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	04/11/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, observation and interview the facility failed to ensure one Resident (#259) out of a total sample of 35 residents did not self-administer medication without an assessment or physician's order. Findings include: Review of the facility policy titled Self-Administration of Medications, dated February 2019, indicated residents are permitted to self-administered medications if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. Resident #259 was admitted to the facility in April 2025 and has diagnoses which include diabetes and depression. Review of Resident #259's Minimum Data Set assessment dated [DATE] indicated a score of 15, signifying intact cognition. Review of Resident #259's clinical record indicated there was no assessment for the self-administration of medications. Review of Resident #259's physician orders dated April 2025 indicated there was no order for the self-administration of medications. Review of Resident #259's care plan failed to indicate a plan of care for Resident #259 to self-administer medications. On 4/8/25 at 8:40 A.M., the surveyor observed Resident #259 sitting in his/her room. Resident #259 was holding a medication cup which contained approximately 7 pills of different sizes and colors. Resident #259 said a nurse handed the cup of pills to him/her this morning and then left the room. Resident #259 said he/she had not taken any of the pills because he/she wanted to ask the nurse a question about one of the medications. Resident #259 said nurses sometimes hand him/her the cup of pills and then leave the room before he/she takes them. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 4/9/25 at 12:30 P.M., she said the facility had not assessed Resident #259 for the ability to self-administer medications. The DON said the interdisciplinary team had not determined whether Resident #259 could safely self-administer medications, and there was not a physician's order for the Resident to self-administer medications. The DON said nursing staff should observe the Resident take all medications before leaving the room and not leave medications with the Resident.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review and interview, the facility failed to ensure it developed a baseline care plan for skin breakdown within 48 hours of admission for one Resident(#181) out of a total sample of 35 residents. Findings include: Review of the facility's policy titled Wound and Skin Care - Pressure Injury Prevention and Management, dated 5/16/24 indicated: - After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Resident #181 was admitted to the facility in March 2025, and has diagnoses which include right hip fracture, severe dementia, depression, muscle weakness and abnormalities of mobility. Review of Resident #181's admission assessment, dated 3/15/25 indicated that he/she had a dressing on the right hip, bruising to bilateral antecubital and redness under both breasts. The assessment indicated Resident #181 triggered for the development of a skin/wound care plan. Review of Resident #181's skin assessment dated [DATE] indicated he/she scored a 9, signifying he/she was at a very high risk for skin breakdown. Review of Resident #181's medical record indicated the first time a skin/pressure/vascular ulcer care plan was initiated, occurred on 3/21/25, four days after the baseline care plan was required. During an interview on 4/10/25 at 9:41 A.M., with the Director of Nursing (DON) she said that Resident #181 was admitted with a risk for skin breakdown. The DON said it is her expectation that staff develop a baseline care plan to address the risk of skin breakdown within 48 hours of admission, and had not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49880 Based on record review, interviews, and policy review, the facility failed to ensure a resident-centered personalized care plan was developed and/or implemented for three Residents (#95, #89 and #8) out of a total sample of 35 residents. Specifically: 1. For Resident #95, the facility failed to develop a Hemodialysis (a medical treatment used for patients with advanced kidney failure It involves a machine that filters wastes and fluids form the body when the kidneys can no longer perform this function adequately) care plan. 2. For Resident #89, who has hearing and vision deficits, the facility failed to develop hearing and vision care plans. 3. For Resident #8, the facility failed to implement his/her right Prevalon boot (pressure relieving boot) per his/her physician's order. Finding Include: Review of the facility policy titled Comprehensive Care Plans, dated, 2/28/24, indicated the following: -It is the policy of this home to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time-frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1. The care planning process will include an assessment of the resident's strengths and needs. Services provided are arranged by the home, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS) assessment. All Care Areas triggered by the MDS will be considered in developing the plan of care. Other factors identified by IDT (interdisciplinary team), or in accordance with the resident's preferences, will also be addressed in the plan of care. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 5. The comprehensive care plan will be reviewed and revised by the IDT after each comprehensive and quarterly MDS assessment. 