STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225489	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvidere Healthcare Center	500 Wentworth Avenue Lowell, MA 01852

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff treated residents in a dignified manner during the dining experience for one Resident (#24) out of a total sample of 22 Residents. Specifically, the facility failed to ensure that staff were not operating a cell phone while assisting Resident #24 with eating breakfast. Findings include: Review of the facility policy titled Quality of Life - Dignity, undated, indicated the following: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Resident #24 was admitted to the facility in November 2024 with diagnoses including Parkinsonism, stage 4 pressure ulcer of sacral region, and unspecified protein calorie malnutrition. Review of Resident #24's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff for all Activities of Daily Living including eating. During a telephone interview on 3/9/25 at approximately 3:30 P.M., the facility's Ombudsman reported to the surveyor that about two weeks prior, he observed a Certified Nursing Assistant (CNA) using her cell phone while feeding a resident and the resident was staring at the CNA with the food being untouched. On 5/13/25 during breakfast service at 8:44 A.M., the surveyor made the following observations: Resident #24 was observed to be assisted by a staff member while eating breakfast. Resident #24's bedroom door was slightly open, the surveyor observed a staff member sitting in a chair next to Resident #24 who was lying in his/her bed. The staff member was observed to be using both of her hands while texting on her cell phone over Resident #24's breakfast tray. At 8:47 A.M., the surveyor observed the staff member to continuing to text on her phone instead of feeding Resident #24. At 8:54 A.M., 10 minutes after the initial observation, the staff member was observed to continue texting on her phone instead of assisting Resident #24 with eating his/her breakfast. Review of the facility's Resident Council Minutes indicated the following: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- February 27, 2025: Nursing - Being on phones has gotten better. - April 24, 2025: Staff using phones and headphones while working is an ongoing issue they (the residents) would like to see resolved, even though it has improved from the past. During an interview on 5/14/25 at 10:05 A.M., Unit Manager #1 said staff members should never be on their cell phones while assisting residents with feeding and every resident should have a dignified dining experience. During a follow up interview on 5/14/25 at 10:18 A.M., Unit Manager #1 said the staff member on her cell phone was Resident #24's hospice CNA (Certified Nurse Aide) from the outside hospice agency. Unit Manager #1 then said she would still expect the hospice CNA to follow the facility's policies and procedures and provide a dignified dining experience for Resident #24. During an interview on 5/14/25 at 10:22 A.M., the Director of Nursing (DON) said it was a hospice CNA who was texting while assisting Resident #24 with feeding. The DON said no staff member should be using their cell phone while assisting a Resident with feeding and Resident #24 should have a dignified dining experience.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on record review and interview the facility failed to ensure Residents were delivered mail on Saturday. Findings include: During the Resident Group Meeting conducted on 5/14/25 at 10:45 A.M. and attended by twelve residents. Multiple residents said they do not get mail delivered on Saturdays. A few residents said they are expecting deliveries of mail. The residents said it is written someplace on the bulletin board. Upon completion of the meeting, one resident directed the surveyor to the Activity Calendar on a large bulletin board. Review of the calendar revealed *Personal Mail will be distributed Mon-Friday. During an interview on 5/14/25 at 12:07 P.M., the Administrator said he was not aware the Activity Calendar indicated mail was delivered Mon-Friday, and did not include Saturday delivery. The Administrator said that was not right.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents at risk for developing pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing for two Resident (#24 and #53) out of a total of 22 Residents. Specifically, the facility failed to ensure the Resident's air mattress were set at the correct setting according to the physician's order. Findings include: Review of the facility policy titled Prevention of Pressure Injuries, dated and revised April 2020, indicated the following: - Support Surfaces and Pressure Redistribution: Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. Resident #24 was admitted to the facility in November 2024 with diagnoses including Parkinsonism, stage 4 pressure ulcer of sacral region, and unspecified protein calorie malnutrition. Review of Resident #24's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has one stage 4 pressure ulcer and is at risk of developing pressure ulcers and is dependent on staff for all activities of daily living. The surveyor made the