STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carvalho Grove Health and Rehabilitation Center	273 Oak Grove Avenue Fall River, MA 02723

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. **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 per rehabilitation staff required the use of a mechanical lift for all transfers, and per facility policy two staff members were required to complete lift transfers, the facility failed to ensure that 1) Resident #1's individualized comprehensive plan of care, which included his/her care Kardex, clearly indicated the number of staff members required to provide assistance during the transfers, and as a result one staff member attempted to transfer him/her alone, he/she fell, and sustained a fracture to his/her left ankle, and 2) failed to ensure they developed and implemented a comprehensive plan of care related to Resident #1's ankle fracture, that accurately identified care and treatment needs associated with new placement of a fiberglass splint, that included appropriate interventions, goals and outcomes.Findings include:Review of the Facility Policy titled, Comprehensive Care Plans, dated as revised May 2025, indicated the following:-the interdisciplinary team (IDT) would develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality;-the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and include an assessment of the resident's strengths and needs;Review of the Facility Policy titled, Safe Resident Handling/Transfers, dated as revised May 2025, indicated the following:-the facility will ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines;-while manual lifting techniques may be utilized if appropriate for the resident's condition and mobility, use of mechanical lifts are a safer alternative and should be used;-the IDT will evaluate and assess each resident's individual mobility needs;-the resident's mobility needs will be addressed based on direct care staff observations or recommendations;-mechanical lifts include equipment such as full body lifts or sit to stand lifts;-two staff members must be utilized when transferring residents with a mechanical lift;-staff members are expected to maintain compliance with safe handling/transfer practices;-resident lifting and transferring will be performed according to the resident's individual care plan;Resident #1 was admitted to the Facility in March 2024 diagnoses included cerebral palsy, embolism and thrombosis of deep veins (blood clot) of left lower extremity, muscle weakness, hypertension, hyperlipidemia, major depressive disorder, osteitis (inflammation of bone tissue) and wedge compression fracture of fifth lumbar vertebra (lower back).Review of his/her Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 was alert and oriented, with a Brief Interview for Mental Status (BIMS) of 15 (intact cognitive function) and was dependent on staff with transfers.1) Review (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
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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	of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 01/02/26, indicated that on 01/01/26 at 7:00 P.M., Resident #1 was assisted by staff via the Sit/Stand Lift when he/she let go of the hand supports and slid out of the lifts sling onto the floor. The Report indicated that Resident #1 complained of pain to his/her left ankle and was transferred to Emergency Department (ED) for evaluation. The Report further indicated that Resident #1 had a fracture of the distal end of the left tibia and left fibula (ankle fracture), was non-weight bearing to his/her left lower extremity and to follow-up with orthopedics. During an interview on 02/03/26 at 1:21 P.M., Resident #1 said that he/she fell out of the Sit/Stand Lift during a transfer and broke his/her left ankle. Resident #1 said that there were always two staff members present when he/she was transferred with the Sit/Stand Lift. Resident #1 said that the day he/she fell out of the Sit/Stand Lift, a male CNA transferred him/her without the assistance of another staff member. Resident #1 said that he/she did not know who the male CNA was who transferred him/her.Review of Resident #1's Care Plan related to Activities of Daily Living (ADL), dated as reviewed and renewed with his/her October 2025 MDS, indicated that he/she required physical assistance to dependence of staff with transfers.However, Resident #1's ADL Care Plan did not indicate the number of staff members that were required to participate in order to safely complete the transfers.Review of Resident #1's Resident Care Card, (used as a reference guide by CNA's, provides direct care staff with a brief overview of each resident's care needs), (reviewed and updated in conjunction with his/her plan of care), indicated that he/she required physical assistance to dependence of staff with transfers.However, Resident #1's Care Card also did not