

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/16/2024
NAME OF PROVIDER OR SUPPLIER  Kimwell Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>36542</p> <p>Based on record review and interview, the facility failed to ensure the Court Order of Appointment of Guardian for an Incapacitated Person was followed for one Resident (#77), in a sample of 20 residents. Specifically, the facility failed to ensure for Resident #77 that the Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) form, which was signed by the previous Health Care Proxy (HCP), was voided with the appointment of a court designated guardian (a professional guardian who is unrelated to the incapacitated adult) who revoked the previous HCP and did not have authority to make advanced directive treatment decisions.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Resident Representative, dated as last revised February 2021, indicated the following:</p> <p>-If the resident is determined to be incompetent under the laws of the state by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed to act on the resident's behalf.</p> <p>-The court-appointed resident representative will exercise the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law.</p> <p>Resident #77 was admitted to the facility in June 2023 with a diagnosis of dementia.</p> <p>Review of the medical record indicated the previous facility in which Resident #77 resided petitioned the court for guardianship in November 2022. In March 2023, the previous facility submitted a Motion to Amend Petition (which was granted) to remove the request for authorization to consent to advanced directives. The Motion indicated Resident #77 had two estranged children, that advanced directives were not recommended by the treating clinicians and were not necessary at that time.</p> <p>Review of the medical record indicated the court designated an attorney as a temporary legal guardian in March 2023 and then ordered the attorney to be the permanent legal guardian in May 2023. Review of both court orders indicated the legal guardian had authority to admit the Resident to a nursing home and to revoke the previous Health Care Proxy. The Order did not indicate the guardian had authority to make decisions regarding advanced directives.</p> <p>Review of the medical record failed to indicate who the previous designated HCP was.</p> <p>(continued on next page)</p>

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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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the medical record included a MOLST form and physician's orders indicating Resident #77 was not to be resuscitated, not to be intubated and not to be transferred to the hospital. The MOLST form was signed by the sister of Resident #77 on 7/30/22, prior to the appointment of the professional guardian.</p> <p>During an interview on 12/12/24 at 9:38 A.M., Resident #77's sister said the previous facility had petitioned for a professional guardian related to discrepancies between herself and the Resident's spouse on the goals of care. She said she was not clear on the role of the professional guardian and her own role and if she maintained any rights as the previous HCP.</p> <p>During an interview on 12/12/24 at 10:17 A.M., the Social Worker said the Director of Social Services usually handles the guardianships for residents but was currently on leave. The Social Worker said she was unfamiliar with the rules for guardianship so could not say if the MOLST form signed by the Resident's sister was valid if there was a court appointed guardian. She said she was not sure if the Resident's sister was previously the HCP and was unable to locate the information in the medical record. She said she did not know why there was a court appointed guardian if there had previously been a HCP and was not sure if there had been any concerns with the previous HCP. She said she would have to bring the information to the Unit Manager to review if the MOLST was valid.</p> <p>During an interview on 12/12/24 at 11:17 A.M., the Director of Nurses (DON) said Resident #77 admitted to the facility as a direct admission from another facility. She said she was able to access the medical records from the previous facility and was able to locate a copy of the HCP, which indicated the Resident had previously designated his/her sister as the HCP. She said when the Resident was admitted to the facility, he/she had a permanent legal guardian. The DON said, because the previous HCP had signed the MOLST form, she assumed it was still valid. She said she had not seen the Motion to Amend Petition which indicated the removal of authority for advanced directives from the guardianship authority. She said she did not know why the previous HCP was revoked.</p> <p>During an interview on 12/12/24 at 3:15 P.M., the DON said she had attempted to contact the guardian to determine if the MOLST was valid, but with no response.</p> <p>During an interview on 12/16/24 at 7:32 A.M., the DON said they had contacted the facility legal counsel regarding Resident #77. She said the legal office advised that when the permanent guardianship became effective the MOLST was no longer effective and should have been voided.</p> <p>During the survey process, the surveyors and the facility attempted to contact the professional guardian with no response.</p>		

