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	06/29/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required daily administration of a diuretic and had been newly admitted from an acute care setting, the Facility failed to ensure he/she was free from a significant medication error, when his/her medication orders were not transcribed correctly by nursing, his/her Furosemide (diuretic) 80 milligrams was omitted and as a result, he/she was not administered his/her diuretic three days in a row.Findings include:The Facility Procedure, titled Incidents and Accidents, dated 01/30/24, indicated an incident was defined as an occurrence or situation that was not consistent with the routine care of a resident, and included medication errors. The Facility Policy, titled Medication Reconciliation, dated 01/30/24, indicated the Facility would:-During the admission process nursing would compare the Facility's orders to Hospital records, and transcribe orders.-Reconcile the resident's medications to ensure the resident was free from medication errors. -The Policy defined Medication Reconciliation as the process of verifying that the resident's current medication list matched the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his/her stay. -Nursing would obtain and transcribe any new orders.-New orders required a second nurse to cosign orders, which indicated there had been a review of the orders for accuracy.-Nursing would perform a 24 hour chart check to verify all new orders had been addressed.The Facility Policy, titled Twenty Four Hour Chart Check Policy, dated as revised 02/2023, indicated medical records would be reviewed nightly for accurate and complete transcription of Physicians' Orders, and corrections would be made if a discrepancy was identified. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/29/26, indicated Resident #1 was admitted to the Facility from the Acute Care Hospital with a Physician's order for Furosemide (diuretic) 80 milligrams (mg) by mouth, daily. The Report indicated nursing failed to transcribe Resident #1's Furosemide order, which resulted in him/her missing three consecutive doses of the medication.Resident #1 was admitted to the Facility in May 2026, diagnoses included acute kidney failure, acute on chronic systolic and diastolic congestive heart failure.Review of Resident #1's Hospital Discharge Medication Summary, dated 05/18/26, indicated he/she had an order for Furosemide 80 mg, by mouth daily to begin on 05/19/26.However, review of Resident #1's Facility Physician's Order Summary Report indicated he she/ had a physician's order, dated 05/21/26 to administer Furosemide 80 mg by mouth daily beginning on 05/22/26. Further review of Resident #1's Medical Record indicated there was no documentation to support that he/she had a Physician's Order to administer Furosemide on 05/19/26, 05/20/26, and 05/21/26.During a telephone interview on 06/29/26 at 11:30 A.M., Nurse #1 said that on 05/18/26, he was the nurse assigned to Resident #1, and he reviewed and transcribed his/her admissions orders from the Hospital discharge summary into the Facility's electronic medication ordering system. Nurse #1 said he accidentally omitted Resident #1's Furosemide 80 mg order when transcribing his/her admission orders. During a telephone interview on 06/29/26 at 11:52 A.M., Nurse Supervisor #1 said that on 05/18/26, he conducted a second check review of Resident #1's admission orders after Nurse #1 had transcribed them i-to the electronic medication ordering system. Nurse Supervisor #1 said he missed that Resident #1's Hospital Discharge Summary had an order for Furosemide 80 mg which had been omitted by Nurse #1. Review of Nurse #2's written statement, (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 05/30/26, indicated he worked the 11:00 P.M., to 07:00 A.M., shift on 05/18/26, and had missed Resident #1's Medical Record that night, and therefore had not completed the necessary twenty-four-hour chart check.During a telephone interview on 06/30/26 at 10:16 A.M., Nurse Practitioner #1 said that she reviewed Resident #1's medical record on 05/21/26 and noticed that his/her Furosemide 80 mg had been omitted from his/her admission orders at the Facility. Nurse Practitioner #1 said she notified Unit Manager #1 about the medication error. During an interview on 06/29/26 at 08:09 A.M., the Director of Nurses (DON) said Nurse #1, Nurse Supervisor #1, and Nurse #2 should have carefully reviewed Resident #1's Hospital Discharge Summary and Facility admission orders to ensure there were no discrepancies or omissions but had not and therefore Resident #1's Furosemide was omitted for three consecutive doses, in error.