1. Resident #95 was admitted to the facility in March 2025 with diagnoses that include end stage renal disease and dependence on renal dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #95's most recent Minimum Data Set (MDS) assessment, date 3/17/25, indicated a Brief Interview for Mental Status exam score of 15 out of a possible 15. indicating that the Resident is cognitively intact. The MDS further indicates that the Resident receives Hemodialysis. Review of physician orders, dated 3/7/25, indicated the following orders: -No blood pressures or blood draws for left arm. -Monitor fistula site for s/s [signs and symptoms] of infection or displacement/bleeding, etc. Auscultate bruit/thrill. Document in progress notes any issues. Notify MD [Medical Doctor]. Review of Resident #95's active care plan failed to indicate a plan of care specific to Hemodialysis management. During an interview on 4/11/25 at 7:17 A.M., Unit Manager #1 said that Resident #95 receives Hemodialysis treatments and should have a comprehensive dialysis care plan in place to include the care of dialysis access and any dietary restrictions, but they did not. During an interview on 4/11/25 at 8:20 A.M., the Director of Nurses said that she would expect a comprehensive dialysis care plan in place for a resident on Hemodialysis. 50338 2. Resident #89 was admitted to the facility in November 2024 with diagnoses that include sensorineural hearing loss, bilateral and blindness in left eye. Review of Resident #89's most recent Minimum Data Set (MDS) Assessment, dated 2/13/25, indicated a Brief Interview for Mental Status exam score of 15 out of a possible 15 indicating that the Resident was cognitively intact. The MDS further indicated that the Resident had adequate vision and hearing. Review of the physician's order, dated 11/8/24, indicated the following order: -Consultation services: audiology, dental, ophthalmology, podiatry, and psych. Review of Resident #89's consultation consent for service, dated 11/8/24, indicated Resident #89 requests for audiology, dental, eye care, and behavioral health. Review of Resident #89's active care plans failed to indicate a plan of care plan specific to vision and hearing impairment. During an interview on 4/10/25 at 1:02 P.M., Resident #89 said that even while wearing hearing aids, his/her hearing has declined since admission to facility. Resident #89 said that he/she has had some falls and thinks that that could be related to his/her impaired vision. Resident #89 said he/she would like to be seen by the doctor that visits the facility to have his/her vision and hearing examined, and although he/she has repeatedly asked the staff to schedule the appointment he/she has not yet been seen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 2:16 P.M., Unit Manager #3 said that Resident #89 has impaired hearing and vision should have a comprehensive care plan in place to include the care of a resident with hearing and vision and impairments, but did not. During an interview on 4/11/25 at 9:52 A.M., the Director of Nurses said that she would expect a comprehensive hearing and vision care plan in place for a resident with hearing and vision impairments. 45343 3. Review of the facility policy titled Wound and Skin Care-Pressure Injury Prevention and Management, dated 6/26/24, indicated the following: -This home is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. -Evidence based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Redistribution pressure (such as repositioning, protecting and/or offloading heels, etc.). Resident #8 was admitted to the facility in June 2024 with diagnoses that included type 2 Diabetes Mellitus, diabetic polyneuropathy, and acquired absence of left leg above the knee. Review of Resident #8's most recent Minimum Data Set (MDS) assessment, dated 2/14/25, indicated he/she has severe cognitive deficits. The MDS further indicated Resident #8 requires dependent assistance for all self-care activities and is at risk for pressure ulcers. Review of Resident #8's physician order, dated 8/1/24, indicated the following: PREVALON BOOT-RIGHT FOOT AT ALL TIMES may remove for hygiene/care every shift. Review of Resident #8's Norton Pressure Ulcer Risk Scale, dated 3/7/25, indicated Resident #8's scored a 6, indicating the Resident was at high risk for developing pressure ulcers. Review of Resident #8's nursing progress notes for the past 30 days failed to indicate the Resident refused a pressure relieving boot to his/her right foot. On 4/8/25 at 8:04 A.M., 4/9/25 at 8:23 A.M., 9:31 A.M., and 4:18 P.M., and 4/10/25 at 6:46 A.M., 8:11 A.M., and 1:36 P.M., Resident #8 was observed lying in his/her bed. Resident #8 was not wearing a Prevalon boot on his/her right foot. The Prevalon boot was not observed in Resident #8's room. During an interview on 4/10/25 at 1:51 P.M., Unit Manager #2 said Resident #8 used to have booties, but doesn't believe he/she wears them anymore, but would need to check. Unit Manager #2 reviewed the current physician's orders and confirmed Resident #8 does currently have an active order for a Prevalon boot to the right foot. Unit Manager #2 said the boot should be worn as ordered by the physician and it should be documented if the resident refuses. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 2:55 P.M., the Director of Nursing said she expects the Prevalon boot to be worn as ordered and documented in the nurse's note if the resident refuses.

