

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER D'Youville Senior Care		STREET ADDRESS, CITY, STATE, ZIP CODE 981 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>37342</p> <p>Based on records reviewed and interviews, for two of three sampled residents, (Resident #1 and Resident #2) the Facility failed to ensure they maintained complete and accurate medical records, when 1) a signed informed written consent was not obtained for Resident #1 related to the administration of psychotropic medications, as required and 2) nursing documentation for Resident #2 related to the conduction of weekly skin assessments was incomplete, and assessments missing.</p> <p>Findings include:</p> <p>The Facility policy, titled Documentation in the Medical Record, dated 11/29/23, indicated each resident's medical record would contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through accurate and timely documentation.</p> <p>1) Review of the Circular Letter 17-2-699 issued by the Massachusetts Department of Public Health, dated 02/01/17, indicated that in order to meet M.G.L Section 72 BB of Chapter 111 requirements for documenting informed consent, the Facility must have completed the Department's prescribed form prior to or upon administration and include the form in the resident's medical record. The Circular Letter indicated written informed consent must be completed, including all necessary signatures, prior to or upon administration, and included in the resident's medical record. Further review of the Circular Letter indicated verbal consent by telephone, even if witnessed by a second staff member of the Facility, did not constitute written consent.</p> <p>The Facility's policy, titled Use of Psychotropic Medications, dated 01/30/24, indicated for each psychotropic medication ordered, consent, either verbal or written from the resident or their representative, would be obtained prior to initiation of the medication, verbal consent would be documented in the interdisciplinary notes as well as in the consent form, and any if a resident was placed on a dose outside the expected range, a new consent would be signed. The Policy indicated the completed, signed, and dated consent would be filed in the resident's medical record.</p> <p>Resident #1 was admitted to the Facility in May 2023, diagnoses included dementia, anxiety, and insomnia.</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Health Care Proxy Activation Form, dated 05/31/23, indicated his/her Health Care Proxy was activated indefinitely, and his/her Health Care Agent (HCA) was responsible for making health care decisions.</p> <p>Review of Resident #1's Order Recap Report, dated 10/01/23 through 02/15/24, indicated he/she had physician orders for the following:</p> <p>A physician's order, dated 10/24/23 for Lorazepam (anxiolytic) 0.5 milligrams (mg) sublingually (under the tongue) every two hours as needed for anxiety/agitation.</p> <p>A physician's order, dated 12/27/23 for Lorazepam 0.5 mg sublingually every day at bedtime before left foot dressing change.</p> <p>Review of Resident #1's Medication Administration Records (MARs) for October 2023, November 2023, December 2023, January 2024, and February 2024 indicated he/she was administered Lorazepam as ordered.</p> <p>Review of Resident #1's Consent Form for the administration of Anxiolytics/Sedatives/Hypnotics, dated 10/25/23, indicated Nurse #1 obtained verbal consent for the administration of Lorazepam 0.5 mg sublingually every two hours as needed from Resident #1's Health Care Agent (HCA) over the phone.</p> <p>Further review of Resident #1's Consent Form for Anxiolytics/Sedatives/Hypnotics indicated the form was not signed by his/her HCA, and did not include documentation that his/her HCA understood the risks and benefits of the use of Lorazepam.</p> <p>Further Review of Resident #1's Medical Record indicated there was no Consent Form for administration of his/her additional dose of an Anxiolytics/Sedatives/Hypnotics documented when the order, dated 12/27/23 for Lorazepam 0.5 mg sublingually every day at bedtime before left foot dressing change was obtained.</p> <p>During an interview on 08/21/24 at 2:20 P.M., the Director of Nurses said informed written consent should be obtained and signed by the resident or their representative whenever a psychotropic medication was ordered and administered, but for Resident #1, it was not.</p> <p>2) The Facility Policy, titled Wound and Skin Care- Skin Assessment, updated 06/26/24, indicated nursing would complete a full body skin check for each resident, and would document the observations in the medical record.</p> <p>Resident #2 was admitted to the Facility in August 2019, diagnoses included chronic obstructive pulmonary disease, chronic congestive heart failure, repeated falls, and dementia.</p> <p>Review of Resident #2's Skin Integrity Care Plan, dated as revised 05/24/24, indicated nursing would complete a weekly skin check.</p> <p>Review of the Weekly Skin Check Schedule for the B Unit indicated Resident #2 was scheduled for weekly skin checks on Thursdays during the 11:00 P.M., to 07:00 A.M., shift.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Medical Record indicated there was no documentation to support that weekly skin checks were completed on 08/01/24, and 08/15/24.</p> <p>During a telephone interview on 08/23/24 at 1:57 P.M., the Director of Nurses (DON) said nurses were expected to complete weekly skin checks for each resident, and document it in their electronic medical record on the residents' Weekly Skin Check assessment tool. The DON said there is a binder on each unit with the weekly skin check schedule, that nursing is expected to follow that schedule and said Resident #2 should have had skin checks completed by nursing every Thursday but did not.</p>		