STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225515	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	981 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on records reviewed and interviews, for one of four sampled residents (Resident #3), who was moderately cognitively impaired and dependent on staff to meet his/her care needs, the facility failed to ensure he/she was treated in a dignified and respectful manner when Hospice Aide #1 was witnessed by staff on more than one occasion respond to Resident #1's adverse behavior by insulting and calling him/her names, and did so in a demeaning manner.Findings include:Review of Facility Policy titled Resident Rights, dated 04/23/23, indicated the facility will protect and promote the rights of the resident and afford each resident his or her basic right to be treated with dignity and respect. The Policy indicated the facility will ensure that all residents are afforded the right to a dignified existence, self determination, respect full recognition of their individuality, consideration and privacy in treatment and care for personal needs. The Policy indicated that all personnel are required to protect and promote the rights of each resident, as well as encourage and assist each resident in the fullest possible exercise of their rights.Review of Resident #3's clinical record indicated his/her diagnoses included Traumatic Brain Injury, Morbid Obesity and Major Depressive Disorder.Review of Resident #3's Significant Change in Status Minimum Data Set assessment, dated 10/21/25, indicated he/she required maximum assistance with activities of daily living, had moderately impaired cognition, and displayed physical, verbal and other behavioral symptoms towards others.During an interview on 01/13/26 at 11:45 A.M., Resident #3 said one day around 10:00 A.M. (exact date unknown), a Hospice Aide (identified as Hospice Aide #1) called him/her a pig and said she'd take him/her to the slaughterhouse to get him/her slaughtered. Resident #3 said a Certified Nurse Aide (later identified as CNA #4) was present when it happened. Resident #3 said Hospice Aide #1 told him/her that he/she was a dog and said that he/she used to live in a cage. Resident #3 said CNA #4 did not say or do anything in response. Resident #3 said he/she told Hospice Aide #1 not to call him/her names. Resident #3 said Hospice Aide #1 made him/her feel terrible.During an interview on 01/13/26 at 3:10 P.M., CNA #4 said on two or three occasions (unable to recall exact dates) she witnessed Hospice Aide #1 be verbally abuse toward Resident #3 while assisting with care. CNA #4 said the first incident occurred around three to four weeks ago. CNA #4 said Hospice Aide #1 had asked for assistance because Resident #3 had directed racial slurs at her. CNA #4 said while in the room, Resident #3 swore and directed racial slurs at Hospice Aide #1, and Hospice Aide #1 responded back and called Resident #3 a fat pig and told him/her they're going to put you in a butcher shop because you have so much meat on you, and then Hospice Aide #1 laughed at Resident #3. CNA #4 said she could not recall all the statements Hospice Aide #1 made to Resident #3 but said this is what she most vividly recalled what was stated to Resident #3 during the incidents. CNA #4 said she felt uncomfortable but did not tell Hospice Aide #1 to stop speaking to Resident #3 in that manner. During an interview on 01/13/26 at 9:30 A.M., the Assistant Director of Nurses (ADON) said on 01/02/26 she interviewed CNA #4 as a part of a facility investigation related to Hospice Aide #1. The ADON said CNA #4 told her she (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witnessed Hospice Aide #1 call Resident #3 a fat pig and say to Resident #3 that they will put you in a butcher shop because you have so much meat on you. The ADON said CNA #4 had not reported this altercation between Resident #3 and Hospice Aide #1 prior to their conversation on 01/02/26. During a telephone interview on 01/15/26 at 3:00 P.M., CNA #5 said sometime around 12/25/25, Hospice Aide #1 requested she assist her and CNA #4 with Resident #3. CNA #5 said when she entered the room, Resident #3 directed a racial slur at Hospice Aide #1. CNA #5 said Hospice Aide #1 immediately said to Resident #3 that if she was a (quoting the racial slur), than you (Resident #3) are fat. CNA #5 said she just continued to assist Hospice Aide #1 with care and did not tell Hospice Aide #1 that it was not acceptable to call Resident #3 names. CNA #5 said since CNA #4 was in the room at the time, she assumed CNA #4 would report the incident, because she was Resident #3's assigned aide.During an interview on 01/13/26 at 4:00 P.M., the ADON said CNA #5 told her today (01/13/26, the day of the survey) that she witnessed Hospice Aide #1 call Resident #3 fat.During a telephone interview on 01/15/26 at 11:00 A.M., the Director of Nurses (DON) said she, along with the ADON and Administrator met with CNA #5 on 01/14/26. The DON said CNA #5 stated that sometime around 12/25/25, after Resident #3 directed a racial slur at Hospice Aide #1, Hospice Aide #1 replied that if she was a (quoting the racial slur) than you (Resident #3) are fat, how do you like that.During a telephone interview on 01/27/26 at 11:40 A.M., the Administrator said no one employed in this environment should speak to a resident in the manner Hospice Aide #1 spoke to Resident #1. The Administrator said residents need to be treated with dignity and not spoken to in an offensive manner.