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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. 41105 Based on record review and interview, the facility failed to ensure care and services were provided according to accepted standards of clinical practice for one Resident (#118) out of a total sample of 35 residents. Specifically, the facility failed to ensure Resident #118's diet was changed as recommended, following a choking incident, that resulted in a hospitalization to have food extricated from his/her esophagus. Findings include: Review of the facility policy titled Verbal Orders, dated 3/27/24, indicated the following: -Physician orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist who is legally authorized to do so. 1. Repeat any prescribed orders back to the physician or health care provider. 2. Use clarification questions to avoid misunderstandings. Resident #118 was admitted to the facility in December 2023 with diagnoses including food in the esophagus causing other injury and esophageal obstruction. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/25 indicated that on the Brief Interview for Mental Status exam Resident #118 scored a 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #118 had no swallowing issues and did not complain of difficulty or pain when swallowing. Review of the record indicates that Resident #118 had a 5 day hospitalization in January 2025. Review of the hospital admission note indicates: Usual state of health until 3 days ago while eating dinner choked on a piece of beef stew. Review of the hospital Discharge Summary, dated 1/19/25, indicated: -Diet/Nutrition: Adult diet room service: full liquid; CHO (consistent carbohydrate diet) consistent 90g (grams). -EGD (Esophagogastroduodenoscopy (EGD) is a test to examine the lining of the esophagus, stomach, and first part of the small intestine) findings: Impression: -Food in the lower third of the esophagus. Removal was successful -Benign appearing esophageal stenosis. Not dilated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Esophagitis with no bleeding -GEJ (Gastro Esophageal Junction) ulcer as detailed -Torturous esophagus -Gastritis, characterized by erythema -Normal examined duodenum Recommendation: -Clear liquid diet today. Tomorrow can carefully advance to mechanical soft diet (a texture modified diet that restricts foods that are difficult to chew or swallow. It is considered Level 2 of the National Dysphagia Diet in the United States . Foods can be pureed, finely chopped, blended or ground to make them smaller, softer and easier to chew) but do not advance beyond to solid food until GI (gastrointestinal) clinic follow-up. -Pertinent Physical Exam at time of discharge: Issues requiring follow-up -Continue with full liquid to mechanical soft diet do not use regular solid food Review of the active Physician's order, with a start date of 1/15/25, indicated the following order: -Diet Type: low sodium (2-3 gram) House Consistent Carbohydrate -Diet Texture: Regular -Fluid Consistency: thin Review of the telephone order, dated 1/24/25, indicated to resume treatments, diet, code status and all ancillaries. Review of the Diet Communication Sheet, dated 1/24/25, indicated the following areas checked off for Resident #118's diet: -Low Sodium (2-3 grams) -House consistent Carbohydrate (3-5 CHO servings). The communication sheet failed to indicate what texture the food should be. Review of the Physician progress note, dated 1/28/25, indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The patient presented to ED (emergency department) on 1/19/25 due to nausea, vomiting and trouble swallowing with concern for possible food impaction. Per chart, the patient was eating dinner when he/she choked on a piece of beef stew and ever since he/she has had trouble swallowing (including medications) and vomiting. -The patent was admitted for further management of food impaction and RUQ (right upper quadrant) epigastric pain. GI (gastroenterologist) was consulted and recommended EGD (Esophagogastroduodenoscopy (EGD) is a test to examine the lining of the esophagus, stomach, and first part of the small intestine). EGD done on 1/9 showed food in the lower third of the esophagus (removal was successful). Benign-appearing esophageal stenosis. - He/she was able to tolerate clear liquid after EGD but needs GI follow up before advancing diet to solid food. GI recommended PO (by mouth) PPI (Proton Pump Inhibitor which is a medication that reduces stomach acid) until the GI clinic followed up discharge, resumed Eliquis 2 days after discharge to ensure biopsy bleeding resolves, continue carafate and repeat endoscopy in 2 months to confirm Esophagitis. Review of Resident #118's care plans indicate the following: 1. A nutritional status care plan, dated as reviewed 1/30/25, indicated the following interventions: -Honor my weight preferences 1/22/24 -Educate me and my family & friends on appropriate foods and food/drink textures to bring in for my enjoyment, as well as foods/textures to avoid. 2/28/24 -HCC, Low Sodium, thin liquids, regular texture. 3/26/24 -House diabetic supplement TID between meals. 3/7/25 -I enjoy double vegetable portions and no starch at lunch and dinner meals. 2/8/24 -I/my representative will meet with dietary and nursing staff to let them know my dietary preferences. 12/26/23 -Offer bedtime snack. 3/8/24 -Provide a diet with my preferences and the appropriate textures of foods and thickness of liquids as ordered by my MD/NP. 12/26/23 The care plan fails to indicate any active or resolved interventions that indicate Resident #118 was ever on a mechanically altered texture or refused a mechanically altered texture. Review of the clinical progress notes indicate the following: -A weight change note by the Dietitian, dated 1/30/25, indicated : (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed soft meal choices and resident aware of ground textured diet. SLP (Speech and Language Pathologist) evaluation ordered. Encouraged importance of caloric and protein intake. Resident agreeable to start house diabetic supplement between meals to meet nutrient needs at this time. Will continue to monitor weight weekly. Review of the Rehab Screening Form, dated 2/3/25, indicated a referral was made on that date to have Resident #118's swallowing ability assessed. The SLP documented the following: -SIGNIFICANT FINDINGS: Pt (patient) denies any difficulty with swallowing; c/o (complain of) food sticking