indicate the number of staff members that were required to participate to safely complete the transfers.Review of Resident #1's Occupational Therapy Recertification, Progress Report and Updated Therapy Plan, dated 12/29/25, indicated he/she was assessed as being dependent for transfers with use of Sit/Stand Lift and required moderate to maximum assistance of two staff members for all transfers.During an interview on 02/03/26 at 11:50 A.M., the Certified Occupational Therapy Assistant (COTA) said that Resident #1 was receiving skilled therapy prior to his/her fall on 01/01/26. The COTA said that Resident #1's lower extremities were weak, that he/she required a Sit/Stand Lift for all transfers and maximal assistance of two staff members with transfers.During an interview on 02/03/26 at 12:06 P.M., the Occupational Therapist (OT) said that Resident #1 had a functional decline prior to his/her fall on 01/01/26 and was on skilled therapy for upper and lower body strengthening. The OT said that Resident #1 required a Sit/Stand Lift for all transfers and maximal assistance of two staff members with transfers.During a telephone interview on 02/04/26 at 10:42 A.M., CNA #1 said that 01/01/26 on the 3:00 P.M. to 11:00 P.M. shift, that it was his first time working at the facility. CNA #1 said that when he received report at the beginning of the shift about the residents on his assignment, that the other staff members that worked with him on the unit that night, informed him that Resident #1 required the use of a Sit/Stand Lift for transfers. CNA #1 said he has been a CNA for 18 years, had been trained on the use of a Sit/Stand Lift, was familiar with the Sit/Stand Lift at the facility and knew how to work the Sit/Stand Lift device. CNA #1 also said that he was aware that transfers with the Sit/Stand Lift required the assistance of two staff members. CNA #1 said there was another CNA nearby in the hallway when he transferred Resident #1 with the Sit/Stand Lift, but she was not in the room during the transfer. CNA #1 said that on 01/01/26 at approximately 7:00 P.M. he transferred Resident #1 using a Sit/Stand Lift without the assistance of another person, that Resident # 1 let go of the bars on the lift and fell to the floor. CNA #1 could not explain why he transferred Resident #1 without the assistance of another staff member.During a telephone interview on 02/04/26 at 11:03 A.M., CNA #4 said that she worked on 01/01/26 during the 3:00 P.M. through 11:00 (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	P.M. shift. CNA #4 said that she reviewed CNA #1's assignment with him at the start of the shift on 01/01/26 and said she told CNA #1 that Resident #1 required the assistance of two staff members for transfers with the Sit/Stand Lift. CNA #4 said that she offered to assist CNA #1 with Resident #1's transfer and was available to help with Resident #1's transfer when needed. CNA #4 said CNA #1 never came to get her during her shift to ask for help.Review of a Nurse Progress Note, dated 01/02/26, (written by Nurse #1) indicated that CNA #1 notified her that during a sit to stand transfer, Resident #1 let go of the sling and slid down to the floor. The Note indicated that Resident #1 complained of left ankle pain and was transferred to the Hospital ED for evaluation.During a telephone interview on 02/03/26 at 4:43 P.M., Nurse #1 said that on 01/01/26, at around 7:00 P.M., CNA #1 (who was an agency CNA) came to the nurse's station and informed her that during a sit to stand transfer, Resident #1 fell from the Sit/Stand Lift onto the floor. Nurse #1 said that Resident #1 required a Sit/Stand Lift for all transfers and said that Sit/Stand Lift transfers always required the assistance of two staff members. Nurse #1 said that when she assessed Resident #1, he/she was sitting on the floor complaining of left ankle pain. Nurse #1 said that Resident #1 was transferred to the Hospital ED for evaluation. Nurse #1 said that she could not recall if CNA #1 transferred Resident #1 with another staff member.During a telephone interview on 02/05/26 at 12:46 P.M., Nurse #4 said that she worked 01/01/26 during the 3:00 P.M. through 11:00 P.M. shift. Nurse #4 said that she was informed by Nurse #1 that Resident #1 fell during a transfer with a Sit/Stand Lift and needed to be transferred to the Hospital ED. Nurse #4 said that when Nurse #1 gave her report she said that CNA #1 transferred Resident #1 with the Sit/Stand Lift without the assistance of another staff member. Nurse #4 said that Resident #1 required the physical assistance of two staff members with transfers and that a Sit/Stand Lift transfer also requires the assistance of two staff members.During an interview on 02/03/26 at 2:30 P.M. and throughout the day of survey, the Director of Nurses (DON) said that she did not know why Resident #1's ADL Care Plan and Resident Care Card indicated that he/she required assistance to dependence with