and undated Advair diskus inhaler with instructions to discard one month after opening the foil pouch or when the counter reads zero, whichever comes first. - An opened and undated Lispro insulin pen which expires 28 days after opening. - A, opened and undated bottle of prosource liquid protein which indicates on the bottle to discard three months after opening. During an interview with Nurse #8 she said the nurse who opens an inhaler, insulin or any other medication with a shortened expiration date is responsible for labeling it with an open date. She said the inhalers, insulin and prosource liquid protein did not have open dates on them and they should have. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 8:07 A.M., the surveyor observed the following in the A wing medication cart #2 - An opened and undated Incruse inhaler with directions to discard six weeks after opening. During an interview on 8/27/24 at 8:09 A.M., Nurse #2 said the inhaler was opened and did not have an open date documented, but it should have one. During an interview on 8/27/24 at 11:37 A.M., the Director of Nurses (DON) said that all medications with shortened expiration dates should be labeled with open dates. She said the nurse who opens the medication is responsible for dating the medication. 2. On 8/27/24 at 11:11 A.M. Nurse #2 opened the medication room door to allow access to the maintenance worker and substance abuse counselor. Once inside, Nurse #2 left the room with those two employees unsupervised in the medication room. During an interview on 8/27/24 at 11:37 A.M., the Director of Nursing said only nurses are allowed in the medication room and if any other employees need to enter the medication room, they must be supervised by a licensed nurse the entire time.

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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. 41105 Based on record review, policy review and interview the facility failed to ensure accurate documentation in the medical record for four Residents (#46, #80, #16 and #53) out of a total sample of 30 residents. Specifically: 1. For Resident #46 staff documented in the medical record that blood pressures were being taken in the left arm, when they were being taken in the right arm. 2a. For Resident #80 the facility failed to maintain a valid Massachusetts Order for Life Sustaining Treatment (MOLST) in the medical record. 2b. For Resident #80 the facility failed to accurately code the MDS regarding Advanced Directive status. 2c. For Resident #80's his/her medical record failed to indicate any physician notes were included in the medical chart. 3. For Resident #16 the facility failed to accurately document the wearing of bilateral lower extremity multipodus boots 4. For Resident #53 staff documented in the medical record that blood pressures were being taken in the left arm, when they were being taken in the right arm. Findings Include: 1. For Resident #46 staff documented in the medical record that blood pressures were being taken in the left arm, when they were being taken in the right arm. Review of the policy titled Hemodialysis, dated April 2015, indicated the following: -Do not take blood pressure readings or perform venipuncture on the access arm. Resident #46 was admitted to the facility in September 2019 and has diagnoses that include End Stage Renal Disease and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated on the Brief Interview for Mental Status exam Resident #46 scored a 12 out of a possible 15 indicating moderately impaired cognition. The MDS further indicated that Resident #46 received dialysis treatment. Review of the care plans for Resident #46 indicated a care plan Resident requires Hemodialysis End Stage Renal Disease (sic). The care plan included the following intervention: -Left arm AV fistula (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No blood pressure or labs/blood drawn to left arm. Review of the current Physician orders for Resident #46 included the following order: HEMODIALYSIS: no BP (blood pressure)/blood draw/IV to left arm due to Hemodialysis fistula, start date 9/12/23. During an interview on 8/26/24 at 7:49 A.M., Resident #46 said he/she goes to dialysis 3 times a week. Resident #46 said that the nurse staff do not take his/her blood pressure from the left arm, they take it from his/her right arm only. Review of the blood pressure summary report for the past 30 days indicated that nurses documented that Resident #46's blood pressure was taken from the left arm on: 8/20/24, 8/13/24, 8/08/24, and 8/01/24. During an interview on 8/27/24 at 11:35 A.M., the Director of Nursing (DON) said that a resident that receives Hemodialysis should never have their blood taken from the arm that the fistula is located due to the risk of bleeding out. The DON said that she expects that the documentation be accurate in the medical record and that if staff are taking the blood pressure from Resident #46's right arm, they document this in the record. 