in esophagus. Educ (educated) to pt on Ground diet option. Pt is aware of his/her issue and prefers to self select softer foods. Pt also with broken top dentures, in process of getting new ones. Pharyngeal swallow appeared WFL (within full limits) for thins. -Pt to f/u (follow-up) with GI for recommendations re: esophageal dysfunction. Review of a GI consult note, dated 2/26/25, indicated the following: Diagnosis: -Recent esophageal food impaction -Dysphagia (difficulty chewing and swallowing) -Peptic esophageal stricture Plan for EGD with stricture dilation in next 1-2 months The GI consult made no recommendations regarding the diet. Review of the GI consult, dated 4/7/25, indicated that biopsies were taken at GE junction. The visit note failed to indicate a diet change was recommended During an interview on 4/09/25 at 10:59 A.M., with Resident #118 he/she said that in January 2025 his/her dentures broke and that while eating beef stew in the unit dining room one day he/she didn't chew the beef right and it got stuck right here (points to middle of his/her chest). Resident #118 said that everyone heard me throwing up for the next two days, but it wouldn't come up and that after two days he/she requested to be sent to the hospital. Resident #118 said that when he/she first returned from the hospital he/she consumed only liquids and then mashed potatoes for a few days, but that after that staff started serving him/her meat again. Resident #118 said I was so scared and would pull it (the meat) apart really small. Resident #118 showed the surveyor his/her dentures that he/she was wearing. The dentures are still broken and missing the entire top left side. Resident #118 said that he/she continues to have a feeling at times that the food is moving down very slowly and that he/she gets scared it will get stuck, however she had a GI follow-up appointment on 4/7/25 and that they told her this was normal because he/she was still healing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 9:40 A.M., with the Food Service Director he said that Resident #118 is on a regular textured diet. He reviewed the history of Resident #118's diet orders and said that it has not changed from a regular texture at any time during 2025. The FSD explained that if a resident requires a mechanical soft diet it is different than a regular, and that it would be ground mechanical soft meat and either pureed vegetables and diced potatoes. During an interview on 4/10/25 at 10:08 A.M., with the Speech and Language Pathologist she said that she screened Resident #118 on 2/3/25, 11 days after his/her return from the hospital. The SLP said that it is not within her scope of practice to override the hospital diet recommendation, but that she did educate Resident #118 about the ground diet at that time. She said that if a Resident is not given their recommended diet she believes that Physician would have a risk benefit conversation with the resident. The SLP added, that Resident #118 should not have a regular texture diet until the facility got the okay from GI. During an interview on 4/11/25 at 8:41 A.M., with the facility Medical Director he said that upon return from the hospital in January he would have expected that the EGD recommendations be followed and that the facility change the Resident's diet to mechanical soft until follow-up with GI. He said that in a case such as this the Physician should have very clearly written the order to change the diet as it was recommended by the hospital so that there was not any ambiguity about the required diet. The Medical Director said that if 11 days later when the resident was seen by the SLP and the resident expressed a diet to self select soft food rather than he would have expected the Physician to be notified so that a decision could be made as to whether they would override the recommendations made by the hospital following the EGD. Prior to doing this he would expect the Physician multiple risk benefit conversations to occur between the MD and Resident so that it was clear how unsafe this could be and for these conversations to be documented in clinical visit notes. The Medical Director said that not following this diet places the Resident at risk of aspiration, choking episodes or death and he would want that to be very clear to the Resident before going against medical advice and not maintaining the appropriate diet. During an interview on 4/11/25 at 9:24 A.M., with Resident #118's Physician he said that he was under the impression that the facility changed Resident #118's diet when he/she returned from the hospital in January. He said that the risk of not ordering the Resident the recommended diet was that the choking could occur again, as well as the risk of aspiration and death. The Physician said that it looks like a mistake happened and luckily nothing happened to him/her. During an interview on 4/11/25 at 9:43 A.M., with the Director of Nursing she said that the diet should have been changed upon return and that she agreed with the Medical Director and Physician, that by not changing Resident #118's diet to the recommended consistency following a choking incident, that this placed Resident #118 at the risk of aspiration and/or death. As well, upon resident's readmission to the facility following the incident, she would have expected nursing to have submitted a diet slip to the kitchen that was accurate.

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	225515	A. Building B. Wing	04/11/2025

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45343 Based on observation, record review and interview the facility failed to ensure nursing staff provided assistance with Activities of Daily Living (ADLs) for one dependent Residents (#43) out of a total sample of 35 residents. Specifically, for Resident #43 the facility failed to provide assistance with the removal of unwanted facial hair. Findings Include: Review of the facility policy titled Activities of Daily Living (ADL's), undated, indicated the following: -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Resident #43 was admitted to the facility in November 2024, with diagnoses including Parkinson's Disease with dyskinesia (uncontrolled, involuntary muscle movement), major depressive disorder, and dementia. Review of Resident #43's most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated the Resident had a Brief Interview for Mental Status exam score of 14 out of a possible 15, indicating he/she has intact cognition. The MDS further indicated Resident #43 requires partial/moderate assistance to substantial/maximal assistance for all self-care activities. On 4/8/25 at 8:00 A.M., 9:31 A.M., and 3:56 P.M., 4/9/25 at 8:05 A.M., and 3:56 P.M., 4/10/25 at 8:12 A.M., 8:42 A.M., and 12:30 P.M., Resident #43 was observed with upper lip and chin hair. Record review of Resident #43's ADL care plan on 4/8/25 at 2:20 P.M., indicated the following: Assist me with personal hygiene. Last revised 11/25/24. Review of the record failed to indicate Resident #43 had refused to have his/her facial hair removed. During an interview on 4/9/25 at 4:06 P.M., Resident #43 said he/she normally does not have facial hair and staff normally remove it for him/her, but haven't done it in a while. Review of Resident #43's shaving care card on 4/10/25 at 9:03 A.M., indicated he/she was last shaved on 3/11/25. (continued on next page)