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<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>36542</p> <p>Based on the Beneficiary Protection Notification Review, the facility failed to issue the Notice of Medicare Non-Coverage (NOMNC) to two of three sampled Residents (#207 and #208) and failed to issue the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to two of three sampled Residents (#208 and #86).</p> <p>Findings include:</p> <p>The NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.</p> <p>The SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.</p> <p>Review of the Beneficiary Protection Notification Review indicated Resident #208 was receiving Medicare Part A services from 8/2/24 with a last covered day of 8/15/24 and then remained at the facility and was not provided the NOMNC or the SNF ABN.</p> <p>Review of the Beneficiary Protection Notification Review indicated Resident #207 was receiving Medicare Part A services from 9/6/24 until he/she discharged to the community on 9/16/24 and was not provided the NOMNC.</p> <p>Review of the Beneficiary Protection Notification Review indicated Resident #86 was receiving Medicare Part A services from 11/16/24 with a last covered day of 11/27/24 and then remained at the facility and was not provided the SNF ABN.</p> <p>During an interview on 12/12/24 at 2:51 P.M., the Administrator said the facility was unable to locate notices for two of the three residents. He said the Social Worker provides the notices to the residents but was unable to provide evidence the notices were issued.</p> <p>During an interview on 12/12/24 at 3:00 P.M., the Social Worker said she had provided the representative for Resident #86 with the NOMNC, but had not provided them with the information for the SNF ABN and she had forgotten to provide the additional notice. She said herself and the Business Office manager were unable to locate any notices for Resident #207 or Resident #208.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>50740</p> <p>Based on record review and interview, the facility failed to ensure that a required Preadmission Screening and Resident Review (PASARR) was completed for one Resident (#2) with a diagnosed mental condition, out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised March 2019, indicated but was not limited to the following:</p> <p>1. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder.</p> <p>a. All residents will receive a Level 1 PASARR screen prior to admission.</p> <p>Resident #2 was admitted to the facility in November 2024 with diagnoses including: bipolar disorder, anxiety, depression, and schizophrenia.</p> <p>Review of the Hospital Discharge Summary, dated 11/15/24, indicated the Resident's past medical history included schizoaffective disorder, schizophrenia, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #2, dated 11/22/24, indicated under Section I (Active Diagnoses) the Resident had anxiety disorder, depression, bipolar disorder, and schizophrenia coded as active diagnoses.</p> <p>Review of the physician's progress note for Resident #2, dated 11/19/24, indicated the Resident's past medical history included paranoid schizophrenia and anxiety. Further review of the physician's progress note indicated the Resident was hospitalized at a psychiatric facility in May 2022 and from October 2022 through March 2023.</p> <p>Review of the medical record failed to indicate a Level 1 PASARR was completed for Resident #2.</p> <p>During an interview on 12/11/24 at 12:20 P.M., the Director of Nurses (DON) said the facility did not have a completed Level 1 PASARR in the medical record for Resident #2.</p> <p>During an interview on 12/11/24 at 2:22 P.M., Social Worker #1 said she had been responsible for completing the PASARR forms since November 2024. She said she looked in the record for a completed Level 1 PASARR for Resident #2 but was unable to find it and probably never completed it.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36542</p> <p>Based on observations, interviews, and maintenance record review, the facility failed to ensure the environment was free from accident hazards for two out of three units in the facility. Specifically, the facility failed to ensure water temperatures were maintained at safe and comfortable levels in resident bathrooms and shower rooms.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Water Temperatures, Safety of, dated 2001, included but was not limited to the following:</p> <p>-Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents.</p> <p>-Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> <li>1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 115 degrees Fahrenheit, or the maximum allowable temperature per state regulation.</li> <li>2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log.</li> <li>3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.</li> <li>4. If at any time water temperatures feel excessive to the touch (such as hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor.</li> <li>5. Direct care staff shall be informed of the risk factors for scalding/burns that are more common in the elderly, such as:             <ol style="list-style-type: none"> <li>a. decreased skin thickness;</li> <li>b. decreased skin sensitivity;</li> <li>c. peripheral neuropathy;</li> <li>d. reduced reaction time;</li> <li>e. decreased cognition;</li> <li>f. decreased mobility; and</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>g. decreased communication.</p> <p>6. The length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help to determine the safety of the situation.</p> <p>Review of the Department of Public Health 105 CMR 150.470 Standards for Long Term Care Facilities indicated hot water supplied to fixtures accessible to residents shall be controlled to maintain a temperature between 110 and 120 degrees Fahrenheit (F).</p> <p>On 12/11/24 at 3:43 P.M., during an environmental tour of the facility, the surveyors tested the temperature of the hot water in resident bathroom sinks and shower rooms with the following results:</p> <ul style="list-style-type: none"> <li>-room [ROOM NUMBER]: 133F at 3:43 P.M.</li> <li>-room [ROOM NUMBER]: 133.2F at 3:50 P.M.</li> <li>-room [ROOM NUMBER]: 124.7F at 3:55 P.M.</li> <li>-Shower room [ROOM NUMBER] (on Unit 2): 138.5F at 4:13 P.M.</li> <li>-Shower room [ROOM NUMBER] (on Unit 2): 133.7F at 4:16 P.M.</li> <li>-Shower room [ROOM NUMBER] (on Unit 3): 135.5F at 4:23 P.M.</li> <li>-Shower room [ROOM NUMBER] (on Unit 3): 138.5F at 4:28 P.M.</li> </ul> <p>During an interview on 12/11/24 at 4:02 P.M., Resident #84 said the water temperature in the shower room could get too hot and was unsafe. Resident #84 said when he/she is in the shower room, he/she is offered to feel the water temperature by the Certified Nursing Assistant (CNA) prior to being showered. Resident #84 said there had been instances when the water was way too hot and he/she could have been scalded had he/she not tested the water temperature. The Resident said residents are at the mercy of the staff and expressed concern that staff could harm residents with the hot water.</p> <p>During an interview on 12/11/24 at 5:04 P.M., the Director of Maintenance (DOM) said he checks water temperatures every week but hadn't in the past two weeks. The DOM said each week he sampled faucet water in ten resident rooms by running the water for three minutes to get it as hot as possible. The DOM said the water in resident and shower rooms should not exceed 110F and anything above 110F could be too hot and unsafe. The DOM said if any resident room or shower room water temperatures exceed 110F, he would then lower the water temperature at the main boiler (a closed vessel in which fluid is heated) and adjust the house mixing valve (a device, also known as a temperature control valve, that controls the mix of hot and cold water in order to deliver water at a consistent, safe temperature) that delivers water to the units, including resident and shower rooms. The DOM said he keeps the boiler temperature at 135-140F, and there have been no water temperature issues since he came to the facility in July 2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/24 at 5:15 P.M., the DOM and surveyors tested the water temperatures for rooms #203, #204, and Shower room [ROOM NUMBER] (on Unit 2) with the following results:</p> <p>-#203: 140F</p> <p>-#204: 158F</p> <p>-Shower room [ROOM NUMBER]: 120F</p> <p>The DOM said these water temperatures were too high and he was surprised by the readings.</p> <p>Review of the Weekly Water Temperature Logs indicated water temperatures had not been monitored for the past 13 days and were last monitored on 11/29/24.</p> <p>The Weekly Water Temperature Logs indicated but were not limited to the following:</p> <p>November 2024</p> <p>-11/6/24, House mixing valve: 120F</p> <p>-11/8/24, House mixing valve: 140F</p> <p>-11/13/24, House mixing valve: 120F</p> <p>-11/15/24, House mixing valve: 120F</p> <p>-11/22/24, House mixing valve: 120F</p> <p>-11/29/24, House mixing valve: 120F</p> <p>-Water temperature ranges for resident rooms and shower rooms sampled this month: 107-112F</p> <p>October 2024</p> <p>-House mixing valve: 140F during four of four days monitored in October</p> <p>-Water temperature ranges for resident rooms and shower rooms sampled this month: 110-112F</p> <p>September 2024</p> <p>-House mixing valve: 140F during six of six days monitored in September</p> <p>-Water temperature ranges for resident rooms and shower rooms sampled this month: 109-112F</p> <p>The Weekly Water Temperature Logs indicated but were not limited to the following:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Please make sure the water in the resident's bath sink, shower room, common area lavatories doesn't exceed 115 or below 110 at the plumbing fixtures. Mixing valve 120. Please report any discrepancies to Director of Maintenance.</p> <p>During an interview on 12/11/24 at 5:30 P.M., the Administrator said the boiler temperature was 135F and he had just lowered the boiler temperature to 120F in recent minutes due to the surveyors' expressed concern over water temperatures.