STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Healthcare	620 Laurel Street Lee, MA 01238

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 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. Based on records reviewed and interviews for one of three sampled residents (Resident #1), the facility failed to ensure they maintained a complete and accurate medical record when on 10/18/25 after Resident #1 was seen by the Physician who made recommendations for interventions related to prevention of pressure injuries, there was no nursing documentation to support they were addressed or followed up on.Findings include:Review of the Facility Policy titled Charting and Documentation, revised 11/2024, indicated that services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical physical, functional or psychosocial condition, should be documented in the resident's medical record. Resident #1 was admitted to the Facility in October 2024, diagnoses included non-displaced comminuted fracture shaft of the left femur (injury where the thigh bone breaks into three or more pieces due to high-energy trauma), and left sided and right sided foot drop (inability to lift the front part of the foot). Review of Resident #1's Physician History and Physical Visit Note, dated 10/18/25, that indicated Resident #1 had complained of right heel pain, and upon assessment there was discoloration to the heel, which was concerning for a developing pressure injury. The Visit Note further indicated for nursing to offload force to the area (reducing or redistributing pressure on a specific area to promote healing and prevent further damage), to have wound care specialist evaluate and follow, and that this visit was discussed with Nursing staff. Review of Resident #1's Medical Record including his/her Treatment Administration Record (TAR) indicated there was no documentation to support nursing implemented the Physician recommendation made on 10/18/25 to offload his/her right heel. During an interview on 11/19/25 at 11:10 A.M., Nurse #1 said he was the only nurse on duty on 10/18/25 when the Physician visited Resident #1. Nurse #1 said he could not remember exactly what the Physician discussed with him pertaining to Resident #1 on that date. Nurse #1 said after the Physician completes his visits, he verbally informs nursing staff of any findings, orders or recommendations, and said the expectation was that nursing staff follow through by entering any orders into the computer. After reviewing Resident #1's Physician Visit Note dated 10/18/25, Nurse #1 said he did not recall entering a treatment order or care plan intervention to offload pressure to Resident #1's right heel. During an interview on 11/19/25 at 2:50 P.M., the Assistant Director of Nursing (ADON) said after Providers visit the residents, they speak with staff nurses directly regarding new orders and recommendations. The ADON said after the Providers review their visits with nursing, it is responsibility of nursing to ensure orders are entered into the computer or any recommendations or other issues that require follow up are passed on to the appropriate people. The ADON said Nurse #1 should have entered the Physician's recommendation to offload Resident #1's right heel into the computer as an order. The ADON said entering the intervention as an order ensures all nursing staff would be aware, and would have to sign off that the intervention was completed. The ADON said while the nursing and Certified Nurse Aide (CNA) staff were likely offloading Resident #1's right heel, there was no documentation to support they were doing so in Resident #1's electronic health record.

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