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	225515	A. Building B. Wing	04/11/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #43's nursing progress notes failed to indicate he/she refused care. During an interview on 4/10/25 at 1:46 P.M., Unit Manager #2 said we normally shave Residents during morning care with their permission. Unit Manager #2 said if a resident refuses care, the Certified Nursing Assistant (CNA) will notify the nurse, and they will reattempt care. If the resident still refuses care, it should be documented in the medical record. During an interview on 4/10/25 at 2:56 P.M., the Director of Nursing said she would expect facial hair to be removed with the resident's permission during routine care and any refusals should be documented in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observation and interview the facility failed to ensure that drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles, and that medication carts were kept clean and tidy in four out of six medication carts reviewed. Specifically, 1. The facility failed to store medications as indicated in the refrigerator. 2. The facility failed to store treatment supplies separate from oral and other medications. 3. The facility failed to maintain clean medication carts without spills. 4. The facility failed to ensure that medication stored in the medication carts were labeled with resident identifiers. Findings include: Review of facility policy titled Medication Storage in the Facility, dated as effective February 2019, indicated the following: -Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. -A. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopoeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medications to the original container. -C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. -D. Orally administered medications are stored separately from externally used medications and treatments. -I. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. -Temperature: -D. Medications requiring refrigeration are kept in the refrigerator at temperatures between 35 degrees Fahrenheit and 46 degrees Fahrenheit. 1. On 4/9/25 at 7:03 A.M., the surveyor observed an unopened vial of Lantus insulin and an unopened vial of Humalog insulin stored in medication cart one on the [NAME] Unit. (continued on next page)

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	225515	A. Building B. Wing	04/11/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/25 at 7:03 A.M., Nurse #1 said that insulin should be stored in the fridge until it is opened, and only once it is opened it can be stored in the medication cart for up to 28 days. During an interview on 4/9/25 at 11:00 A.M., Unit Manager #1 said that insulin should be stored in the fridge until it is opened. 2. On 4/9/25 at 9:09 A.M., the surveyor observed treatment supplies unbagged bottles of nystatin powder were stored in the medication cart with oral medications in the long term care medication cart on the [NAME] Lane Unit. During an interview on 4/9/25 at 9:10 A.M., Nurse #2 said that treatment supplies should not be stored with oral medications. 3. On 4/9/25 at 9:09 A.M., the surveyor observed the bottom of a drawer in the long term care medication cart on the [NAME] Unit to have a sticky brown substance spilled on it. When the surveyor lifted medication bottles from the draw, they stuck to the substance. On 4/9/25 at 12:45 P.M., the surveyor observed the bottom of a drawer in medication cart 2 on the [NAME] Unit to have a sticky brown substance spilled in it where medications to be administered were stored. During an interview on 4/9/25 at 9:10 A.M., Nurse #2 said that sometimes medications leak, but that the medication cart should be kept clean. 4. On 4/9/25 at 12:38 P.M., The surveyor observed medication cart 1 on the [NAME] Lane to have one open vial of Lantus insulin and one open vial of Humalog insulin labeled with open and expiration dates, but no resident identifiers on the vials. The vials were both stored freely in the cart and not in original packaging. The surveyor also observed one Albuteral inhaler stored in the top draw of the medication cart. The inhaler did not have a resident identifier on it and was stored freely in the medication cart, and not in it's original packaging. During an interview on 4/9/25 at 12:43 P.M., Nurse #3 said that the inhaler probably came out of the emergency medication kit and that's why it is not labeled, but whoever removed it should have labeled it with the resident's name. Nurse #3 also said that the insulin vials should have resident names on them because you cannot use one vial of insulin for administration to more than one resident. On 4/9/25 at 2:35 P.M., the surveyor observed medication cart 2 on the Wannalancit Unit to have two vials of Humalog Insulin with open and expiration dates on the label, but no resident identifiers on the vial. The Vials were stored freely in the medication cart and were not in their original packaging. During an interview on 4/9/25 at 2:38 P.M., Nurse #4 said that sometimes the insulin is taken from the emergency kit so there is no resident name on it, but it should have been labeled with a resident name when it was taken for use. (continued on next page)

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	225515	A. Building B. Wing	04/11/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/25 at 2:52 P.M., the Director of Nurses said that she would expect that medication carts are kept clean and that medications are labeled for individual resident use as appropriate.

