STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225458	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Healthcare Center	476 Varnum Avenue Lowell, MA 01854

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure they maintained a complete and accurate medical record that included nursing documentation related to assessments of a new area of skin alteration that had developed on his/her left thigh.Findings include:The Facility Policy, titled Nursing Documentation Policy, undated, indicated the Facility required that nursing documentation be timely, accurate, complete, factual, and reflective of the resident's condition, care provided, notifications made, and follow up completed. The Policy indicated nursing staff would document resident condition changes, assessments and observations, wound care and skin findings, and changes of condition.The Facility Policy, titled Wound Care Policy, undated, indicated that when a wound was found, nursing staff would assess and document date and time found, location of the wound, type of wound, if known, size including length, width, and depth, wound bed appearance, drainage amount, color and odor, surrounding skin condition, pain or tenderness, signs of infection, possible cause, if known, and whether the wound was present on admission or was Facility acquired, if known. Resident #1 was admitted to the Facility in January 2025, diagnoses included diabetes, dementia, and chronic kidney disease. Review of the report submitted by the Facility via the Health Care Facilities Reporting System (HCFRS) dated 04/29/26, indicated that on the morning of 04/25/26 Certified Nurse Aide #1 reported to Nurse #1 that Resident #1 had a new reddened area on his/her right (later clarified as the left) thigh. During a telephone interview on 06/15/26 at 11:27 A.M. CNA #1 said that on 04/25/26 during routine care she observed a new reddened area on Resident #1's left thigh and said she reported it to Nurse #1. CNA #1 said she was familiar with Resident #1 and had never seen that reddened area before.During a telephone interview on 06/15/26 at 1:17 P.M., Nurse #1 said that on 04/25/26 CNA #1 told her that Resident #1 had a new reddened area on his/her left thigh. Nurse #1 said she assessed the area and said that it was a large, red and blanchable (an area of skin that temporarily turns white or pale when you press your finger on it and release). Nurse #1 said she had not been previously aware of a reddened area on Resident #1's left thigh. Nurse #1 said she did not measure the area or document her assessment.During a telephone interview on 06/15/26 at 11:48 A.M., Nurse #2 said that on 04/25/26 she worked the 3:00 P.M., to 11:00 P.M., shift and said that during shift report, Nurse #1 did not tell her that Resident #1 had a new area of skin alteration on his/her left thigh. Nurse #2 said the area had been assessed by her on 04/19/26 and was included in her progress note.Review of Resident #1's medical record indicated there was a nursing note, signed by Nurse #2, dated 04/19/26, that indicated Resident #1 was assessed as having left leg swelling and redness, however the note did not indicate any measurements of the area or specific information about a reddened area on his/her left thigh.During an interview on 06/15/26 at 01:04 P.M., Nurse #3 said that on the morning of 04/26/26 a CNA told him and Nurse #4 that Resident #1 had a new reddened area that appeared to be caused by pressure on his/her left thigh. Nurse #3 said he assessed the wound, it was reddened and blanchable but said he did not document his assessment of the wound.During a telephone interview on 06/15/26 at 01:52 P.M., Nurse #4 said that on 04/26/26 at 07:00 A.M., she was giving shift report to Nurse #3 when a CNA told her and Nurse #3 that Resident #1 had a reddened area that appeared to be from (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure on his/her left thigh. Nurse #4 said she assessed the area, which was red and blanchable, but said she did not document her assessment of the wound.During a telephone interview on 06/15/26 at 11:11 A.M., Nurse #5 said that on 04/26/26 at 04:30 P.M., CNA #3 reported to her that Resident #1 had an open area on his/her left thigh. Nurse #5 said she assessed Resident #1's left thigh and there was a new open blister surrounded by reddened skin. Nurse #5 said this was the first time she was aware of there being a wound on Resident #1's left thigh.Review of the Nurse Practitioner's Progress Note, dated 04/26/26 and timed 04:28 P.M., indicated Nurse #5 notified the on-call provider that Resident #1 had a new wound on his/her left thigh. The Note indicated the wound measured 6 centimeters (cm) by 6 cm, the wound bed was pale pink, and the surrounding skin had mild erythema (redness) and was tender.Further review of Resident #1's medical record indicated there was no documentation to support any of the facility nurses that had assessed Resident #1's left thigh area had documented measurements, wound bed description, and surrounding skin description, prior to the description in the Nurse Practitioner's Progress Note dated 04/26/26.During an interview on 6/15/26 at 02:43 P.M., the Administrator said Nurse #1, Nurse #2, Nurse #3, and Nurse #4 should have documented their assessments of the reddened area on Resident #1's left thigh but had not.