</p> <p>During an interview on 12/12/24 at 7:43 A.M., Certified Nursing Assistant (CNA) #1, who normally works on the first floor, said the water temperatures in resident bathroom sinks can vary and would get too hot in rooms [ROOM NUMBERS]. She said this was not a new issue and she thought management knew.</p> <p>During an interview on 12/12/24 at 7:48 A.M., CNA #2, who normally works on the first floor, said the sink water can run too hot sometimes and she tries to fill basins right when she turns the water on before it gets too hot.</p> <p>During an interview on 12/12/24 at 2:25 P.M., the DOM and surveyor observed the boiler and the house mixing valve. The pipe extending from the house mixing valve had a dial thermometer around the piping. The DOM said the thermometer measured the temperature of the water delivered to the units and it was this thermometer that he used to measure the temperature for the house mixing valve on the Weekly Water Temperature Logs.</p> <p>The DOM and surveyor reviewed the Weekly Water Temperature Logs, specifically the values for the house mixing valve where the value was 140F. The DOM said he adjusted the temperature of the house mixing valve based on the water temperature values obtained from resident rooms and shower rooms during weekly water temperature monitoring. The DOM said if the house mixing valve thermometer read 140F, it was possible for 140F water to travel from the mixing valve to the units, and the temperature of water traveling from the mixing valve to the units should not exceed 115-120F per facility policy and regulation.</p> <p>49428</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36542</p> <p>Based on observations, interview, and record review, the facility failed to follow professional standards of practice to administer oxygen therapy as ordered for one Resident (#68), in a total sample of 20 residents. Specifically, the facility administered Oxygen at 5 liters (L) per minute for Resident #68 with an order for Oxygen at 2L.</p> <p>Findings include:</p> <p>Resident #68 was admitted to the facility in May 2024 with a diagnosis of chronic obstructive pulmonary disease (COPD- a lung disease that blocks airflow and makes it difficult to breathe) and had an active diagnosis of pneumonia during the survey period.</p> <p>Review of the Physician's Orders included an order to administer Oxygen at 2L via nasal cannula effective 11/10/24.</p> <p>Review of the Nurse Practitioner (NP) Progress Note, dated 11/11/24, indicated Resident #68 had COPD and to continue Oxygen at 2 to 3L.</p> <p>Review of the NP Progress Note, dated 11/14/24, indicated Resident #68 had COPD and to continue Oxygen at 2 to 3L.</p> <p>Review of the nursing progress notes indicated the following:</p> <p>-12/6/24: Resident's oxygen saturation increased from 83% to 98% with raising the head of the bed, Resident on 2L of Oxygen</p> <p>-12/6/24: Resident's oxygen saturation at 80% with head of bed low (10%), head of bed raised and nebulizer treatment provided and oxygen saturation increased to 98% on 2L of Oxygen</p> <p>-12/9/24: Resident's oxygen saturation at 89% with head of bed at 30% and Resident refusing to increase the head of bed elevation, nebulizer treatment administered</p> <p>-12/9/24: vital signs stable with oxygen saturation at 92% on 2L of Oxygen</p> <p>-12/10/24: Resident's oxygen saturation at 85% and head of bed almost all the way down, head of bed was raised, oxygen saturation increased to 91% on 2L of Oxygen</p> <p>-12/10/24: Resident stable with oxygen saturation at 90-93% on 2L of Oxygen</p> <p>On 12/11/24 at 10:13 A.M., the surveyor observed Resident #68 in bed, wearing a nasal cannula. The oxygen concentrator was observed set to 5L.</p> <p>On 12/11/24 at 2:47 P.M., the surveyor observed Resident #68 in bed, wearing a nasal cannula. The oxygen concentrator was observed set to 5L.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/24 at 8:05 A.M., the surveyor observed Resident #68 in bed, wearing a nasal cannula. The oxygen concentrator was observed set to 5L.</p> <p>During an interview on 12/12/24 at 8:24 A.M., Nurse #3 said she was caring for Resident #68 on this day and had been in to the room to administer a nebulizer breathing treatment to the Resident. She said the Resident has an order for the Oxygen to be administered at 2 liters per minute and she thinks she confirmed the administration on the concentrator this morning.</p> <p>During an interview with observation on 12/12/24 at 8:26 A.M., Nurse #3 observed the Oxygen concentrator for Resident #68 set at 5L. She said the Oxygen concentrator should not be set at 5L and should be set at 2L. She reviewed the medical record and confirmed the physician orders were to administer the Oxygen at 2L. She said she was not sure how the setting was changed to 5L and she should have noticed this morning when administering the nebulizer treatment.</p> <p>During an interview on 12/12/24 at 3:13 P.M., the Director of Nurses (DON) said the physician's orders for administering Oxygen should be followed and the physician should be contacted for any changes.