transfers and said there have been issues with consistency with the care plans. The DON said that Care Plans and Resident Care Cards should specifically indicate the number of staff assistance required. The DON said that if a resident requires a mechanical lift, it should be on their ADL Care Plan and Resident Care Card, and that both should indicate that two staff members are required during the transfer. The DON said that dependent level of care meant that the resident requires the physical assistance of two staff members. The DON said that it was her expectation that there would be two staff members present during any mechanical lift transfer. Refer to F6892) Review of Hospital Emergency Department (ED) Discharge summary, dated [DATE], indicated that Resident #1 presented to the ED after a fall at the facility. The Summary indicated that Resident #1 sustained a fracture of the distal end of left tibia and left fibula and that a short leg ortho fiberglass splint (pre-padded splinting solution used for immobilizing lower leg injuries) was applied to his/her left ankle.Review of a Resident #1's Orthopedic Consultations, dated 01/09/26 and 01/23/26 indicated to keep splint on his/her left lower extremity and maintain non-weight bearing status.Review of Resident #1's Resident Care Card, reviewed and updated in conjunction with his/her plan of care, indicated to encourage use of CAM boot to left lower extremity when out of bed and that his/her mobility status was non-weight bearing to the left lower extremity.Review of Resident #1's Care Plan related to ADL's, dated as revised 01/22/26, indicated Left Lower Extremity CAM boot while out of bed, check Circulation Sensation Motion (CSM) and skin integrity while on.Review of Resident #1's Care Plan related to Alteration in Musculoskeletal status due to recent fall with left distal tibia and fibula fracture, dated as initiated 01/08/26, indicated to encourage use of CAM boot to left lower extremity (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	when out of bed and that his/her mobility status was non-weight bearing to the left lower extremity. During a telephone interview on 02/04/26 at 4:43 P.M., Nurse #1 said that Resident #1 sustained a fractured left ankle from a fall out of a Sit/Stand Lift during a transfer. Nurse #1 said that Resident #1 was transferred to the Hospital ED and returned with a fiberglass splint on his/her left lower extremity. Nurse #1 said that Resident #1 did not have a CAM boot on his left lower extremity, and that the Care Plan was not accurate.During an interview on 02/03/26 at 3:10 P.M., Nurse #3 said that Resident #1 had a fiberglass splint with an Ace (elastic compression bandage) wrap on his/her left lower extremity. Nurse #3 said that Resident #1 did not have a CAM boot on his left lower extremity.During a telephone interview on 02/05/26 at 12:46 P.M., Nurse #4 said that Resident #1 did not have a CAM boot on his/her left lower extremity.A CAM boot is an external removable orthopedic walking boot allowing you to bear weight, designed to immobilize and protect the foot or ankle during recovery from injuries or surgery. Unlike a traditional splint, it is removable which permits hygiene, wound care and rehabilitation exercises.A fiberglass splint is a device that supports and protects a broken bone, helps reduce pain and promote healing by keeping the injured part of your body still. It is held in place with an elastic bandage, is not a removable device and cannot support walking and weight bearing. Resident #1's Care Plans indicated for his/her to wear a CAM boot when out of bed, check CSM and skin integrity while on. A CAM boot cannot be worn over a fiberglass splint, and a fiberglass splint cannot be removed to check skin integrity. With a fiberglass splint, the nurse can check CSM, check that it is intact and held in place with an elastic bandage (ACE) but it cannot be removed and worn when out of bed only. A fiberglass splint must remain on at all times until an orthopedic physician orders otherwise.The Surveyor observed Resident #1 during the survey on 02/03/26. Resident #1 was observed with a left lower extremity splint covered with an Ace (elastic compression bandage) wrap. The Surveyor did not observe a CAM boot on Resident #1's left lower extremity and the staff were unable to locate a CAM boot that belonged to Resident #1. During an interview on 02/03/26 at 2:30 P.M. and throughout the day of the survey, the Director of Nurses (DON) said that Resident #1 had a fiberglass splint and an Ace wrap. The DON said that the Care Plans stated that Resident #1 had a CAM boot to his/her left lower extremity in error, that the Care Plans should have indicated he/she had a splint and said that the Care Plans were not accurate. The DON said that the Care Plans should have been updated after the Orthopedic Consults but were not, and should have included appropriate interventions, goals and outcomes.