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on records reviewed and interviews, for two of four sampled residents (Resident #1, Resident #3), the facility failed to ensure staff consistently implemented and followed their abuse policy related to protecting residents and reporting abuse allegations, when 1) on 12/19/25 Resident #1 reported to Nurse #1 that he/she had been slapped in the face, and 2) despite multiple staff member witness Hospice Aide #1 allegedly verbally abuse Resident #3, neither of these incidents were immediately reported to a Supervisor or Administrative staff, as required. Findings included: Review of Facility Policy titled Abuse, Neglect and Exploitation, dated 05/28/25, indicated the home will report all alleged violations to the Administrator, Medical Director, state agency, adult protective services and to all other required agencies immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse. The Policy indicated it would achieve in providing staff information on how and to whom they may report concerns and incidents without fear of retribution, and assigning responsibility for the supervision of staff on all shifts for identifying inappropriate behaviors. The Policy indicated the home will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The Policy indicated efforts are not limited to responding immediately to protect the alleged victim and integrity of the investigation, removal of the alleged perpetrator(s) from the facility, and staffing changes if necessary to protect the resident from the alleged perpetrator.1) Review of Resident #1's clinical record indicated his/her diagnoses included Dementia, Osteoarthritis, and Mood DisorderDuring a telephone interview on 01/15/25 at 2:20 P.M., Certified Nurse Aide (CNA) #2 said on 12/19/25 around 7:00 P.M., while she and CNA #1 were transferring Resident #1 to bed, she heard a slap sound and immediately thereafter a cry from Resident #1. CNA #2 said Resident #1 yelled out she slapped me, swore at CNA #1 and held his/her face. CNA #2 said the door to the room opened, and Nurse #1 asked them if Resident #1 was slapped. CNA #2 said she did not recall what was said, and that Nurse #1 left the room. CNA #2 said after she and CNA #1 finished caring for Resident #1, they left the room and Nurse #1 told her to report the incident. CNA #2 said she immediately reported the incident to the Nursing Supervisor, which was around 30 minutes after Resident #1 alleged to have been slapped. During an interview on 01/13/26 at 4:15 P.M., Nurse #1 said in the evening on 12/19/25 (exact time unknown) she heard a slap sound, followed by a scream from Resident #1's room. Nurse #1 said she immediately left her medication cart located outside Resident #1's room and entered. Nurse #1 said CNA #1 and CNA #2 were in the room with Resident #1. Nurse #1 said she asked (to neither in particular) did you slap Resident #1? Nurse #1 said one of the two CNAs replied no. Nurse #1 said Resident #1 covered his/her face and said she hit my face, I can't see. Nurse #1 said she stepped out of the room and returned to her work at the medication cart since one of the CNAs replied no and assumed no one had hit Resident #1. Nurse #1 said she waited about 15 minutes until CNA #1 and CNA #2 finished caring for Resident #1, had exited his/her room, and then asked CNA #2 what happened in Resident #1 room. Nurse #1 said that CNA #2 (who seemed visibly shaken) replied that she did not know why people can't control their temper. Nurse #1 said without asking for further clarification from her, she told CNA #2 to go report whatever she saw to the Nursing Supervisor. Nurse #1 said the Nursing Supervisor ensured CNA #1 and CNA #2 were removed from resident care areas for further investigation. Nurse #1 said she should have intervened immediately by asking CNA #1 and CNA #2 to leave Resident #1's room, and she should have reported the allegation of physical abuse immediately to the Nursing Supervisor. During an interview on 01/13/26 at 2:45 P.M., the Nursing Supervisor said on 12/19/25 at around 8:00 P.M. CNA #2 reported to her that CNA #1 allegedly slapped Resident #1. The Nursing (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisor said she immediately contacted the Director of Nurses and removed CNA #1 from the unit.During an interview on 01/13/26 at 10:00 A.M., the Director of