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>49424</p> <p>Based on record review and interview, the facility failed to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, as required placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurse Aides (CNA) that the RN was responsible for overseeing with provision of resident care. Specifically, the facility failed to provide the services of a RN for at least eight consecutive hours a day, seven days a week when no staffing waivers were in place on four days for the period of 7/1/24 to 9/30/24.</p> <p>Findings include:</p> <p>1. Review of the Payroll Based Journal (PBJ) Staffing Data Report, dated Quarter 4: 2024 (July 1 - September 30), indicated the following:</p> <p>-One Star Staffing Rating Triggered = Star Staffing Rating Equals 1</p> <p>-No RN Hours Triggered = Four or More Days Within the Quarter with no RN Hours</p> <p>Review of the as worked nursing schedule provided by the facility failed to indicate that a RN worked for eight hours in the facility on the following days:</p> <p>-8/3/24</p> <p>-8/4/24</p> <p>-8/25/24</p> <p>-9/21/24</p> <p>During the Entrance Conference Interview on 12/10/24 at 8:58 A.M., the Administrator and the Director of Nurses (DON) said the facility did not have any nurse waivers in place.</p> <p>During an interview on 12/16/24 at 9:17 A.M., Human Resource Manager #1 said the facility was aware of the PBJ report triggering for four or more days within the quarter with no RN during Quarter 4. She said she submits the information for the PBJ report. She said she confirmed before submitting the data that there was no RN coverage for those days.</p> <p>During an interview on 12/16/24 at 12:00 P.M., the Administrator said he is aware of the need to have RN coverage for a consecutive eight hours a day for seven days a week in the building, but there is on call coverage available from the nurse management team for clinical needs. We identified we did not have the coverage we are required to have.</p>

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NAME OF PROVIDER OR SUPPLIER  Kimwell Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  495 New Boston Road Fall River, MA 02720	
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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>36542</p> <p>Based on record review and interview, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one Resident (#77), in a total sample of 20 residents. Specifically, the facility failed to obtain a social history for Resident #77 which included complicated family relations, possible lack of care in the community from a family member, and a history of substance use disorder.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Social Services, dated as revised in September 2021, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>-the facility staff are able to identify and address factors that have potentially negative effect on psychosocial functioning of a resident; examples include: situations that impede the resident's dignity and sense of control, lack of family/community support system, substance abuse;</li> <li>-the social worker/social service staff are responsible for: identifying and seeking ways to support residents needs through the assessment and care planning process</li> </ul> <p>Review of the facility's policy titled Social Assessment, dated as revised in July 2014, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>-a social assessment will be done to help identify the resident's personal and social situation, needs, and problems;</li> <li>-social service staff will obtain information during the initial interview of the family and upon the resident's admission;</li> <li>-the purpose is to identify information to help staff develop a personalized plan of care that will utilize the individual's existing strengths, try to compensate for physical and functional deficits, optimize function and quality of life, and meet the individual's needs and preferences</li> <li>-Components of the Social Assessment include: personal and family history, employment and professional history, hobbies and interests, personal preferences, and wishes about medical treatment and care, including advanced directives</li> </ul> <p>Resident #77 was admitted to the facility in June 2023 with a diagnosis of dementia and had a court Order of Appointment of Guardian for an Incapacitated Person.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/20/24, indicated Resident #77 scored 0 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident had a severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record indicated a petition for guardianship was filed in November 2022, prior to admission. In March 2023 the previous facility submitted a Motion to Amend Petition (which was granted) to remove the request for authorization to consent to advanced directives. The Motion indicated Resident #77 had two estranged children, that advanced directives were not recommended by the treating clinicians and were not necessary at that time.</p> <p>Further review of the medical record included a MOLST form and physician's orders indicating Resident #77 was not to be resuscitated, not to be intubated and not to be transferred to the hospital. The MOLST form was signed by the sister of Resident #77 on 7/30/22, prior to the appointment of the professional guardian.