2a. For Resident #80 the facility failed to maintain a valid MOLST in the medical record. The facility policy titled Medical Orders for Life Sustaining Treatment MOLST (Massachusetts & Rhode Island), dated August 2015, indicated the following: -Once the MOLST form is completed, it must be signed by the resident/patient, or if the resident/patient lacks decision-making capacity the resident's/patient's legally recognized health care agent, and the attending health care provider. Resident #80 was admitted to the facility June 2024 and has diagnoses that include Alzheimer's disease and Major Depressive Disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/12/24, indicated that on the Brief Interview for Mental Status exam Resident #80 scored a 0 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #80 had an activated Health Care Proxy (HCP) and orders for Do Not Resuscitate (DNR) and Do Not Intubate (DNI). Review of the record indicated Resident #80 had a MOLST in the medical record however the section for the signature of Resident #80 or the responsible party was blank. During an interview on 8/29/24 at 8:18 A.M., with Resident #80's Nurse (#6) she said that the MOLST needs to be signed by the responsible party for it to be valid. She reviewed the unsigned MOLST in Resident #80's record and she said that is not valid and a new one will need to be completed. During an interview on 8/29/24 at 9:37 A.M., with the Director of Nursing (DON) she said that without a signature from the Resident or responsible party on the MOLST, it is not valid. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 9:47 A.M., with the Social Worker (#1) she and Director of Social Service, Resident #80's MOLST was reviewed and they said it is not valid because it is not signed. 2b. Review of the record indicated Resident #80: -Had a MOLST in the medical record however the section for the signature of Resident #80 or the responsible party was blank. -Had a Health Care Proxy (HCP) on record, however the HCP activation form was blank and there was not an order to invoke the HCP. During an interview on 8/29/24 at 8:18 A.M., with Resident #80's Nurse #6 she said: -The MOLST needs to be signed by the responsible party for it to be valid. She reviewed the unsigned MOLST in Resident #80's record and she said that is not valid and a new one will need to be completed. -She reviewed the blank HCP activation form and said that Resident's HCP is not activated without the form being completed and without an order to invoke the HCP by the Physician. During an interview on 8/29/24 at 9:37 A.M., with the Director of Nursing (DON) she said: -Without a signature from the Resident or responsible party on the MOLST it is not valid. -The HCP is not activated until the Physician completes the HCP activation form and writes an order to invoke the HCP. -The MDS is inaccurately coded in Section S. She said that until there is a valid MOLST in place, Resident #80 should not be coded as being DNR/DNI status and until the Physician completes the HCP activation form and writes an order to invoke the HCP, the MDS should not be coded as being activated. During an interview on 8/29/24 at 9:45 A.M., with the MDS Nurse (#1) she said that the Social Workers complete section S of the MDS. MDS Nurse #1 said that the MDS coordinator reviews the completed MDS but she is not sure if it is for accuracy or for completion. During an interview on 8/29/24 at 9:47 A.M., with the Social Worker (#1) she said that she completed Section S of the MDS. Social Worker #1 said that she coded the MDS based off of what she read in the hospital paperwork and was not aware that the MOLST was not valid at the time she completed the MDS or that the Physician had not completed the HCP activation form and had not written an order to invoke the HCP. 41456 2c. Review of Resident #80's medical record failed to indicate any physician notes were included in the medical chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 12:39 P.M., Corporate Nurse #1 said the medical record is not complete without the physician documentation and the facility needs to put a process in place to ensure this documentation is included in the medical record. 45343 3. For Resident #16, the facility failed to accurately document the wearing of bilateral lower extremity multipodus boots. Resident #16 was admitted to the facility in May 2022 with diagnoses that included cerebral infarction, chronic leg syndrome, and cellulitis of the left toe. Review of Resident #16's most recent Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident #16 scored a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she is cognitively intact. Further review of the MDS indicated Resident #16 requires substantial/maximal to dependent assistance for all self-care activities and is at risk for pressure ulcers. On 8/26/24 at 8:33 A.M., 8/27/24 at 7:24 A.M., and 12:01 P.M., and 8/28/24 6:30 A.M. Resident #16 was observed lying in his/her bed. Resident #16 was not wearing his her multipodus boots on his/her feet. The mutlipodus boots were observed on Resident #16's windowsill. Review of Resident #16's physician order, dated 3/1/24, indicated Multipodus boots at 6PM, off at midnight for skin check. Reapply and remove after morning care. On at all times when OOB (out of bed) in w/c (wheelchair). Skin checks every shift as needed. Every shift for preventative maintenance. Review of Resident #16's nursing progress notes for the past 30 days failed to indicate the Resident refused pressure relieving boots to his/her feet. Review of Resident #16's Medication Administration Record (MAR) for 8/26/24 through 8/28/24 indicated staff had signed off that he/she was wearing his/her multipodus boots. During an interview on 8/28/24 at 10:36 A.M., Nurse #10 said Resident #16 has booties that he/she wears during the night and are removed during morning care. Nurse #10 said it should be documented correctly in the medical record and indicated if the resident refuses. During an interview on 8/28/24 at 10:45 A.M., the Director of Nursing said she expects the booties to be worn as ordered by the physician, accurately documented in the medical record, and indicated if the resident refuses. 