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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. **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 had recently sustained a fracture of the distal end of the tibia and left fibula (fracture of the ankle), the Facility failed to ensure nursing staff provided care and services that met professional standards of quality, when nurses were unaware of what type of orthotic device he/she was wearing and were documenting they were providing care and treatment to his/her left ankle that they could not have completed, based on the type of orthotic device he/she had in place.Findings include:Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Resident #1 was admitted to the Facility in March 2024 diagnoses included cerebral palsy, embolism and thrombosis of deep veins (blood clot) of left lower extremity, muscle weakness, hypertension, hyperlipidemia, major depressive disorder, osteitis (inflammation of bone tissue) and wedge compression fracture of fifth lumbar vertebra (lower back).Review of the Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 was alert and oriented, with a Brief Interview for Mental Status (BIMS) of 15 (intact cognitive function) and was dependent on staff with transfers.Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 01/02/26, indicated that on 01/01/26 at 7:00 P.M., Resident #1 was assisted by staff via the Sit/Stand Lift when he/she let go of the hand supports and slid out of the sling onto the floor. The Report indicated that Resident #1 complained of pain to his/her left ankle and was transferred to Emergency Department (ED) for evaluation. The Report further indicated that Resident #1 had a fracture of the distal end of the left tibia and left fibula (ankle) and was placed in a Controlled Ankle Motion (CAM) boot, was non-weight bearing to his/her left lower extremity and to follow-up with orthopedics. However, review of ED Discharge summary, dated [DATE], indicated that Resident #1 presented to the ED after a fall at the facility. The Summary indicated that Resident #1 sustained a fracture of the distal end of left tibia and left fibula and that a short leg ortho fiberglass splint (pre-padded splinting solution used for immobilizing lower leg injuries) was applied to his/her left ankle.Review of Resident #1's Care Plan related to ADL's, dated as revised 01/22/26, indicated he/she was to have Left Lower Extremity CAM boot while out of bed, check Circulation Sensation Motion (CSM) and skin integrity while on.Review of Resident #1's Care Plan related to Alteration in Musculoskeletal status due to recent fall with left distal tibia and fibula fracture, dated as initiated 01/08/26, indicated to encourage use of CAM boot to left lower extremity when out of bed.Review of Resident #1's Treatment Administration Record (TAR), dated January 1st, 2026 through February 3rd, 2026, indicated that the following treatments were signed off as being completed by the licensed nurses on all shifts:- Left lower extremity CAM boot on when out of bed every shift;- left heel apply skin prep for prevention every shift;- remove CAM boot as tolerated to assess skin for breakdown or signs/symptoms of swelling or infection.However, Resident #1 was not fitted with and never had a CAM boot on his/her left ankle.During an (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 02/03/26 at 4:00 P.M., Resident #1 said that he/she fell out of the Sit/Stand Lift during a transfer and broke his/her left ankle. Resident #1 said that he/she went to the hospital after the fall and the hospital placed a splint on his/her left lower extremity. Resident #1 said that the nurses had not removed the splint.The Surveyor observed Resident #1 during the survey on 02/03/26. Resident #1 was observed with a left lower extremity splint covered with an Ace (elastic compression bandage) wrap. The Surveyor did not observe a CAM boot on Resident #1's left lower extremity and the staff were unable to locate a CAM boot that belonged to Resident #1. Review of Resident #1's Orthopedic Consultations, dated 01/09/26 and 01/23/26 indicated to keep splint on his/her left lower extremity and maintain non-weight bearing status.During an interview on 02/03/26 at 3:10 P.M., Nurse #3 said that she had completed and signed off on Resident #1's treatments as having been completed. Nurse #3 said that Resident #1 had a splint with an Ace (elastic compression bandage) wrap on his/her left lower extremity. Nurse #3 said that she did not know what a CAM boot was and that Resident #1 did not have a CAM boot on his left lower extremity. Nurse #3 said that she had not applied skin prep to Resident #1's left heel and that had not removed a CAM boot from his/her left foot, even though she signed off the TAR as having done so. Nurse #3 said she could not explain why she signed off the TAR as having completed those treatments earlier in her shift when she had not.During a telephone interview on 02/04/26 at 4:43 P.M., Nurse #1 said that Resident #1 sustained a fractured left ankle from a fall out of a Sit/Stand Lift during a transfer. Nurse #1 said that Resident #1 was transferred to the Hospital ED and returned from the Hospital ED with a splint on his/her left lower extremity. Nurse #1 said that Resident #1 did not have a CAM boot on his left lower extremity.During a telephone interview on 02/05/26 at 12:46 P.M., Nurse #4 said that Resident #1 sustained a fractured left ankle from a fall out of a Sit/Stand Lift during a transfer. Nurse #4 said that Resident #1 was transferred to the Hospital ED and returned with a splint on his/her left lower extremity. Nurse #4 said that Resident #1 did not have a CAM boot on his/her left lower extremity.During an interview on 02/03/26 at 2:30 P.M. and throughout the day of the survey, the Director of Nurses (DON) said that Resident #1 had a splint and an Ace wrap on his/her left lower extremity, and not a CAM boot. The DON said that Resident #1's treatments should have been updated after the Orthopedic Consultations. The DON said that the TAR should have indicated that Resident #1 had a splint and that his/her orders on the TAR should have been specific to nursing care, treatment and monitoring for the splint.