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	225515	A. Building B. Wing	04/11/2025

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 45763 Based on interviews, record review and observation, the facility failed to provide the prescribed therapeutic diet to one Resident (#16), out of a total sample of 35 residents. Specifically, the facility failed to provide Resident #16 with a ground textured diet as prescribed by the physician. Findings Include: Review of the facility policy titled Therapeutic diets, revised July 2023, indicated, but was not limited to, the following: - The attending physician will prescribe a therapeutic diet. - A tray identification system is established to ensure that each patient/resident receives his or her diet as ordered. - The dietitian records in the patients/residents medical record significant information relating to the patients/residents response to his or her therapeutic diet. - Mechanically altered diets will be considered therapeutic diets. Resident #16 was admitted to the facility in May 2022 with a diagnosis of macular degeneration. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/23/25, indicated that Resident #16 scored an 11 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident had moderate cognitive impairment. Review of Resident #16's incident report form, submitted on 11/6/24, indicated the Resident experienced a choking episode on 11/4/24. Further review of the report indicated the Resident required an abdominal thrust and that the Resident had expelled a portion of a muffin from his/her mouth. Review of Resident #16's Speech Language Pathologist's (SLP's) evaluation and plan of care, dated 11/14/24, indicated the Resident was referred to the SLP for a swallowing assessment due to a choking incident. Review of Resident #16's SLP encounter note, dated 11/26/24, indicated the Resident benefited from well moistening his/her muffin and portioning into small bite size pieces to facilitate better bolus cohesion and oral transit. Review of Resident #16's SLP discharge summary, dated 11/27/24, indicated a recommendation for a ground diet with moistened soft bread allowed. Review of Resident #16's care plans indicated that the Resident was at risk for choking/aspiration due to a choking episode on 11/4/24, with the following intervention: (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ground texture with meals, initiated 11/23/24. Review of Resident #16's physician's orders indicated the following active order: - House/regular diet, ground texture, thin liquids consistency, moistened soft bread allowed, initiated 11/14/2024. Review of the facilities dietary manual indicated that potato chips should be avoided on a ground diet. Review of the quick reference diet guide indicated that hard or crunchy foods should be avoided on a ground diet. On 4/8/25 at 5:14 P.M., the surveyor observed Resident #16 eating dinner, the Resident was served potato home fries which were not peeled/had skins on them. On 4/9/25 at 8:29 A.M. the surveyor observed Resident #16 eating breakfast; the Resident was served a muffin. The muffin was whole and not moistened with butter or jelly. On 4/9/25 at 12:04 P.M. the surveyor observed Resident #16 eating lunch; the Resident was served potato chips. On 4/10/25 at 8:11 A.M. the surveyor observed Resident #16 eating breakfast; the Resident was served a muffin. The muffin was whole and not moistened with butter or jelly. During a continuous observation starting at 11:40 A.M., the Surveyor observed Resident #16 arriving to the dining room. The Resident was not asked what he/she wanted to eat for lunch and at 12:00 P.M., the Resident was served a tuna salad sandwich and potato chips. The Resident's meal ticket indicated a ground diet with alfredo and a roll. At 12:09 P.M., the surveyor observed Resident #16 eating the potato chips off his/her plate. During an interview on 4/10/25 at 12:52 P.M., the SLP said that she would expect a physician's order with exceptions regarding food items prohibited by a resident's prescribed textural diet. The SLP said there would need to be an order for an exception for potato chips for any resident on a ground diet. The SLP said that Resident #16's muffin should be moistened by staff as the Resident has had several choking episodes in the past and that the Resident should not be receiving potato chips or potatoes with skins on them. The SLP said that potato chips, potatoes with skins and muffins that were not moistened could put the Resident at risk for choking/aspiration and downstream risks of aspiration like pneumonia. (continued on next page)

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	225515	A. Building B. Wing	04/11/2025

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 1:14 P.M., the Food Service Director (FSD) said he would expect that if a resident was on a ground diet that any muffins served to the resident would be moistened with butter and/or jelly at point of service by staff. The FSD said the Quick Reference Diet Guide was posted on the wall for staff reference and that residents on ground diets should not receive potatoes with skin on them as that would be a choking hazard. The FSD said he would expect the diet manual to be followed and that he would expect a physician order to be in place with exceptions for any food items prohibited by a prescribed diet. The FSD said that if a resident wanted a food item prohibited by his/her prescribed diet that staff should reach out to a nurse and the SLP for evaluation who will update the diet order; the FSD said that he would expect this process to happen before the resident was served a food item prohibited by his/her diet. Review of the record failed to indicate the MD was aware that the Resident was being served items not permitted on a ground diet. Following observations and interviews with the Surveyor a care plan intervention was revised on 4/10/25 by Unit manager #4 with the following addition: - Ground texture with meals, I and my HCP have opted to waive diet option and allow chips when I want them with supervision. During an interview on 4/11/25 at 9:57 A.M., Unit Manager #4 said that if staff were unsure if certain foods were allowed on a particular diet that they should ask the Unit Manager or dietary staff. Unit Manager #4 said she spoke with the Resident's health care proxy and Nurse Practitioner on 4/10/25 and updated the Resident's care plan regarding the potato chips after the Resident had been served potato chips, but would have expected that process to have happened before the Resident was served potato chips. Unit Manager #4 said the Residents daughter was planning on coming in to sign a waiver to allow the Resident to eat potato chips, but had not yet done so. Review of Resident #16's progress note, dated 4/10/25 at 3:14 P.M., indicated that the Resident's health care proxy will be coming in that night to sign a waiver to allow the Resident to eat potato chips despite being prescribed a ground diet. Further review of Resident #16's physician's orders indicated the following order: - May have chips with meals, initiated on 4/10/25 at 4:50 P.M. Review of the order indicated that the exception for chips was initiated after the surveyor had brought the concern to the attention of the facility and after the surveyor had observed the Resident being served potato chips twice. During an interview on 4/11/25 at 10:20 A.M. the Director of Nursing (DON) said texture restrictions should be followed unless there was a waiver or physician-ordered exception.