following observations: - On 5/13/25 at 9:40 A.M.,12:05 P.M. and 4:25 P.M., Resident #24 was lying on his/her bed. An air mattress was present and operating and was set to the first bar which indicated the softest setting. Next to the setting dial was a diagram indicating what each setting's corresponding weight setting should be. The setting at which Resident #24's air mattress pump was set to was for 50 pounds. - On 5/14/25 at 6:52 A.M., and 8:31 A.M., Resident #24 was sleeping in his/her bed. An air mattress was present and operating and was set to the first bar which indicated the softest setting. Next to the setting dial was a diagram indicating what each setting's corresponding weight setting should be. The setting at which Resident #24's air mattress pump was set to was for 50 pounds. Review of Resident #24's Physician's order dated 11/22/24 indicated the following: - Alternating pressure air mattress set to 150, check setting q (every) shift. Review of Resident #24's most recent weight dated 5/8/25 indicated that the Resident last weighed 91.5 lbs. (pounds). Review of Resident #24's skin integrity risk and sacral pressure ulcer care plan dated 11/21/24, indicated the following intervention: Air mattress as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's Norton's Scale for Predicting Pressure Ulcers (an assessment that indicates the risk of developing pressure ulcers) dated 4/10/24 indicated that the Resident scored a 6 which indicates the Resident is at a high risk of developing pressure ulcers. During an interview on 5/14/25 at 8:55 A.M., Nurse #1 said air mattress settings are set to each resident's weight and by physician's order. During an interview on 5/14/25 at 10:05 A.M., Unit Manager #1 said air mattress settings are set by a resident's weight. Unit Manager #1 reviewed Resident #24's weight and the surveyor's photo of the air mattress pump and she said the settings are too low and they need to be adjusted. Unit Manager #1 said if the air mattress settings are too low it could affect Resident #24's skin and increase pressure ulcer risk. During an interview on 5/14/25 at 10:22 A.M., the Director of Nursing (DON) said air mattress settings should be set by a resident's weight and by the physician's order. The DON reviewed the surveyor's photo of Resident #24's air mattress settings, and she said it was set too low. 2.Resident #53 was admitted to the facility in March 2024 with diagnoses including adult failure to thrive. Review of Resident #53, the most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 2 out of a total possible 15 on the Brief Interview for Mental Status indicating he/she was severely cognitively impaired. The MDS further indicated the Resident was dependent for positioning and was at risk for developing pressure ulcers. On 5/13/25 at 8:07 A.M., the Surveyor observed Resident #53 lying in his/her bed. The air mattress was set at 380 lbs. (pounds). On 5/13/25 at 12:16 P.M., the Surveyor observed Resident #53 lying in his/her bed. The air mattress was set at 380 lbs. (pounds). On 5/13/25 at 4:28 P.M., the Surveyor observed Resident #53 lying in his/her bed. The air mattress was set at 380 lbs. (pounds). Staff entered the Resident's room and repositioned him/her. On 5/14/25 at 7:49 A.M., the surveyor and Nurse #1 observed the Resident lying in his/her bed the air mattress was set at 380 lbs. Nurse #1 said the air mattress should not be set that high as the Resident weighed less than 100 lbs. Review of the physician's order dated 8/26/24 indicated the following: -Air mattress with bolsters on bed set at 150 check setting every shift. Review of care plan Resident has potential for skin/tissue integrity risk related to decreased mobility, dated 4/3/25 indicated the following intervention: -Air mattress with bolsters on bed check each shift for proper inflation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 7:49 A.M., Nurse #1 said she had not done her rounds yet to ensure air mattress was in the correct setting, she said nurses are responsible for ensuring correct setting every shift. During an interview on 5/14/25 at 8:35 A.M., Unit Manager #1 said air mattresses are set to resident's weights and that Resident #53's air mattress should be set to less than 100lbs and not 380 lbs. During an interview on 5/14/25 at 10:31 A.M., the Director of Nursing said physician orders should be followed for proper air mattress setting.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to provide continued therapy services and recommended by the Occupational Therapist for one Resident #24 out of a total sample of 22 Residents. Specifically, the facility failed to ensure that Resident #24 continued to receive Occupational Therapy services as recommended for the use of a hand orthotic while under hospice services. Findings include: Review of the facility policy titled Scheduling Therapy Services, dated and revised July 2013, indicated the following: - Therapy services shall be scheduled in accordance with the resident's treatment plan. - The therapist shall interview the resident and consult with the attending physician as to the type of treatment to be administered. - Therapy is scheduled in coordination with nursing service and is documented