

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/14/2025
NAME OF PROVIDER OR SUPPLIER  Catholic Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE  2446 Highland Avenue 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 0656  Level of Harm - 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.  (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on records reviewed, and interviews for one of three sampled residents (Resident #1), who was at risk for falls, had severe cognitive impairment, and whose plan of care indicated he/she required continual supervision while ambulating, the Facility failed to ensure staff consistently implemented and followed his/her care plan interventions, when 09/19/25 sometime around 7:15 P.M. Resident #1 ambulated off of his/her unit undetected by staff, walked to the main entrance where he/she opened the main entrance door and fell. Resident #1 was transferred to the Hospital's Emergency Department (ED) for evaluation and was diagnosed with a pelvic fracture. Findings include: Review of the Facility's policy, titled Comprehensive Care Plan, dated as revised July 2025, indicated that the Facility would develop and implement a comprehensive person-centered care plan for each resident that will meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 09/20/25, indicated that on 09/19/25 at 7:15 P.M., Resident #1 wandered [off his/her unit] and was observed by staff (later identified as Receptionist #1) as he/she walked quickly towards the main entrance door, opened the door and fell. The Report indicated that Receptionist #1 was able to get the attention of a visitor who went to get help. The Report indicated that Resident #1 was sent to the Hospital ED and diagnosed with a left pubic ramus (pelvic) fracture. Review of the Hospital Emergency Department Aftercare Summary, dated 09/23/25, indicated that Resident #1 sustained a left inferior pubic ramus fracture (pelvic fracture). Resident #1 was admitted to the Facility in December 2022, diagnoses included dementia, epilepsy and anxiety. Review of Resident #1's Minimum Data Set (MDS) Quarterly Assessment, dated 08/07/25, indicated Resident #1 had severe cognitive impairment and required partial assistance for ambulation. Review of Resident #1's Care Plan, titled Ambulation/Locomotion, reviewed and renewed with his/her Quarterly MDS Assessment, dated 08/07/25, indicated that Resident #1 required continual supervision for ambulation with a rolling walker due to poor safety awareness. Review of Resident #1's Care Plan, titled Falls, reviewed and renewed with his/her Quarterly MDS Assessment, dated 08/07/25, indicated that -he/she had poor sense of direction, destination, and poor safety awareness due to poor cognition, -he/she was at risk for eloping from his/her unit, and -he/she was not safe to leave his/her unit or building unassisted. Review of Resident #1's Resident Profile (care card utilized by staff providing direct care, identifies individual residents' care needs) indicated that as of 12/21/22, he/she required continual supervision for ambulation with his/her rolling walker. Review of Receptionist #1's Written Witness Statement, dated 09/19/25, indicated that on 09/19/25, sometime around 7:15 P.M. -7:30 P.M., he saw Resident #1 walk quickly towards the main entrance door and that he tried to stop him/her (Resident #1), but it was too late. The Statement indicated that he (Receptionist #1) rushed over to help him/her, but Resident #1 had already pushed the main entrance door open and fallen. The Statement indicated he (Receptionist #1) yelled out for help, a visitor came to help, and he asked the visitor to go get staff to help. During a telephone interview on 10/24/25 at 10:39 A.M., Certified Nurse Aide (CNA) #4 said Resident #1 had been on her assignment during the 3:00 P.M. to 11:00 P.M. (evening) shift on 09/19/25 and said Resident #1 needed continual supervision for safety because he/she was a fall risk. CNA #4 said that Resident #1's information about level of assistance he/she required could be found on his/her care plan or on his/her resident profile card. CNA #4 said Resident #1 had been standing up frequently that evening and that she (CNA #4) had been in the dining room supervising him/her. CNA #4 said that when she had to care for another resident, she asked CNA #1 to supervise Resident #1 while she (CNA #4) stepped away. CNA #4 said that when she returned to supervise Resident #1, she heard Resident #1 had fallen. During a telephone interview on 10/14/25 at 12:38 P.M., (which included review of her Written Witness Statement, dated 09/19/25), CNA #1 said that she had not typically worked on Resident #1's unit but said she was familiar with Resident #1 and knew he/she required continual supervision due to his/her fall risk. CNA #1 said that on 09/19/25, Resident #1 kept trying to go to the exits at the ends of his/her unit hallway and she had stopped him/her (Resident #1) twice already before she had to go provide care for another resident. CNA #1 said as she was walking into another resident's room, she saw Resident #1 walking towards another CNA, so she figured Resident #1 would be supervised. CNA #1 said that by the time she was done providing care for another resident, Resident #1 had already left his/her unit. During an interview on 10/14/25 at 3:16 P.M., Nurse #1 said Resident #1 required continual supervision and should