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	225515	A. Building B. Wing	04/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that food was dated in the main kitchen and on three of five unit kitchenettes, that produce showing significant signs of decomposition was discarded, that food was not stored on or below potential sources of environmental contamination, that food was not stored directly on the floor and that the facility process for dented cans was followed. Findings include: Review of the facility's policy titled Storage of Food in Refrigerator, revised [DATE], indicated, but was not limited to, the following: - Food being returned to storage after cooking or preparation must be covered tightly, labeled and dated. - Food items that remain sealed from the supplier may be held until the expiration date if unopened. Review of the facility's policy titled Food brought in by Family or Visitors - Use and Storage, revised [DATE], indicated, but was not limited to, the following: - It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. - All food items that are already prepared by the family or visitor brought in must be labeled with resident name, content and date. a. The facility may refrigerate labeled and dated prepared items in the Unit nourishment refrigerator. b. The perishable food must be consumed by the resident within 3 days. c. If not consumed within 3 days, food will be thrown away by facility staff. d. The facility will not be responsible for maintaining any reusable items. e. Dining services monitor the Unit nourishment refrigerator and monitor. On [DATE] at 7:11 A.M., the surveyor made the following observations during the initial walk through of the main kitchen: - A can of tuna with a significant dent on the lid and rim of the can in the dry storage area, stored with the other cans of food; the can was not labeled do not use or stored in a box. (continued on next page)

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	225515	A. Building B. Wing	04/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A can of white kidney beans with a significant dent on the rim of the can in the dry storage area stored with other cans of food; the box containing the can was open and the can was not labeled do not use. - A can of mushroom stems and pieces with a significant dent on the lid and rim of the can in the dry storage area, stored with the other cans of food; the box containing the can was open and the can was not labeled do not use. - A bug-trapping light/device on the wall in the dry-storage area, there was a viscous yellow liquid containing trapped insects that was in the process of dripping over the edge of the device; there was a large container of oatmeal stored directly below the device. - Three boxes of coffee ice cream stored directly on the freezer floor. - Black and blueish-white wispy growth on multiple spots on the shelving unit in the walk-in refrigerator; there was food stored on and below the shelves. - Thickened apple juice opened and dated ,d+[DATE] in the walk-in refrigerator. - Six plastic containers labeled AS ,d+[DATE] in the walk-in refrigerator. - [NAME] cooking wine stored directly on the floor propping the door open in the dry storage area. - Whipped cream in a piping bag, open but undated, in the reach-in refrigerator. - A container with pastries labeled Danish dated ,d+[DATE] and ,d+[DATE]. - Cabbage with significant signs of decomposition including textural and color changes in the walk-in refrigerator. - A bag of herbs with significant signs of decomposition including textural and color changes in the walk-in refrigerator. On [DATE] at 8:15 A.M., the surveyor made the following observations in the S unit kitchenette refrigerator: - A plastic bag with three containers of food, undated. - A take-out food leftover container, undated. On [DATE] at 8:22 A.M., the surveyor made the following observations in the A unit kitchenette refrigerator: - A cup containing a thick brown liquid, the cup was labeled with a Resident name but was undated. On [DATE] at 8:24 A.M., the surveyor made the following observations in the C unit kitchenette refrigerator: (continued on next page)

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	04/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A container of food that was undated. - A baked good consistent in appearance with cornbread that was wrapped but undated. On [DATE] at 11:02 A.M., the surveyor made the following observations in the C unit kitchenette refrigerator: - A nutritionally fortified supplemental shake that was open but undated and unlabeled. On [DATE] at 11:04 A.M., the surveyor made the following observations in the A unit kitchenette refrigerator: - Two nutritionally fortified supplemental shakes that were open but undated and unlabeled. During an interview on [DATE] at 7:44 A.M., the executive chef said all food should be labeled and dated when opened or prepared and discarded after three days. The executive chef said that food should not be stored directly on the floor. The executive chef said that the staff member who receives and puts stock away should inspect cans and should remove dented cans from dry storage and set them aside in the main kitchen to be returned, notify management about the dented cans, and label the cans with do not use; the executive chef said the dented cans should have been set aside when the boxes containing the cans were opened. During an interview on [DATE] at 7:51 A.M., the Registered Dietitian (RD) said dented cans pose a risk for food borne illness, thickened juices should be labeled, and that the whipped cream piping bag should have been dated when it was opened. The RD said the cabbage and herbs should be discarded. During an interview on [DATE] at 5:18 P.M., the Food Service Director (FSD) said kitchen staff will check unit kitchenettes for expired and undated food in the morning and at night before they leave. The FSD said that nursing staff were dating and checking food if family brings food in from outside of the facility. During an interview on [DATE] at 11:05 A.M., Unit Manager #2 said if family brings food in from outside of the facility that nurses will date the food. Unit Manager #1 said that undated food must be discarded, that open supplements should be dated when opened, and that nurses check the unit refrigerators daily.

