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	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Advanced Directives and Physician's Order indicated his/her elected code status was Do Not Resuscitate (DNR, medical order written by a physician, which instructs healthcare providers not to do cardiopulmonary resuscitation in the event of cardiac or respiratory arrest) the Facility failed to ensure nursing staff honored his/her right to self-determination, when after being found unresponsive and without a pulse, nursing staff initiated life saving measures.Findings include:The Facility Policy, titled, Resident Rights, dated [DATE], indicated all residents were afforded their right to a dignified existence, self-determination, respect, and full recognition of their individuality.The Facility Policy, titled, Advanced Directive and Care Planning Policy, dated [DATE], indicated:-Upon admission, the Facility would identify if the resident had an advanced directive and the resident's choices would be incorporated into their plan of services, care and services.-Examples of advanced directives included a Living Will, a pre-existing medical order for Do Not Resuscitate (DNR) or another document directing the resident's health care such as a Massachusetts Order for Live Sustaining Treatment (MOLST).The Facility Policy, titled Cardiopulmonary Resuscitation (CPR), dated [DATE], indicated the Facility would adhere to the resident's rights to formulate advance directives, and if the resident experienced a cardiac arrest, facility staff would provide basic life support, including CPR, in accordance with the resident's advanced directives.Resident #1 was admitted to the Facility in [DATE], diagnoses included left hip fracture, diabetes, chronic kidney disease, morbid obesity, and high cholesterol.Review of Resident #1's Massachusetts Medical Orders for Life Sustaining Treatment (MOLST), dated [DATE], and signed by Resident #1, indicated he/she was a Do Not Resuscitate (DNR), Do Not Intubate (DNI), and to transfer to the Hospital.Review of Resident #1's Physician's Orders, dated [DATE], (related to his/her advanced directives) indicated Do Not Resuscitate (DNR) and Do Not Intubate (DNI).Review of Resident #1's Discharge Summary Due to Death in Facility, dated [DATE], indicated he/she was admitted to the Facility that evening, and was later found unresponsive by nursing. The Discharge Summary indicated nursing initiated CPR, and while CPR was being performed, Resident #1's MOLST was discovered and verified, at which time CPR was discontinued.During an interview on [DATE] at 02:27 P.M., Nurse #1 said that on [DATE] he was Resident #1's assigned nurse. Nurse #1 said at 9:15 P.M., he had prepared Resident #1's scheduled medications and upon entering his/her room, found Resident #1 unresponsive. Nurse #1 said he called out for help and said Unit Manager #1 and Nurse #2 responded. Nurse #1 said when Unit Manager #1 asked what his/her code status was, Nurse #2 (who was in the room at the time) said he/she was a full code. Nurse #1 said that he did not double check Resident #1's physician's orders or MOLST and just repeated to Unit Manager #1 what Nurse #2 said, that he/she was a full code, and then Unit Manager #1 began chest compressions.During a telephone interview on [DATE] at 4:01 P.M., Nurse #2 said that on [DATE] at 9:15 P.M., Nurse #1 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called for help because Resident #1 was unresponsive. Nurse #2 said she assessed Resident #1 and he/she was unresponsive, not breathing, and did not have a pulse. Nurse #2 said she asked Nurse #1 what Resident #1's code status was and he (Nurse #1) said he/she was a full code. Nurse #2 said she did not verify what Nurse #1 said and said while Unit Manager #1 began CPR she left the room to call a Code Blue, call 911, and to begin gathering information needed to transfer Resident #1 to the Hospital. Nurse #2 said when she reviewed Resident #1's MOLST, she realized that he/she was a DNR, and immediately went and notified Unit Manager #1, Nurse #1, and other nurses who had responded to the code blue, and said CPR was then discontinued.During an interview on [DATE] at 11:56 A.M., Unit Manager #1 said that on [DATE], Nurse #1 who was assigned as Resident #1's primary nurse that evening, called for help because Resident #1 was found unresponsive. Unit Manager #1 said when she asked Nurse #1 what Resident #1's code status was, Nurse #1 said he/she was a full code (initiate CPR).Unit Manager #1 said Resident #1 was not breathing, and did not have a pulse, so she told Nurse #2 (who had also responded) to call a Code Blue and initiate 911. Unit Manager #1 said she started chest compressions, the Automated Electrical Device (AED, delivers an electric shock) was applied, and said a total of two rounds of chest compressions was performed. Unit Manager #1 said while chest compressions were underway, Nurse #2 came to Resident #1's room holding his/her MOLST, which indicated he/she was a DNR/DNI, and upon confirmation that it was Resident #1's MOLST, CPR was discontinued.Unit Manager #1 said CPR should never have been initiated for Resident #1, as his/her advanced directives were to be DNR/DNI.During an interview on [DATE] at 07:56 A.M., the Director of Nurses said staff should have verified Resident #1's code status before they initiated CPR, but had not.