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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. **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 required the use of a Sit/Stand Lift (mobility aid that helps people transition safely from sitting to standing), for all transfers, with two staff members present to assist and complete the transfer, the Facility failed to ensure he/she was provided with the necessary level of staff assistance, in accordance with facility policy, to maintain his/her safety and prevent an incident/accident resulting in a significant injury. On 01/01/26, Certified Nurse Aide (CNA) #1 transferred Resident #1 with a Sit/Stand Lift, without another staff member present to assist him, Resident #1 slid out of the sling, fell onto the floor, complained of pain to his/her left lower extremity, was transferred to the Hospital Emergency Department (ED) and diagnosed with a left ankle fracture.Findings include:Review of the Facility Policy titled, Safe Resident Handling/Transfers, dated as revised May 2025, indicated the following:-the facility will ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines;-while manual lifting techniques may be utilized if appropriate for the resident's condition and mobility, use of mechanical lifts are a safer alternative and should be used;-mechanical lifts include equipment such as full body lifts or sit to stand lifts;-two staff members must be utilized when transferring residents with a mechanical lift;-staff members are expected to maintain compliance with safe handling/transfer practices;Resident #1 was admitted to the Facility in March 2024 diagnoses included cerebral palsy, embolism and thrombosis of deep veins (blood clot) of left lower extremity, muscle weakness, hypertension, hyperlipidemia, major depressive disorder, osteitis (inflammation of bone tissue) and wedge compression fracture of fifth lumbar vertebra (lower back).Review of the Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 was alert and oriented, with a Brief Interview for Mental Status (BIMS) of 15 (intact cognitive function) and was dependent on staff with transfers.Review of Resident #1's Care Plan related to Activities of Daily Living (ADL), dated as reviewed and renewed with his/her October 2025 MDS, indicated that he/she required physical assistance to dependence of staff with transfers.Review of Resident #1's Resident Care Card, (used as a reference guide by CNA's, provides direct care staff with a brief overview of each resident's care needs), (reviewed and updated in conjunction with his/her plan of care), indicated that he/she required physical assistance to dependence of staff with transfers.Review of Resident #1's Occupational Therapy Recertification, Progress Report and Updated Therapy Plan, dated 12/29/25, indicated he/she was assessed as being dependent with use of Sit/Stand Lift and required moderate/maximum assist of two staff members for transfers.Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 01/02/26, indicated that on 01/01/26 at 7:00 P.M., Resident #1 was assisted by staff via the Sit/Stand Lift when he/she let go of the hand supports and slid out of the sling onto the floor. The Report indicated that Resident #1 complained of pain to his/her left ankle and was transferred to ED for evaluation. The Report further indicated that Resident #1 had a fracture of the distal end of the left tibia and left fibula (ankle), was non-weight bearing to his/her left lower extremity and to follow-up with orthopedics. Review of Hospital Emergency Department (ED) Discharge summary, dated [DATE], indicated that Resident #1 presented to the ED after a fall at the facility. The Summary indicated that Resident #1 sustained a fracture of the distal end of the left tibia and left fibula (ankle) and that a short leg ortho fiberglass splint (pre-padded splinting solution used for immobilizing lower leg injuries) was applied to his/her left ankle.During an interview on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	02/03/26 at 11:50 A.M., the Certified Occupational Therapy Assistant (COTA) said that Resident #1 was receiving skilled therapy prior to his/her fall on 01/01/26. The COTA said that Resident #1's lower extremities were weak, and he/she required a Sit/Stand Lift for all transfers and maximal assistance of two staff members with transfers.During an interview on 02/03/26 at 12:06 P.M., the Occupational Therapist (OT) said that Resident #1 had a functional decline prior to his/her fall on 01/01/26 and was