STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225401	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview House Skld Nrsg and Residential Care Fac	87 Shattuck Street Haverhill, MA 01830

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician of a significant change in status for one Resident (#2) out of a total sample of 14 residents. Specifically, after the worsening of a pressure wound on the sacrum of Resident #2. Findings include:Review of the facility policy titled Wound Care Protocol, undated, indicated the following: If a resident is found to have a wound/pressure area present at the time of amission, the following steps will be followed: Notification of the PCP (primary care physician) for treatment and/or evaluation/consult orders. Notification of Director/Assistant of Nurses.Orders for treatment will be addressed immediately. Assessments will be performed on an ongoing basis to ensure optimal healing. Wounds should be assessed and evaluated at each dressing change and updates made to the plan of care at this time if warranted. Resident #2 was admitted in April 2021 with diagnoses including dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #2 scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. Review of the MDS indicated Resident #2 is at risk for developing pressure ulcers. Review of the Norton Pressure Ulcer Scale for Resident #2, dated 10/2/24, indicated that Resident #2 scored a 9 on the scale, indicating high risk for pressure ulcer development. Review of the medical record indicated that on 10/2/24, Resident #2 had developed a pressure wound of the sacrum (a triangular bone at the base of the spine). Review of the physician's orders indicated that Medihoney wound gel was implemented. Review of the skin check, dated 2/19/25, indicated that the pressure ulcer of the sacrum measured 0.4 (width) x 0.3 (length) centimeters (cm). Review of the skin check, dated 2/26/25, indicated that the pressure ulcer of the sacrum measured 1.3 cm (width) x 1 cm (length). Review of the nursing progress note, dated 2/26/25, indicated the following:-Skin note: Sacrum open area is larger. Res has started AB (antibiotic) therapy as well as Prednisone therapy this week due to URI. (upper respiratory infection) Review of the medical record failed to indicate that the nurse practitioner or physician had been notified of the change. Review of the skin check, dated 3/5/25, indicated that the sacrum wound measured at 1.8 cm x 1.5 cm, indicating further worsening of the wound. Review of the nursing progress note, dated 3/5/25, indicated the following:Skin note: Res. sacrum has not improved this week-larger. Review of the record failed to indicate any physician or nurse practitioner notes in the medical record between 2/26/25 and 3/7/25. Review of the physician's orders indicated that an air mattress and multivitamin was implemented on 3/7/25 for wound management, one week after the initial decline had been identified. Review of the nurse practitioner note, dated 3/7/25, indicated the following:-History dementia/rosecea; pt (patient) non-ambulant and is bed and chair bound; stage 2 sacral decub healed; pt eating and sleeping well without acute issues no falls; Patient is seen in the nursing facility for a planned Wellness Physical Visit. During an interview on 7/30/25 at 7:33 A.M., Nurse Practitioner #1 said that if a wound was deteriorating or worsened that staff should notify her, the physican or the other covering nurse practitioner. Nurse Practitioner #1 could not say if she was notified of Resident #2's worsening pressure ulcer. Nurse Practitioner #1 said that if there is a change in a Resident's wound status then it should be addressed. During an interview on 7/30/25 at 7:39 (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M., Physician #1 said that the nurse should call him or a nurse practitioner if there is a change in a Resident's wound. Physician #1 said he would try something to improve wound in house or maybe more frequent wound changes if the wound declined. Physician #1 said he would expect staff to notify him immediately and an intervention to be put in place immediately if a wound declined. During an interview on 7/30/25 at 7:48 A.M., Nurse #1 said that she did the skin check on 2/26/25 when the wound initially worsened and she notified the oncoming nurse that came on the next shift. Nurse #1 said that she notifies the nurse because it's too early to call the physician or nurse practitioner when she gets off of her shift. Nurse #1 said she would have expected the next shift nurse to notify the physician or nurse practitioner. During an interview on 7/30/25 at 9:57 A.M., the Director of Nursing and Assistant Director of Nursing said that if staff identify a worsening wound, then the process is to notify the nurse practitioner or physician right away and get in a new treatment. The DON and ADON said that it would be documented in the nurse practitioner's or physician's notes if they were notified about the worsening wound. The Director of Nursing said that since there was no documentation of the notification, the facility could not say that the provider was notified.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to review and revise the care plan by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 Residents (#7 and #21) out of a total sample of 14 residents. Specifically:For resident #7 the facility failed to review and/or revise the care plan after the completion of a quarterly MDS dated [DATE].For Resident #21 the facility failed to review and/or revise the care plan after the completion of a comprehensive MDS dated [DATE]. Findings include:Review of the facility policy titled Care Plan Process, not dated, indicated care plans can be updated and revised when necessary and again quarterly. 1. Resident #7 was admitted to the facility in February 2023 with diagnoses including frontotemporal neurocognitive disorder, bipolar disorder and stroke. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating severely impaired cognition. Further review indicated Resident #7 is totally dependent on staff for all activities of daily living. Review of the electronic and paper clinical medical record failed to indicate a current care plan. Further review indicated that the existing care plan had a next review date of 2/16/25 and had a target date for the next review of 5/17/25. During an interview on 7/29/2025 at 1:05 P.M. the MDS coordinator said that Resident #7 should have had an updated care plan, but she was behind and had not updated his/her care plan until today when it was bought to her attention that the care plans were out of date. 2. Resident #21 was admitted to the facility in May 2019 with diagnoses including dementia, heart disease and anxiety. Review of Resident #21's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated Resident #21 is mostly independent for activities of daily living. Review of the electronic and paper clinical medical record failed to indicate a current care plan. Further review indicated that the existing care plan had a next review date of 4/19/25. During an interview on 7/29/2025 at 1:09 P.M. the Minimum Data Set (MDS) Coordinator said that she updated the care plans today after it was brought to her attention that the care plans had not been reviewed after the last MDS assessment. The MDS Coordinator said that the care plans should be reviewed after each MDS assessment. She then said that she was behind reviewing and updating the care plans.