49880 4. Review of the policy titled Hemodialysis, dated April 2015, indicated the following: -Do not take blood pressure readings or perform venipuncture on the access arm. Resident #53 was admitted to the facility in May 2024 with diagnoses including fluid overload and dependence on renal dialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #53's most recent Minimum Data Set (MDS) Assessment, dated 5/25/24, indicate a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating that the Resident has moderate cognitive impairment. The MDS further indicates that Resident #53 receives dialysis. On 8/28/24 at 8:28 A.M., Resident #83 said that he/she is on dialysis and has a left arm fistula used for dialysis treatments. Resident #83 said that he/she cannot have blood pressures done on his/her left arm. Review of physician's orders indicated the following: -Site of AV (arteriovenous) shunt check bruit and thrill every shift, dated 8/2/24. Review of Resident #53's active care plan indicated that the Resident requires hemodialysis for end stage renal disease. Review of blood pressure readings indicated that blood pressure was documented as being obtained on Resident #53's left arm on 5/19/24, 5/20/24, 8/3/24, 8/4/24, and 8/5/24. During an interview on 8/28/24 at 2:36 P.M., the Director of Nurses (DON) said that blood pressures are not taken in an arm with dialysis access and that the medical record was inaccurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49880 Based on observation, interviews, and policy review, the facility failed to ensure transmission-based precautions were followed to prevent the spread of infections, and that appropriate hand hygiene practices were followed. Specifically, 1. The facility failed to ensure a nurse and a certified nursing assistant (CNA) appropriately donned (put on) a precaution gown while caring for a Resident on enhanced barrier precautions (EBP). 2. The facility failed to ensure a nurse performed hand hygiene between glove use. Findings Include: 1. Review of facility policy titled Enhanced Barrier Precautions Policy, undated, indicated the following: -It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targets multidrug resistant organisms (MDROs). Novel or targeted MDROs are organisms that are resistance to all or most antibiotics tested , are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other genes. -Enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multidrug- resistant organisms. High contact resident care activities include bathing/ showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. -Enhanced barrier precautions will be continued while the qualifying condition or indwelling device is still active or in use. On 8/27/24 at 11:42 A.M., the surveyor observed a pressure ulcer wound with Nurse #2. Upon entry into the Resident room, there was a sign posted at the doorway that indicated the resident was on EBP and that everyone must wear gloves and gown for high-contact resident care activities including wound care. Certified Nurse Aid (CNA) #3 assisted Nurse #2 with a pressure ulcer dressing change. Both Nurse #2 and CNA #3 wore gloves into the room but did not don a precaution gown, and both wore only gloves for the duration of the procedure. During an interview on 8/27/24 at 11:54 A.M., CNA #3 said that the EBP sign outside of the Resident's room was just a warning that the resident has a wound and that it is optional to wear a gown. During an interview on 8/27/24 at 11:55 A.M., Nurse #2 said that EBP should have been followed including donning a precaution gown to perform the dressing change. She said that she did not wear a gown for the dressing change, but she should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 10:25 A.M., the Infection Preventionist said she could not recall what personal protective equipment (PPE) should be worn for EBP and said, but it's on the sign. The surveyor shared the concerns regarding the CNA and Nurse's lack of PPE during a wound treatment of a resident on EBP and she said that she would educate the staff on what PPE to wear. During an interview on 8/29/24 at 10:46 A.M., the Director of Nurses (DON) said that EBP should have been followed and she would expect that staff don a precaution gown and gloves when performing a dressing change. 2. Review of facility policy titled Hand Hygiene, dated April 2015, indicated the following: -Policy: to protect residents/patients from health-care associated infections. -When to use the alcohol hand sanitizer: after removing gloves. On 8/27/24 at 11:42 A.M., the surveyor observed a pressure ulcer wound dressing change with Nurse #2. Nurse #2 donned gloves upon entering the Resident's room. She then removed the old dressing, removed her gloves, and donned new gloves without performing hand hygiene between glove use. Nurse #2 then cleansed the wound and removed her gloves again, followed by donning new gloves, without performing hand hygiene. Nurse #2 then removed the gloves that she had just donned because she forgot her scissors on her medication cart, left room to get them, came back and donned new gloves, again without performing hand hygiene. Nurse #2 then applied the new dressing to the Resident's wound. During an interview on 8/27/24 at 11:55 A.M., Nurse #2 said that she should have performed hand hygiene each time she removed her gloves, but she did not since she forgot her hand sanitizer, so she couldn't. During an interview on 8/27/24 at 10:46 A.M., the Director of Nurses (DON) said that staff should perform hand hygiene every time they remove gloves and before donning new gloves.