</p> <p>Review of the medical record indicated the first Social Service Assessment was completed on 9/27/23, three months after the Resident was admitted to the facility. The Social Service Assessment indicated the following:</p> <ul style="list-style-type: none"> <li>-highest level of education: unknown</li> <li>-occupation: unknown</li> <li>-advanced care planning: Health Care Proxy (guardianship was not indicated)</li> <li>-code status reviewed: yes</li> <li>-marital status: widowed</li> <li>-number and names of children: see face sheet</li> <li>-identified support system: family</li> <li>-drug/alcohol abuse: no</li> <li>-source of information: Resident</li> </ul> <p>Review of the medical record included Social Service Assessments from the following dates: 1/9/24, 4/3/24, 6/26/24, 9/19/24 all indicated the following:</p> <ul style="list-style-type: none"> <li>-highest level of education: unknown</li> <li>-occupation: unknown</li> <li>-advanced care planning: Health Care Proxy (guardianship was not indicated)</li> <li>-code status reviewed: yes</li> <li>-marital status: widowed</li> <li>-number and names of children: see face sheet</li> </ul> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-identified support system: family</p> <p>-drug/alcohol abuse: no</p> <p>-source of information: Resident</p> <p>During an interview on 12/12/24 at 9:38 A.M., Resident #77's sister said Resident #77 previously lived at home with his/her spouse, was losing weight and had bed sores which he/she has been gauging with his/her fingers. She said the Resident was admitted to the hospital and then sent to a nursing home. She said the spouse of Resident #77 and herself did not get along and she had been threatened by the spouse. She said the spouse of Resident #77 had been visiting the Resident at the facility up until six months ago. She said the Resident had two children, both who had not been to visit in over a year. The Resident's sister said she was previously the designated HCP, but there was now a professional guardian, and she was not clear on if she was still able to make any medical decisions.</p> <p>During an interview on 12/12/24 at 10:17 A.M., the Social Worker said she had been at the facility since October 2023 and was the Social Worker for Resident #77. She reviewed the medical record and said she was unable to find any social service documentation prior to September 2023. She said Social Service Assessments were completed upon admission and every quarter for each resident. She said she had completed the last four Social Service Assessments for Resident #77. She said the process was to copy the answers from the previous assessments and she had not reached out to any family members for Resident #77 to obtain a social history. She said she did not think the Resident was married or had any children. The Social Worker then reviewed the Resident's contacts and said, Oh, he/she is married.</p> <p>During the continued interview, the Social Worker said the Director of Social Services usually handles the guardianships for residents but was currently on leave. The Social Worker said she was unfamiliar with the rules for guardianship and could not say if the MOLST form signed by the Resident's sister was valid if there was a court appointed guardian. She said she was not sure if the Resident's sister was previously the HCP and was unable to locate the information in the medical record. She said she did not know why there was a court appointed guardian if there had previously been a HCP and was not sure if there had been any concerns with the previous HCP. She said she had indicated on the Social Service Assessment that she had reviewed the advanced directives but would have to check with a nurse to see if the MOLST was valid.</p> <p>During an interview on 12/12/24 at 11:17 A.M., the Director of Nurses (DON) said Resident #77 was admitted to the facility as a direct admission from another facility and was admitted to be closer to a family member, but not a spouse and that the Resident was not married. She said she was able to access the medical records from the previous facility and was able to locate a copy of the HCP, which indicated the Resident had previously designated his/her sister as the HCP. She said when the Resident was admitted to the facility, he/she had a permanent legal guardian. The DON said because the previous HCP had signed the MOLST form she assumed it was still valid. She said she had not seen the Motion to Amend Petition which indicated the removal of authority for advanced directives from the guardianship authority. She said she did not know why the previous HCP was revoked.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24 at 1:33 P.M., the Social Worker said she had called the sister of Resident #77 to obtain a social history and found out the Resident was still married and had two children who were estranged. She said the sister identified that the Resident also had a history of alcohol abuse. She said the facility was unaware of this information prior.