Nurses (DON) said the Nursing Supervisor notified her in the evening on 12/19/25 that it was alleged CNA #1 slapped Resident #1. The DON said based on facility investigation, Nurse #1 should have immediately removed CNA #1 and CNA #2 from Resident #1's room when she heard and suspected that he/she was slapped by one of the CNAs, instead of allowing for the completion of his/her care. 2. Review of Resident #3's clinical record indicated his/her diagnoses included Traumatic Brain Injury, Morbid Obesity, and Major Depressive Disorder.During an interview on 01/13/26 at 11:45 A.M., Resident #3 said one day around 10:00 A.M. (exact date unknown), a Hospice Aide (identified as Hospice Aide #1) called him/her a pig and said she'd take him/her to the slaughterhouse to get him/her slaughtered. Resident #3 said a Certified Nurse Aide (later identified as CNA #4) was present when it happened. Resident #3 said Hospice Aide #1 told him/her that he/she was a dog and that he/she used to live in a cage. Resident #3 said CNA #4 did not say or do anything in response, to Hospice Aide #1's comments.During an interview on 01/13/26 at 3:10 P.M., CNA #4 said on two or three occasions (unable to recall exact dates) she witnessed Hospice Aide #1 allegedly verbally abuse Resident #3. CNA #4 said the first incident occurred around three to four weeks ago. CNA #4 said Hospice Aide #1 asked for assistance because Resident #3 had directed racial slurs at her. CNA #4 said while in the room, Resident #3 swore and directed racial slurs at Hospice Aide #1, and Hospice Aide #1 responded back and called Resident #3 a fat pig and told him/her they're going to put you in a butcher shop because you have so much meat on you, and then Hospice Aide #1 laughed at Resident #3. CNA #4 said she did not report any of these incidents of alleged verbal abuse until she was interviewed as a part of a Facility investigation related to Hospice Aide #1.During an interview on 01/13/26 at 9:30 A.M., the Assistant Director of Nurses (ADON) said on 01/02/26 she interviewed CNA #4 as a part of a facility investigation related to Hospice Aide #1. The ADON said CNA #4 told her she witnessed Hospice Aide #1 call Resident #3 a fat pig and say to Resident #3 that they will put you in a butcher shop because you have so much meat on you. The ADON said CNA #4 had not reported that Resident #3 was allegedly verbally abused by Hospice Aide #1 prior to their conversation on 01/02/26. During a telephone interview on 01/15/26 at 3:00 P.M., CNA #5 said sometime around 12/25/25, when she entered Resident #3's room, Resident #3 directed a racial slur at Hospice Aide #1. CNA #5 said Hospice Aide #1 immediately said if she was a (quoting the racial slur), then you (Resident #3) are fat in a matter-of-fact tone. CNA #5 said since CNA #4 was in the room at the time, she assumed CNA #4 would report it as Resident #3's assigned aide. CNA #5 said although she initially denied any knowledge of Resident #3 being verbally abused during a facility investigation, she later decided to report the incident on 01/13/26 (during the Department of Public Health investigation).During an interview on 01/13/26 at 4:00 P.M., the Assistant Director of Nurses (ADON) said CNA #5 told her today (01/13/26, the day of the survey) that she lied a few weeks ago when questioned if she witnessed Resident #3 being verbally abused by Hospice Aide #1. The ADON said CNA #5 told her she had witnessed Hospice Aide #1 call Resident #3 fat and had not previously reported it to anyone.During a telephone interview on 01/15/26 at 11:00 A.M., the Director of Nurses (DON) said CNA #5 denied any knowledge when asked by the ADON on 01/02/26 if Resident #3 had been allegedly verbally abused by the Hospice Aide. The DON said she, along with the ADON and Administrator met with CNA #5 on 01/14/26, and CNA #5 stated to them that sometime around 12/25/25, after Resident #3 directed a racial slur at Hospice Aide #1, Hospice Aide #1 replied that if she was a (quoting the racial slur) than you (Resident #3) are fat, how do you like that. The DON said CNA #5 told them that when she was initially interviewed (on 01/02/26), she lied because it was her day off from work and did not want to (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be asked to come into the Facility to provide information. The ADON said CNA #5 told her because she did not report it immediately, she lied to avoid getting in trouble. The DON said staff were expected to report allegations of abuse immediately per Facility's Abuse Policy.During an interview on 01/13/26 at 2:25 P.M., the Administrator said it was the facility's expectation that staff immediately report allegations of suspected abuse per facility policy, and through training provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for one of three sampled Residents (Resident #3) the facility failed to ensure that staff immediately reported incidents of alleged verbal abuse to