in the resident's medical record. - Nursing service shall be responsible for preparing and escorting the resident to the therapy area unless such treatment is scheduled in the resident's room. Resident #24 was admitted to the facility in November 2024 with diagnoses including Parkinsonism, pressure ulcer of sacral region, stage 4 and unspecified protein calorie malnutrition. Review of Resident #24's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has upper extremity impairment on one side and is dependent on staff for all Activities of Daily Living. During an observation on 5/13/25 at 9:40 A.M., Resident #24 was lying in his/her bed, his/her left hand was clenched in a fist position. The surveyor asked and motioned if the Resident was able to open his/her left hand, the Resident attempted to but was unable to. The surveyor did not observe any handroll or splinting device in the Resident's room. During observations throughout the survey period from 5/13/25 through 5/14/25, the surveyor did not observe any hand splint device or any orthotics in use or in Resident #24's bedroom. Review of Resident #24's visits from the Nurse Practitioner (NP) indicated the following: - Dated 3/20/25: Left hand in fist while in resting position. Able to open with some stiffness noted. PLAN: spoke with DOR (Director of Rehab) regarding stiffness to left hand. Therapy to evaluate as member may benefit from handroll. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 3/25/25: Left hand in fist with flexed wrist while in resting position. Able to open with some stiffness noted. Seen by OT (Occupational Therapist) with plans for splint. SW (social worker) met with HCP (health care proxy) earlier today, agreeable to hospice at home. Hospice referral placed while at SNF (senior nursing facility). - Dated 4/3/25: Left hand in fist with flexed wrist while in resting position. Able to open with some stiffness noted. Seen by OT with plans for splint. Review of Resident #24's Occupational Therapy Evaluation and Plan of Treatment dated 3/24/25 indicated the following: - Reason for Referral/Current Illness: Pt is a 79 y/o male/female who been a LTC (long term care) resident of this facility who was referred to OT services to assess L (left) hand for hand roll due to limited ROM (range of motion)/increased tightness in flexed position. - Assessment Summary: Pt noted to have pain with L wrist and hand movement. Pt would benefit from OT services to address deficits with limited L wrist and hand ROM and splinting for proper positioning of L UE (upper extremity). Review of Resident #24's Occupational Therapy Discharge summary dated [DATE] indicated the following: - Discharge Recommendations and Status: Pt seen for OT evaluation only due to pt transitioning to Hospice Care. Recommend splinting care under Hospice services. Review of Resident #24's physician's order dated 3/25/25 indicated the following: Hospice evaluation and admit if appropriate. Review of Resident #24's care plans failed to indicate a care plan for the use of Occupational Therapy or the use of any hand orthotic/device. During an interview on 5/14/25 at 8:03 A.M., Certified Nursing Assistant (CNA) #1 said Resident #24's hand has always been flexed in a fist position and she does not remember ever seeing a hand towel or splint in use. During an interview on 5/14/25 at 8:55 A.M., Nurse #1 said Resident #24 was admitted with his/her hand flexed and tightened. Nurse #1 said when therapy services make recommendations, they will tell nursing who will ensure an order gets implemented. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 9:27 A.M., the Director of Rehab (DOR) said residents are seen by therapy upon admission to the facility, quarterly and if nursing makes a request for the resident to be seen by therapy services. The DOR said if therapy recommendations are made, we would evaluate the resident, make a care plan and have a physician's order implemented for any recommendations made by therapy. The DOR then said Resident #24 was referred to OT by the Nurse Practitioner due to his/her left hand positioning. The DOR said after the NP made the recommendations for OT, Resident #24 was admitted to hospice services on 3/25/25 so the Resident did not see OT. The DOR reviewed the NP recommendation on 4/3/25, eight days after Resident #24 was admitted to hospice services, the DOR said she did not know the NP still planned for a hand splint. The DOR then reviewed the OT Discharge summary dated [DATE] and she was not aware that the OT recommended splinting care under hospice services. The DOR said the facility should have coordinated with hospice services to ensure that Resident #24 was being evaluated by OT to see if a splint would be recommended. During an interview on 5/14/25 at 10:22 A.M., the Director of Nursing (DON) said Therapy should have followed up with hospice services to see if therapy would be recommended and to see if a hand device would be appropriate for Resident #24. During a follow up interview on 5/14/25 at 10:58 A.M., the DOR said she spoke with hospice services, and they approved Resident #24 to be seen by OT. The DOR said she evaluated Resident #24 and she is trialing the use of a hand roll for Resident #24 now.