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	04/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45343 Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for three Residents (#8, #40 and #95), out of a total sample of 35 residents. Specifically: 1. For Resident #8, the nurses documented in the Treatment Administration Record (TAR) the Resident was wearing his/her right lower extremity Prevalon boot (pressure relieving boot) when he/she was not. 2. For Residents #40 and #95 the facility failed to accurately document the location of blood pressure (BP) readings. Findings Include: Review of the facility policy titled Documentation in the Medical Record, dated 11/29/23 indicated the following: Policy: - Each resident's medical record shall 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. Policy Explanation and Compliance Guidelines: -Documentation should be factual, objective and resident centered. -Documentation should be accurate, relevant, and contain sufficient details about the resident's care and/or response to care. 1. Resident #8 was admitted to the facility in June 2024 with diagnoses that included Type 2 Diabetes Mellitus, diabetic polyneuropathy, and acquired absence of left leg above the knee. Review of Resident #8's most recent Minimum Data Set (MDS) assessment, dated 2/14/25, indicated he/she has severe cognitive deficits. The MDS further indicated Resident #8 requires dependent assistance for all self-care activities and is at risk for pressure ulcers. On 4/8/25 at 8:04 A.M., 4/9/25 at 8:23 A.M., 9:31 A.M., and 4:18 P.M., and 4/10/25 at 6:46 A.M., 8:11 A.M., and 1:36 P.M., Resident #8 was observed lying in his/her bed. Resident #8 was not wearing his/her Prevalon boot on his/her right foot. The Prevalon boot was not observed in Resident #8's room. Review of Resident #16's physician order, dated 8/1/24, indicated the following: PREVALON BOOT-RIGHT FOOT AT ALL TIMES may remove for hygiene/care every shift. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's Norton Pressure Ulcer Risk Scale, dated 3/7/25, indicated Resident #8's scored a 6. 0, indicating the Resident was at high risk for developing pressure ulcers. Review of the April 2025 Treatment Administration Record (TAR) indicated that nursing documented on all shifts for April 8th, 9th and day shift on April 10th, that Resident #8 was wearing his/her right Prevalon boot, contrary to direct observation he/she was not. Review of Resident #8's medical record on 4/9/25 at 9:31 A.M., failed to indicate he/she refused to wear his/her right lower extremity Prevalon boot. During an interview on 4/10/25 at 1:51 P.M., Unit Manager #2 said Resident #8 used to have booties, but doesn't believe he/she wears them anymore, but would need to check. Unit Manager #2 reviewed the current physician's orders and confirmed Resident #8 currently has an active order for a Prevalon boot to the right foot. Unit Manager #2 said the boot should be worn as order by the physician and documented accurately in the medical record During an interview on 4/10/25 at 2:55 P.M., the Director of Nursing said she expects application of the Prevalon boot to be accurately documented in the medical record, and indicated if the resident refuses. 45763 2a. Resident #40 was admitted to the facility in January 2018 with a diagnosis of end stage renal disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/27/25, indicated that Resident #40 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact Review of Resident #40's care plans indicated the Resident required Hemodialysis due to end stage renal disease, with the following intervention: - Note: Do not draw blood or take B/P (blood pressure) in left arm with graft, initiated 10/21/2020. Review of Resident #40's active physician orders indicated the following order: - No BPs or lab draws in L (left) arm, initiated 11/4/2019. Review of Resident #40's blood pressure readings indicated nursing obtained his/her blood pressure on his/her left arm on the following dates: 7/4/24, 7/14/24, 7/23/24, 9/19/24, 11/17/24, 11/19/24, 11/29/24, 12/30/24 and 1/15/25. During an interview on 4/9/25 at 3:15 P.M., Resident #40 said staff only use his/her right arm to take blood pressure readings, never his/her left arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 10:41 A.M., Unit Manager #1 said Resident #40's left arm should not be used to take blood pressure readings as the Resident had a dialysis fistula on that arm. Unit Manager #1 said the nurses had documented that the blood pressure was taken using Resident #40's left arm in error as they only use the Resident's right arm. During an interview on 4/9/25 at 10:51 A.M., the Director of Nursing said she would expect nurses to document the location of a blood pressure reading accurately. 49880 2b. Resident #95 was admitted to the facility in March 2025 with diagnoses that include end stage renal disease and dependence on renal dialysis Review of Resident #95's most recent Minimum Data Set (MDS) assessment, date 3/17/25, indicated a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating that the Resident is cognitively intact. The MDS further indicates that the Resident receives Hemodialysis. Review of physician orders dated 3/7/25 indicated the following orders: -No blood pressures or blood draws for left arm. -Monitor fistula site for s/s [signs and symptoms] of infection or displacement/bleeding, etc. Auscultate bruit/thrill. Document in progress notes any issues. Notify MD [Medical Doctor]. Review of Resident #95's care plan failed to indicate a plan of care specific to Hemodialysis management. Review of the weights and vital signs portal in the Electronic Medical Record (EMR) indicated that on 3/17/25 and on 3/19/25 blood pressures were obtained on the left arm. During an interview and observation on 4/10/25 at 11:11 A.M., the surveyor observed a fistula to Resident #95's left arm. Resident #95 said that he/she has restrictions in his/her left arm and would not let a nurse or anyone else check blood pressure on the left arm. During an interview on 4/9/25 at 10:53 A.M., Unit Manager #1 said that Resident #95 is alert and oriented and would not allow staff to obtain blood pressure on his/her left arm. She said she believes this is a documentation error. During an interview on 4/9/25 at 10:51 A.M., the Director of Nursing said she would expect nurses to document the location of a blood pressure reading accurately.