on skilled therapy for upper and lower body strengthening. The OT said that Resident #1 required a Sit/Stand Lift for all transfers and maximal assistance of two staff members with transfers.During an interview on 02/03/26 at 1:21 P.M., Resident #1 said that he/she fell out of the Sit/Stand Lift during a transfer and broke his/her left ankle. Resident #1 said on the day he/she fell out of the lift, that the male CNA transferred him/her without the assistance of another staff member. Resident #1 said that he/she did not know who the male CNA was who transferred him/her with the Sit/Stand Lift, that day. Resident #1 said before that day, that there were always two staff members present when he/she was transferred with the Sit/Stand Lift.During a telephone interview on 02/04/26 at 10:42 A.M., CNA #1 said on 0/01/26, at the beginning of his shift (3:00 P.M. to 11:00 P.M.) he got report on the residents on his assignment and said that the other staff members that worked with him that night on the unit, informed him that Resident #1 required a Sit/Stand Lift for transfers. CNA #1 said he has been a CNA for 18 years and knew how to work the Sit/Stand Lift device. CNA #1 said that he was aware that transfers a Sit/Stand Lift required the assistance of two staff members. CNA #1 said that on 01/01/26 around 7:00 P.M., he transferred Resident #1 using a Sit/Stand Lift without the assistance of another staff member and that Resident # 1 let go of the bars on the lift and fell to the floor. CNA #1 said that there was another CNA nearby in the hallway when he transferred Resident #1 with the Sit/Stand Lift, but she was not in the room during the transfer. CNA #1 could not explain why he transferred Resident #1 without the assistance of another staff member.During a telephone interview on 02/04/26 at 11:03 A.M., CNA #4 said that she worked on 01/01/26 during the 3:00 P.M. through 11:00 P.M. shift. CNA #4 said that she reviewed CNA #1's assignment with him at the start of the shift on 01/01/26 and said she told CNA #1 that Resident #1 required the assistance of two staff members for transfers with the Sit/Stand Lift. CNA #4 said that she offered to assist CNA #1 with Resident #1's transfers. CNA #4 said CNA #1 never came to get her during the shift to ask for assistance with Resident #1's transfer.Review of a Nurse Progress Note, dated 01/02/26, (written by Nurse #1) indicated that CNA #1 notified her that during a sit to stand transfer, Resident #1 let go of the sling and slid down to the floor. The Note indicated that Resident #1 complained of left ankle pain and was transferred to the Hospital ED for evaluation.During a telephone interview on 02/03/26 at 4:43 P.M., Nurse #1 said that Resident #1's fall occurred on 01/01/26 around 7:00 P.M. Nurse #1 said that CNA #1 (who was an agency CNA) came to the nurse's station and informed her that during a sit to stand transfer, Resident #1 fell from the sit to stand lift onto the floor. Nurse #1 said that Resident #1 required a Sit/Stand Lift for all transfers and said that Sit/Stand Lift transfers always require the assistance of two staff members. Nurse #1 said that when she assessed Resident #1, he/she was sitting on the floor complaining of left ankle pain. Nurse #1 said that Resident #1 was transferred to the Hospital ED for evaluation. Nurse #1 said that she could not recall if CNA #1 transferred Resident #1 with another staff member.During a telephone interview on 02/05/26 at 12:46 P.M., Nurse #4 said that she worked 01/01/26 during the 3:00 P.M. through 11:00 P.M. shift. Nurse #4 said that she was informed by Nurse #1 that Resident #1 fell during a transfer with a Sit/Stand Lift and needed to be transferred to the Hospital ED. Nurse #4 said that when Nurse #1 gave her report she (Nurse #1) said that CNA #1 had transferred Resident #1 with the Sit/Stand Lift without the assistance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carvalho Grove Health and Rehabilitation Center	273 Oak Grove Avenue Fall River, MA 02723

