STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225194	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimwell Nursing and Rehabilitation	495 New Boston Road Fall River, MA 02720

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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
	225194	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimwell Nursing and Rehabilitation	495 New Boston Road Fall River, MA 02720

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who became unsteady during a transfer and was lowered to the floor by staff, the Facility failed to ensure staff provided quality of care consistent with professional standards of practice, when on 08/30/25, after Resident #1 was lowered to the floor, two Certified Nurse Aides (CNAs) transferred him/her up off the floor without informing and having the nurse assess him/her first for the potential for physical injury, Resident #1 exhibited a sudden change in his/her condition, with signs and symptoms of severe pain, was transferred to the Hospital Emergency Department (ED) for evaluation and was diagnosed with a fracture of his/her left hip.Findings include:Review of the Facility's Policy, titled Falls and Fall Risk, Managing, dated as revised March 2018 indicated the following:-a fall is defined as: unintentionally coming to rest on the ground, floor or other lower level; an episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall.-a fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.Review of the Facility's Certified Nursing Assistant (CNA) Job Description, dated as revised October 2020, indicated the following:-the primary purpose of this position is to provide residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as directed by supervisors. -report all changes in the resident's condition to the Charge Nurse/ Nurse Supervisor as soon as practical.-perform all assigned tasks in accordance with established facility policies and procedures, and as instructed by your supervisors.Resident #1 was admitted to the Facility in November 2023, diagnoses included Dementia, cognitive communication deficit, disorders of bone density and structure (affects strength and composition of bones), rheumatoid arthritis, and hypertensive heart disease (high blood pressure).Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 07/04/25, indicated that he/she was severely cognitively impaired.Review of Resident #1's Fall Risk Assessment, dated 08/21/25, indicated that he/she was at moderate risk for falls.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 09/05/25, indicated on 08/30/25 at approximately 11:30 A.M., CNA #1 was transferring Resident #1 to the toilet, he/she became unsteady, and CNA #1 lowered him/her to the floor. The Report indicated that CNA #1 called for assistance (from another CNA), both CNA #1 and CNA #2 stood Resident #1 up and pivoted him/her onto the toilet, he/she then had a sudden change in his/her (facial) color, was diaphoretic (sweating) and the CNAs called out for the nurse. The Report further indicated that Resident #1 complained of pain 10/10 (a pain scale where 0 is no pain and 10 is the worst pain imaginable, severe or unbearable pain), but the origin of pain could not be identified, he/she was sent to the hospital for evaluation, a Computed Tomography (CT) scan (imaging test that uses X-rays) of his/her abdomen revealed a left hip fracture, and he/she was admitted .Review of Resident #1's Nurse Progress Note, dated 08/30/25 (written by Nurse #1), indicated that Nurse #1 was called to Resident #1's bathroom related to a change in his/her condition and when Nurse #1 entered the room Resident #1 was sitting on the toilet. The Note indicated that Resident #1 looked ashy in color and when asked if he/she was having pain, Resident #1 answered yes but he/she was unable to identify the location of his/her pain.The Note indicated that Resident #1's vital signs, range of motion and neurological signs were assessed, he/she continued to yell out in pain, clenching his/her body with facial grimacing and was noted to be crying. The Note further indicated that the Nurse Practitioner was notified immediately, and an order was given to send Resident #1 to the hospital for evaluation and treatment.Review of Resident #1's Pain Assessment, dated 08/30/25, indicated that Resident #1 was unable to verbally answer but exhibited non-verbal/non-cognitive signs of pain that included crying/whimpering, frowning/scowling, grimacing, groaning, guarding, moaning and perspiration, according to the faces on the pain Scale, his/her pain was noted as hurts worst. The Assessment indicated that his/her pain intensity was a 10 out 10 and the location of his/her pain was unable to be identified.During an interview on 10/07/25 at 12:54 P.M., (which included review of her written statement dated 08/30/25) CNA #1 said on 8/30/25 around 11:30 A.M. she went to toilet Resident #1, assisted him/her to a standing position and his/her whole body started shaking. CNA #1 said she lowered Resident #1 to the floor because he/she was unsteady and she did not want him/her to fall. CNA #1 said she yelled out to CNA #2 for help and said they stood Resident #1 up, then transferred him/her onto the toilet. CNA #1 said Resident #1 started to look pale, his/her face was sweating, and she called for the nurse. CNA #1 said she should have called for the nurse