therefore always be in staff's line of site. Nurse #1 said Resident #1 had been antitated during the evening shift on 09/19/25 because he/she</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was at risk for falls, had been exhibiting exit seeking behaviors, was at increased risk for elopement, poor safety awareness and required continual supervision by staff while ambulating, the Facility failed to ensure he/she was provided with the necessary level of staff supervision to prevent an incident resulting in injury, when on 09/19/25 sometime around 7:15 P.M., Resident #1 ambulated off of his/her unit undetected by staff, and walked to the Facility's main entrance where he/she opened the main entrance door and fell. Resident #1 was transferred to the Hospital's Emergency Department (ED) for evaluation and was diagnosed with a pelvic fracture. Findings include:Review of the Facility Policy titled Fall Prevention Program, dated as revised 10/2024, indicated that:-the Facility would prevent resident falls through systemic and regular identification of risk factors for each resident, and-interdisciplinary care plans would be established, revised and/or renewed each time a resident falls, and appropriate interventions to maintain resident's safety would be included. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 09/20/25, indicated that on 09/19/25 at 7:15 P.M., Resident #1 wandered [off his/her unit] and was observed by staff (later identified as Receptionist #1) as he/she walked quickly towards the main entrance door, opened the door and fell. The Report indicated that Receptionist #1 was able to get the attention of a visitor who went to get help. The Report indicated that Resident #1 was sent to the Hospital's ED and diagnosed with a left pubic ramus (pelvic) fracture. Review of the Facility's Event Report, dated 09/19/25, indicated that Resident #1 was found outside on the front steps with complaints of left hip and leg pain. The Report indicated that the on-call provider was notified and Resident #1 was sent to the Hospital's ED. Review of the Hospital's ED Aftercare Summary, dated 09/23/25, indicated that Resident #1sustained a left inferior pubic ramus fracture (pelvic fracture). Resident #1 was admitted to the Facility in December 2022, diagnoses included dementia, epilepsy and anxiety. Review of Resident #1's Health Care Proxy Activation Form, dated 003/09/23, indicated his/her Health Care Proxy (HCP) had been activated. Review of Resident #1's Minimum Data Set (MDS) Quarterly Assessment, dated 08/07/25, indicated Resident #1 had severe cognitive impairment and required partial assistance for ambulation. Review of a Fall Risk Assessment, dated 08/08/25, indicated that Resident #1 was at risk for falls. Review of Resident #1's Care Plan, titled Falls, reviewed and renewed with his/her Quarterly MDS Assessment, dated 08/07/25, indicated the following:-he/she had poor sense of direction, destination, and poor safety awareness due to poor cognition, -he/she was at risk for eloping from his/her unit, and-he/she was not safe to leave his/her unit or building unassisted. Review of Resident #1's Care Plan, titled Ambulation/Locomotion, reviewed and renewed with his/her Quarterly MDS Assessment, dated 08/07/25, indicated that Resident #1 required continual supervision for ambulation with a rolling walker due to poor safety awareness. Review of Receptionist #1's Written Witness Statement, dated 09/19/25, indicated that on 09/19/25 sometime around 7:15 P.M. -7:30 P. M., he saw Resident #1 walk quickly toward the main entrance door, and that he tried to stop him/her (Resident #1), but it was too late. The Statement indicated that he rushed over to help him/her, but Resident #1 had already pushed the main entrance door open and fallen. The Statement indicated he (Receptionist #1) yelled out for help and a visitor came to help him, and he asked the visitor to go get staff to help. During a telephone interview on 10/24/25 at 10:39 A.M., Certified Nurse Aide (CNA) #4 said Resident #1 was on her assignment during the 3:00 P.M. to 11:00 P.M. (evening) shift on 09/19/25 and said Resident #1 needed continual supervision for safety because he/she was a fall risk. CNA #4 said Resident #1 had been standing up frequently and that she (CNA #4) had been in the dining room supervising him/her but had to care for another resident. CNA #4 said she then asked CNA #1 to supervise Resident #1 when she left the dining room to care for another resident. During a telephone interview on 10/14/25 at 12:38 P.M., CNA #1 said that she had not typically worked on Resident #1's unit but said she was familiar with Resident #1 and knew he/she required continual supervision due to his/her fall risk. CNA #1 said she had been supervising Resident #1 when she had to leave him/her to answer another resident's call light. CNA #1 said as she was walking into another resident's room, she saw Resident #1 walking toward another CNA, so she figured Resident #1 would be supervised. CNA #1 said that by the time she was done providing care for another resident, Resident #1 had already left his/her unit. During an interview on 10/14/25 at 3:16 P.M., Nurse #1 said Resident #1 requires continual supervision and should therefore always be in staff's line of site. Nurse #1 said Resident #1 had been agitated during the evening shift on 09/19/25 because he/she thought he/she</p>		