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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	of another staff member. Nurse #4 said that Resident #1 required the physical assistance of two staff members with transfers and that a Sit/Stand Lift transfer also requires the assistance of two staff members.During an interview on 02/03/26 at 2:30 P.M. and throughout the day of the survey, the Director of Nurses (DON) said that she could not recall what the facility's policy was for a Sit/Stand Lift and said she assumed that it required two staff members with mechanical lifts. The DON said that she did not know if there were two staff members present during Resident #1's Sit/Stand transfer on 01/01/26. The DON said that CNA #1 was an agency CNA and said she did not interview him, about the transfer. The DON said that dependent level meant that the resident requires the physical assistance of two staff members. The DON said that it was her expectation that there would be two staff members present during any mechanical lift transfer and that staff members follow the facility's policies.Refer to F656

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	02/03/2026

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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. **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 was dependent on the physical assistance of staff with Activities of Daily Living (ADL), the Facility failed to ensure they maintained a complete and accurate medical record, when Certified Nurse Aide (CNA) ADL Flow Sheets, daily documentation by CNA's (for all three shifts) were not consistently completed, with flow sheets left blank.Findings include:Review of the Facility's Policy tilted, Charting and Documentation, dated May 2023, indicated the following:-services provided to the resident to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record;-objective observations, treatments or services performed, are documented in the resident medical record;Resident #1 was admitted to the Facility in March 2024 diagnoses included cerebral palsy, embolism and thrombosis of deep veins (blood clot) of left lower extremity, muscle weakness, hypertension, hyperlipidemia, major depressive disorder, osteitis (inflammation of bone tissue) and wedge compression fracture of fifth lumbar vertebra (lower back).Review of Resident #1's Care Plan related to Activities of Daily Living (ADL), dated as reviewed and renewed with his/her October 2025 MDS, indicated that he/she required partial to moderate assistance of staff with bed mobility, required substantial assistance to total dependence of staff with bathing, dressing and grooming and toileting and was dependent on the physical assistance of staff for transfers and showers.Review of the Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 was alert and oriented and was dependent on the physical assistance of staff with transfers, dressing, personal hygiene, bathing and toileting.Review of Resident #1's CNA Documentation Record (ADL Flow Sheets), dated 12/01/25 through 12/31/25, indicated that for the following shifts, documentation on the flow sheets for all ADL care areas were incomplete:-7:00 A.M. to 3:00 P.M. - 6 days (out of 31) ADL care areas were left blank-3:00 P.M. to 11:00 P.M. - 17 days (out of 31) ADL care areas were left blank-11:00 P.M. to 7:00 A.M. - 20 days (out of 31) ADL care areas were left blankReview of Resident #1's CNA Documentation Record (ADL Flow Sheets), dated 01/01/26 through 01/31/26, indicated that for the following shifts, documentation on the flow sheets for all ADL care areas were incomplete:-7:00 A.M. to 3:00 P.M. - 7 days (out of 31) ADL care areas were left blank-3:00 P.M. to 11:00 P.M. - 18 days (out of 31) ADL care areas were left blank-11:00 P.M. to 7:00 A.M. - 24 days (out of 31) ADL care areas were left blankDuring an interview on 02/03/26 at 1:11 P.M., Certified Nurse Aide (CNA) #2 said that the documentation of ADL's is done in Point of Care (POC) in the Electronic Medical Record (EMR) and has to be completed by the end of the shift.During a telephone interview on 02/04/26 at 10:42 A.M., CNA #1 said that the documentation of ADL's is done in POC in the EMR and has to be completed by the end of the shift.During a telephone interview on 02/04/26 at 10:55 A.M., CNA #3 said that the documentation of ADL's is done in POC in the EMR and has to be completed by the end of the shift.During a telephone interview on 02/04/26 at 11:03 A.M., CNA #4 said that the documentation of ADL's is done in POC in the EMR and has to be completed by the end of the shift.During an interview on 02/03/26 at 4:15 P.M., the Director of Nurses (DON) said CNA documentation has been an issue at the facility. The DON said that CNA's document the ADL's they provided to the residents in POC in the EMR and that daily documentation should not be incomplete. The DON said it was her expectation that the CNA's should be documenting all care provided to residents by the end of every shift and should not be left blank.