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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** Based on observation, record review and interview, the facility failed to ensure practices to support nutritional needs for one Resident (#48), out of a total sample of 22 residents were implemented in accordance with professional standards of care. Specifically, Resident #48, who was assessed for nutritional risk, experienced a severe weight loss, which was not evaluated by the registered dietitian. Findings include: Review of the facility's policy titled, Weight Assessment and Intervention, revision date March 2022 indicated the following: Residents weights are monitored for undesirable and unintended weight loss or gain. Weight Assessment 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team., 2. Weights are recorded in each unit's weight record or chart and in the individual's medical record. 3. Any wight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. if the weight is verified, nursing will immediately notify the dietician in writing. 4. Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss=(usual weight-actual weight)/(usual weight) x 100): a. 1 month-5% wight loss is significant; greater than 5% is severe. b. 3 months-7.5 % weight loss is significant; greater than 7.5 % is severe. c. 6 months-10% wight loss is significant; greater than 10 % is severe. Resident #48 was admitted to the facility in July 2024 and has diagnoses that include but are not limited to Parkinson's disease without dyskinesia, unspecified dementia, and depression. Review of the most recent comprehensive Minimum Data Set assessment dated [DATE], indicated Resident #48 scored an 8 out of 15 on the Brief Interview for Mental Status exam, indicating Resident #48 has moderately impaired cognition. Further, the MDS indicated Resident #48 requires supervision or touching assistance to eat, is 71 (5 foot nine inches) in height and weighs 130 pounds and is on a mechanically altered diet. On 5/13/25 at 7:44 A.M., and 8:31 A.M., Resident #48 was observed on his/her back in bed. Resident #48 did not respond to the surveyors greeting. Resident #48 was administered oxygen through a nasal cannula and looked to be frail and dependent. An open carton of Ensure (a dietary supplement) was on his/her bedside table. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 12:26 P.M., Resident #48 was sitting up in bed with a Certified Nursing Assistant (CNA) assisting him/her with eating his/her lunch. CNA # 3 said Resident #48 eats a little at a time and needs assistance. On 5/14/25 at 8:30 A.M., Resident #48 was observed sitting up in a wheelchair eating his/her breakfast. Resident #48 was feeding him/herself. His/her tray consisted of a pureed entree, whole milk, mighty shake (a dietary supplement), and hot cereal. The food was partially consumed by Resident #48. Review of Resident #48's care plan with the focus: Resident is at nutrition related risk d/t (due to) altered skin integrity and pmh (past medical history) including dementia, DVT (deep vein thrombosis) PNA (pneumonia) Parkinson's, TIA (transient ischemic attack), and depression. Date initiated 7/24/24 Goal: 1. Maintain a weight free from significant changes. 2. PO (by mouth) intake to meet daily nutrition and hydration needs. 3. Tolerates diet/textures a/o (as ordered), 4. Nutritional related labs wnl (within normal limits) and 5. Improved skin integrity, date initiated 7/24/2024 revision on 4/4/2025. Interventions included but not limited to Monitor/Record/report to MD (medical doctor) s/sx (signs /symptoms of malnutrition: Emaciation (cachexia) muscle wasting, significant weight loss: 3 lbs. (pounds) in 1 week, greater than 5% in 1 month, greater than 7. 