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose Advanced Directives indicated he/she was a Do Not Resuscitate (DNR, medical order written by a physician, it instructs healthcare providers not to do cardiopulmonary resuscitation in the event of cardiac or respiratory arrest), the Facility failed to ensure services provided by nursing met professional standards of quality, when nursing initiated life saving measures including performing Cardiopulmonary Resuscitation on a resident who was a DNR.Findings include:Standard Reference: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered and practical nurse incorporated into the plan of care and implement prescribed medical regimens. The rules and regulations 9.03 defined standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice.Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, Titled Nursing Practice and Cardiopulmonary Resuscitation, dated as revised 12/2018, indicated that as a Standard of Nursing Practice, the nurse licensed by the Board is expected to engage in the practice of nursing in accordance with accepted standards of practice. It is the Board's position that these standards, in the context of practice in all settings where health care is delivered require initiating cardiopulmonary resuscitation when a patient has been found unresponsive and has not yet been declared dead by a provider authorized pursuant to M.G.L. c. 46, S 9, except when the patient has a current, valid Do Not Resuscitate order/status.It further indicated, that for the purpose of this Advisory Ruling, the licensed nurse must, at a minimum, attain and maintain the following competencies through successful completion of entry-level nursing education programs or continuing education experiences, the nurse's role in obtaining accurate information about the DNR status of all assigned patients.The Facility Policy, titled Cardiopulmonary Resuscitation (CPR), dated [DATE], indicated the Facility would adhere to the resident's rights to formulate advance directives, and if the resident experienced a cardiac arrest, facility staff would provide basic life support, including CPR, in accordance with the resident's advanced directives.Resident #1 was admitted to the Facility in [DATE], diagnoses included left hip fracture, diabetes, chronic kidney disease, morbid obesity, and high cholesterol.Review of Resident #1's Massachusetts Medical Orders for Life Sustaining Treatment (MOLST), dated [DATE], and signed by Resident #1, indicated he/she was a Do Not Resuscitate (DNR), Do Not Intubate (DNI), and to transfer to the Hospital.Review of Resident #1's Physician's Orders, dated [DATE], (related to his/her advanced directives) indicated Do Not Resuscitate (DNR) and Do Not Intubate (DNI).Review of Resident #1's Discharge Summary Due to Death in Facility, dated [DATE], indicated he/she was admitted to the Facility that evening, and was later found unresponsive by nursing. The Discharge Summary indicated nursing initiated CPR, and while CPR was being performed, Resident #1's MOLST was discovered and verified, at which time CPR was discontinued.During an interview on [DATE] at 02:27 P.M., Nurse #1 said that on [DATE] he was Resident #1's assigned nurse. Nurse #1 said at 9:15 P.M., he had prepared Resident #1's scheduled medications and upon entering his/her room, found Resident #1 unresponsive. Nurse #1 said he called out for help, and said Unit (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager #1 and Nurse #2 responded. Nurse #1 said when Unit Manager #1 asked what his/her code status was, Nurse #2 (who was in the room at the time) said he/she was a full code. Nurse #1 said that he did not double check Resident #1's physician's orders or MOLST, just repeated to Unit Manager #1 what Nurse #2 had said, that he/she was a full code, and that Unit Manager #1 then began chest compressions.During a telephone interview on [DATE] at 4:01 P.M., Nurse #2 said that on [DATE] at 9:15 P.M., Nurse #1 called for help because Resident #1 was unresponsive. Nurse #2 said she assessed Resident #1 and he/she was unresponsive, not breathing, and did not have a pulse. Nurse #2 said she asked Nurse #1 what Resident #1's code status was and he (Nurse #1) said full code. Nurse #2 said she did not verify what Nurse #1 said and said while Unit Manager #1 began CPR she left the room to call a code blue, call 911, and to begin gathering information needed to transfer Resident #1 to the Hospital. Nurse #2 said when she reviewed Resident #1's MOLST, she realized that he/she was a DNR, and immediately went and notified Unit Manager #1, Nurse #1, and other nurses who had responded to the code blue, and said CPR was then discontinued.During an interview on [DATE] at 11:56 A.M., Unit Manager #1 said that on [DATE], Nurse #1 who was assigned as Resident #1's primary nurse that evening, called for help because Resident #1 was found unresponsive. Unit Manager #1 said when she asked Nurse #1 what Resident #1's code status was, that Nurse #1 said he/she was a full code (initiate CPR).Unit Manager #1 said Resident #1 was not breathing, and did not have a pulse, so she told Nurse #2 (who had also responded) to call a Code Blue and initiate 911. Unit Manager #1 said she started chest compressions, the Automated Electrical Device (AED, delivers an electric shock) was applied, and said a total of two rounds of 30 chest compressions was performed. Unit Manager #1 said while chest compressions were underway, Nurse #2 came to Resident #1's room holding his/her MOLST which indicated he/she was a DNR/DNI, and upon confirmation that it was Resident #1's MOLST, CPR was discontinued.Unit Manager #1 said CPR should never have been initiated for Resident #1, as his/her advanced directives were to be DNR/DNI.During an interview on [DATE] at 07:56 A.M., the Director of Nurses said staff should have verified Resident #1's code status before they initiated CPR but had not.