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review the facility failed to ensure that one Resident (#8), out of a total sample of 14 residents, received proper treatment to maintain vision ability. Specifically, the facility failed to review and implement the optometrist's recommendation for a follow-up appointment and initiation of artificial tears (lubricating eye drops used to relieve dryness and irritation in the eyes). Findings include: Review of the undated facility policy, titled Opthalmology Services (sic.) indicated, but was not limited to, the following:- - All residents shall have proper eye care and eye wear appropriate to their needs.- - When services of an optometrist are needed or requested, such services shall be rendered with the knowledge of the attending physician.- - All ophthalmology/optometry services shall be documented and retained in the residents' medical record. Resident #8 was admitted to the facility in November 2010 with a diagnosis of bilateral age-related cataracts, and type 2 diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/3/25, indicated that Resident #8 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #8's consent form, signed 3/25/22, indicated the Resident consented to being seen by an optometrist. During an interview on 7/29/25 at 12:53 P.M. Resident #8 said he/she was waiting to be seen by the eye doctor because his/her eyes started bothering him/her about a week ago and that he/she had told staff about this. Resident #8 said that his/her eyes tend to be watery and that recently his/her vision has become blurry. The Resident said he/she had not used eye drops in the last year. Review of Resident #8's optometrist evaluation, dated 10/31/24 indicated the Resident had dry eyes, glaucoma suspect, pseudophakia (an artificially implanted lense), opacification (a clouding or loss of transparency in normally clear ocular tissues) and hyperopic astigmatism and presbyopia (two distinct vision conditions that can affect how clearly a person sees) with the following plan/recommendations:- New medication Order: Artificial tears solution apply one drop, both eyes, twice daily for indefinitely; follow up: 3-4 months.- Monitor IOP (Intraocular Pressure); follow-up: 3-4 months. Review of Resident #8's medical record failed to indicate that the optometry recommendations made on 10/31/25 were reviewed, that the artificial tears were implemented or that the Resident had been seen by an optometrist since 10/31/24. Review of the Eye Care Group Schedule indicated Resident #8 was scheduled to be next seen on 9/5/25, 10 months after the Resident's last optometry visit. During an interview on 7/30/25 at 11:57 A.M. the optometrist who had evaluated Resident #8 on 10/31/24 said that the Resident had dry eyes and that he had seen in the Resident's record that he/she had previously received artificial tears but was not receiving them at the time of the evaluation, so he recommended to initiate artificial tears. The optometrist said that untreated dry eyes can cause blurry vision and watery eyes. The optometrist said that based on his exam he was concerned about the Resident developing glaucoma and for that reason wanted to follow up in three to four months for a pressure check, to evaluate the effectiveness of the artificial tears and to check if the artificial tears were getting administered. The optometrist said that he would have expected the artificial tears to have been implemented, and the Resident had seen an optometrist three to four months after his evaluation on 10/31/24; the optometrist said that there were no contraindications for the implementation of either of his recommendations. The optometrist said that the facility could reach out to his company to schedule a follow up. During an interview on 7/29/25 at 12:49 P.M. Nurse #2 said Resident #8 was last seen by an optometrist on 10/31/25. During an interview on 7/30/25 at 8:37 A.M. the physician said that when a Resident is seen by specialty services that nursing will show the providers a copy of the specialists' recommendations and the providers will then review and sign the note. The physician said that he would expect a prn (as needed) order for artificial tears for a resident with dry eyes. During interviews on 07/29/2025 at 1:02 P.M., 7/29/25 at 2:59 P.M. and 7/30/25 at 10:12 A.M. the Director of Nursing (DON) said that she and the medical records staff review optometry recommendations and that Resident #8 should have been seen three to four months (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following the 10/31/24 optometry visit based on the optometrists recommendation and that the artificial tears were not implemented after the 10/31/24 optometry visit. The DON said she was not sure if any provider reviewed the 10/31/24 optometry recommendations and that providers would document if they had disagreed with the recommendations. The DON said that if the original optometrist was unable to see the Resident the facility could facilitate a visit with another optometrist.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one Resident (#7) out of a total sample of 14 residents. Specifically, the facility failed to complete a significant change MDS when Resident #7 signed on to hospice.Findings include:Resident #7 was admitted to the facility in February 2023 with diagnoses including frontotemporal neurocognitive disorder, bipolar disorder and stroke. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #7 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating severely impaired cognition. Further review indicated Resident #7 is totally dependent on staff for all activities of daily living. Review of the physician's order dated 6/9/25 indicated the following order:-Pt (patient) may be seen by hospice and admitted if appropriate. Review of the progress note dated 6/11/25 indicated that hospice met with Resident #7 and deemed him/her appropriate for hospice services and was admitted to hospice. Review of Resident #7's medical record failed to indicate that a significant change MDS was completed within the required time frame of 14 days after a significant change. During an interview on 7/29/2025 at 1:05 P.M. the MDS coordinator said that Resident #7 should have had a significant change MDS completed when he/she signed on to hospice.