5% in 3 months, and greater than 10% in 6 months. RD (registered dietitian) to evaluate and make diet change recommendations PRN (as needed). Review of Resident #48's medical record indicated in part, the following on the weights and vitals summary. -10/4/2024 170.1 (sitting) -10/9/2024 167.6 (sitting -10/16/2024 165.6 (sitting) -10/24/2024 167.4 (sitting) -11/2/2024 167.4 (sitting -11/8/2024 168.6 (sitting) -11/13/2024 168 lbs. (sitting) -11/20/2024 166.8 lbs. (sitting) -12/4/2024 167.2 lbs. (sitting) -1/5/2025 166 lbs. (sitting) -1/23/2025 144 lbs. (sitting) a 13.25 % loss of total body weight since 1/5/25, 19 days, which meets the criteria of severe weight loss. -1/30/2025 140.8 lbs. (mechanical lift) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/21/2025 130 lbs. (bed scale) -4/7/2025 131 lbs. (mechanical lift) -5/14/2025 132.1 lbs. (mechanical lift) Review of Resident 48's medical record did not indicate Resident #48 was in the hospital from 10/4//24 through 1/23/25 when Resident #48 sustained a severe weight loss. Review of Resident #48's active physician's orders indicated the following: Diet-order summary, -regular diet pureed texture. Thin liquids consistency, order date 1/22/2025 Dietary Supplements order summary -Ensure three times a day or nutritional equivalent order date 5/14/2025 -Mighty shake three times a day or nutritional equivalent order date 1/16/2025 -ProSource/liquid Protein (30 ml) two times per day, order date 5/142025. Review of active and discontinued dietary orders failed to indicate any new dietary orders were entered after the severe weight loss experienced by Resident #48 on 1/23/25 until 5/14/25. Review of Resident #48's medical record indicated the following: -A [NAME]-Nutrition Assessment Comprehensive with an effective date 7/24/2024 indicated a BMI (body mass index) of 20.9, most recent weight 149.9. oral supplement 237 ml Ensure TID (three times a day). -A [NAME]-Nutritional Assessment with an effective date 10/15/2024 with a most recent weight of 167.6 and BMI of 23.4. Oral supplement 237 ml Ensure TID (three times a day). -A [NAME]-Nutritional Assessment Comprehensive with an effective date 1/15/2025 with the most recent date weight of 166.0 and a BMI of 23.1, with Oral supplement to include: liquid protein and BID (twice a day) mighty shake TID (three times a day) Resident now receiving regular/pureed diet with thin liquids. Will cont. (continue) to monitor. Review of Resident #48's medical record failed to indicate a nutritional assessment was conducted when Resident #48's weight went from 166 pounds on 1/5/25 to 144 pounds on 1/23/25 a 13.25 % severe weight loss, occurring a week after the [NAME]-Nutritional Assessment Comprehensive dated 1/15/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225489	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvidere Healthcare Center	500 Wentworth Avenue Lowell, MA 01852

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated a progress note dated 1/16/25 and entered by the Registered Dietitian indicated: RT (resident) with poor intake and altered skin integrity. Diet orders remain appropriate with textures per the SLP (speech language pathologist) Rec [recommend] add 30 ml liquid protein BID (twice a day) and mighty shake TID (three times a day) to better meet nutrition needs. Will continue to monitor. Review of the medical record indicated a [NAME]-Nutrition Assessment Comprehensive dated 3/26/2025, 63 days since Resident #48 sustained a severe total weight loss of 13.25 % in one week and continued to have weight loss as indicated by the weight entered on 1/30/25 at 140.8 lbs. equaling a 15.18 % of total body weight. indicated the most recent weight of 130.0 lbs. and a BMI of 18.1. During an interview on 5/14/25 at 9:57 A.M., Unit Manager #1 said Resident #48 was monitored closely for weight loss. She said Resident #48 was at baseline and began to stop eating and drinking around January. Unit Manager #1 said Resident #48 was downgraded to puree diet texture change which he/she did not like and may have contributed to the weight loss. Unit Manager #1 said the Dietitian is involved in risk meetings where Residents are reviewed for weight loss. Unit Manager #1 said Resident #48 did have supplements ordered. Unit Manager #1 said the family was aware and a decision was made to put Resident #48 on hospice services. During an interview on 5/14/25 at 10:11 A.M., the Registered Dietitian (RD) said she is in the facility two times a week. The RD said on admission all residents are assessed, and a nutritional care plan is implemented as most residents are at some nutritional risk. The RD said residents