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>36542</p> <p>Based on interview and record review, the facility failed to provide the Pneumococcal and Influenza immunizations as requested/consented for three Residents (#94, #90 and #11), out of a total sample of five residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Influenza Vaccine, dated as revised in September 2024, indicated the following:</p> <ul style="list-style-type: none"> <li>-between as early as August 1st through March 31st of the following year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated, or the resident has already been immunized</li> <li>-residents admitted between August 1st (or when the vaccine is available) and March 31st of the following year shall be offered the vaccine within five (5) working days of the resident's admission to the facility</li> </ul> <p>Review of the facility's policy titled Pneumococcal Vaccine, dated as revised in March 2023, indicated the following:</p> <ul style="list-style-type: none"> <li>-all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections</li> <li>-prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series and when indicated/available, are offered the vaccine series within the facility unless medically contraindicated, awaiting shipments of vaccines, or the resident has already been vaccinated</li> <li>-assessments of pneumococcal vaccination status are conducted within thirty (30) days of the resident's admission if not conducted prior to admission</li> <li>-administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination</li> </ul> <p>During an interview on 12/12/24 at 12:15 P.M., the Infection Control Preventionist said when a resident admits to the facility the admitting nurse will review the vaccine options and obtain either consent or declination for the vaccines. She said she will then review the risks and benefits with the Resident, check the Massachusetts Immunization Information System (MIIS) for a history of immunizations, and then administer immunizations as indicated and document in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record for Resident #94 indicated the Resident was admitted to the facility in October 2024. Review of the Immunization Consent form indicated the Resident consented to the Pneumococcal vaccine and had declined the influenza vaccine and any COVID-19 boosters. Review of the electronic medical record indicated Resident #94 declined the Pneumococcal vaccine and the influenza vaccine. Record review failed to indicate the Resident had been administered the Pneumococcal vaccine.</p> <p>During an interview on 12/12/24 at 12:15 P.M., the Infection Control Preventionist said she thinks she might have gone to offer Resident #94 the Pneumococcal vaccine, but she couldn't be sure. She said she reviewed the medical record and was unable to find any documentation to indicate if she had and she would have to meet with the Resident again to administer the vaccine.</p> <p>Review of the medical record for Resident #90 indicated the Resident was admitted to the facility in October 2024. Review of the Immunization Consent form indicated the Resident consented to the Influenza vaccine and the Pneumococcal vaccine. Review of the electronic medical record indicated Resident #90 declined the Influenza and the Pneumococcal vaccines. Record review failed to indicate the Resident had been administered either vaccine.</p> <p>During an interview on 12/12/24 at 12:15 P.M., the Infection Control Preventionist said the consent form had been missed and she had not gone to offer either of the vaccines to Resident #90 and should have.</p> <p>Review of the medical record for Resident #11 indicated the Resident was admitted to the facility in November 2024. Review of the Immunization Consent form indicated the Resident's representative consented to the Influenza, the Pneumococcal and the COVID-19 booster vaccines. Review of the electronic medical record indicated Resident #11 was administered the Influenza vaccine at the facility on 11/21/24. The electronic medical record indicated the Resident had received the PCV (Pneumococcal conjugate vaccines)-13 vaccine on 2/3/23. The medical record failed to indicate if the Resident had been assessed eligibility for additional Pneumococcal vaccines.</p> <p>Further review of the paper medical record for Resident #11 indicated the previous facility had sent an immunization history for the Resident indicating the Resident had received their 2024-2025 flu season Influenza vaccine on 9/27/24.</p> <p>During an interview on 12/12/24 at 12:15 P.M., the Infection Control Preventionist said she had not assessed the eligibility guidelines for additional Pneumococcal vaccines for Resident #11. She said in reviewing the guidelines, Resident #11 was eligible to receive the PCV 20 vaccine and had not been administered the vaccine. She said she would have to review the medical record and the MIIS to determine how the Resident was administered the Influenza vaccine in September 2024 and November 2024.</p> <p>During an interview on 12/12/24 at 1:25 P.M., the Infection Control Preventionist said Resident #11 had been administered the Influenza vaccine at the previous facility and at the current facility. She said she had not reviewed the discharge paperwork sent from the previous facility to note the administration of the Influenza vaccine and had relied on the MIIS being up to date.</p>		