administration staff as required, so they could report timely to the necessary state agencies.Findings include:Review of Facility Policy titled Abuse, Neglect and Exploitation, dated 05/28/25, indicated the home will report all alleged violations to the Administrator, Medical Director, state agency, adult protective services and to all other required agencies immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse. Review of Resident #3's clinical record indicated his/her diagnoses included Traumatic Brain Injury, Morbid Obesity, and Major Depressive Disorder.During an interview on 01/13/26 at 11:45 A.M., Resident #3 said one day around 10:00 A.M. (exact date unknown), a Hospice Aide (identified as Hospice Aide #1) called him/her a pig and said she'd take him/her to the slaughterhouse to get him/her slaughtered. Resident #3 said a Certified Nurse Aide (later identified as CNA #4) was present when it happened. Resident #3 said Hospice Aide #1 told him/her that he/she was a dog and that he/she used to live in a cage. Resident #3 said CNA #4 did not say or do anything in response to Hospice Aide #1's remarks.During an interview on 01/13/26 at 3:10 P.M., CNA #4 said on two or three occasions (unable to recall exact dates) she witnessed Hospice Aide #1 interact with Resident #3 in an allegedly verbally abuse manner. CNA #4 said the first incident occurred around three to four weeks ago (sometime in December 2025). CNA #4 said Hospice Aide #1 asked for assistance because Resident #3 had directed racial slurs at her. CNA #4 said while in the room, Resident #3 swore and directed racial slurs at Hospice Aide #1, and Hospice Aide #1 responded back and called Resident #3 a fat pig and told him/her they're going to put you in a butcher shop because you have so much meat on you, and then Hospice Aide #1 laughed at Resident #3. CNA #4 said she did not report any of these incidents to anyone until she was interviewed as a part of a Facility investigation related to Hospice Aide #1.During an interview on 01/13/25 at 9:30 A.M., the Assistant Director of Nurses (ADON) said on 01/02/26 she interviewed CNA #4 as a part of a facility investigation related to Hospice Aide #1. The ADON said CNA #4 told her she witnessed Hospice Aide #1 called Resident #3 a fat pig and say to Resident #3 that they will put you in a butcher shop because you have so much meat on you. The ADON said CNA #4 had not reported that Resident #3 was allegedly verbally abused by Hospice Aide #1 prior to their conversation on 01/02/26. During a telephone interview on 01/15/26 at 3:00 P.M., CNA #5 said sometime around 12/25/25, when she entered Resident #3's room, Resident #3 directed a racial slur at Hospice Aide #1. CNA #5 said Hospice Aide #1 immediately responded back and said if she was a (quoting the racial slur), then you (Resident #3) are fat in a matter-of-fact tone. CNA #5 said since CNA #4 was in the room at the time, she assumed CNA #4 would report it as Resident #3's assigned aide. CNA #5 said although she initially denied any knowledge of Resident #3 being allegedly verbally abused during a facility investigation, she later decided to report the incident on 01/13/26 (during the Department of Public Health investigation).During an interview on 01/13/26 at 4:00 P.M., the Assistant Director of Nurses (ADON) said CNA #5 told her today (01/13/26, the day of survey) that she lied a few weeks ago when questioned if she witnessed Resident #3 being verbally abused by staff and had denied hearing anything. The ADON said CNA #5 said she had witnessed Hospice Aide #1 call Resident #3 fat and had not previously reported it to anyone.During a telephone interview on 01/15/26 at 11:00 A.M., the Director of Nurses (DON) said CNA #5 denied any knowledge when asked by the ADON on 01/02/26 if Resident #3 had been verbally abused by the Hospice Aide. The DON said she, along with the ADON and Administrator met with CNA #5 on 01/14/26, and that said CNA #5 stated that sometime around 12/25/25, after (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 directed a racial slur at Hospice Aide #1, she heard Hospice Aide #1 say that if she was a (quoting the racial slur) than you (Resident #3) are fat, how do you like that. The DON said staff were expected to report allegations of abuse immediately per Facility's Abuse Policy.During an interview on 01/13/26 at 2:25 P.M., the Administrator said it was the facility's expectation that staff immediately report allegations of suspected abuse per facility policy, and the Facility in turn to report allegations of suspected abuse no later than two hours after the allegation was made, to the required agencies.Review of the Health Care Facility Reporting System indicated the Facility's report regarding an allegation of verbal abuse of Resident #3 by Hospice Aide #1, was created and submitted on 12/31/25 at 2:35 P.M. which was at least five days after one of the alleged verbally abusive incidents took place.