are followed for the length of their stay. RD said she runs weight reports each week which tells her if there are any weight changes for residents including gains or losses. The RD said if there is a 3 lb. weight change a re-weigh is obtained to determine if it is significant or not and she will assess the resident to see if new interventions are required. The RD reviewed Resident #48's weights entered into the medical record. The RD said Resident #48 was on hospice. The RD said Resident #48 was followed in risk meetings. The RD said Resident #48 had desired weight gain after admission, and she assessed him/her in January before the significant weigh loss occurred. The RD reviewed the record and said she did not enter a note that she was aware of the significant/severe weight loss or that she re-evaluated Resident #48's nutritional status after the significant weight loss. The RD said she should have conducted an assessment or a thorough review of Resident #48's weight loss, even if he/she was signing on to hospice. During an interview on 5/14/25 at 12:47 P.M., the Director of Nursing (DON) said weights are entered in the electronic medical record and reviewed for gains or loss. The DON said Resident #48 was followed in risk meetings and the RD is present at the meetings. The DON said the RD drives the care plan for nutritional care planning and interventions and should have provided an assessment/evaluation after Resident #48 sustained a significant (severe) weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225489	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvidere Healthcare Center	500 Wentworth Avenue Lowell, MA 01852

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure standards of practice to prevent the spread infection were implemented. Specifically, a Laboratory Technician providing laboratory services to residents, failed to adhere to infection control practices when she placed her bag, which she uses to store supplies and specimens and uses in other facilities, on top of a resident's bed. Findings include: During an observation on 5/13/25 at 11:36 A.M., a Laboratory Technician was observed in a resident room occupied by two residents. The room was marked by a sign at the door indicating enhanced barrier precautions. The Laboratory Technician's bag with her supplies was on top of the resident's bed and in contact with the linen. The lab technician did the blood draw to the resident in bed 2 and then moved to the bedside table of the resident in bed one to fill out a form and then removed her gloves and placed the specimen in a plastic bag and into the bag that was on the bed. During an interview on 5/13/25, when the Laboratory Technician exited the room, the Laboratory Technician said she goes to assisted living and nursing homes during the day to draw blood. The Laboratory Technician said she has been educated on infection control and uses PPE (personal protection equipment) as needed and always uses gloves. The Laboratory Technician said she put the bag on the resident's bed because it fell off the counter. The Laboratory Technician demonstrated that the bag had wheels used to push or pull the bag on the floor. During an interview on 5/14/25 at 8:39 A.M., Nurse #4 who was caring for the residents in the room, said the resident in bed 2 had laboratory services on 5/13/25. Nurse #4 said the Laboratory Technician should be following infection control guidance while performing services for the facility and said the bag should not be on a resident's bed. During an interview on 5/14/25 at 9:56 A.M., Unit Manager #1 said the Laboratory Technician should be following infection control practices when they are providing a service in the facility. During an interview on 5/14/25 at 7:52 A.M., the Infection Preventionist said she expects vendors, including laboratory technicians, to follow the facility's infection control practices, including standard precautions. The Infection Preventionist said the Laboratory Technician should not place an unclean bag that is in regular contact with the floor on top of a resident's bed or linen. The Infection Preventionist said this breach could potentially contaminate the bed and linen.