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	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove at Carvalho	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Maintain an infection prevention and control program with a complete system of surveillance to identify any trends of actual or potential infections within the facility; and 2. Ensure appropriate personal protective equipment (PPE) was utilized when providing care to two Residents (#11, #5) on Enhanced Barrier Precautions (EBP: infection prevention practice of wearing gown and gloves while performing direct care activities to reduce transmission of multi-drug-resistant organisms [MDRO's - bacteria that are resistant to three or more types of antimicrobial drugs]) including one Resident (#23) on Transmission-Based Precautions (TBP: additional infection control measures beyond standard precautions to prevent the spread of highly transmissible pathogens); and3. Ensure Resident #15's nebulizer treatment equipment, including mask and tubing, were stored in a sanitary manner. Findings include:1. Review of the facility's policy titled Infection Surveillance, dated as reviewed/revised December 2025, indicated but was not limited to the following: -A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. -The Infection Preventionist (IP) serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility. -The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread. -Updated McGeer criteria (surveillance-based definitions used to track confirmed infections) or other nationally recognized surveillance criteria will be used to define infections. -All infections will be tracked Review of the facility's policy titled Infection Prevention and Control Program (IPCP), undated, indicated but was not limited to the following: -The program is based on accepted national infection prevention and control standards. -An IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemic. During an interview on 4/2/26 at 1:26 P.M., the IP said the facility utilizes McGeer Criteria to determine if an illness meets the criteria for an infection requiring use of antibiotics. The IP said she completes the McGeer criteria on paper and keeps the completed documents in her office. Review of the facility's surveillance sheets titled [Facility Name] Line Listing for the months of December 2025, January 2026, February 2026, and March 2026 indicated the following: -The December 2025 line listing 20 out of 20 residents met McGeer criteria for infection and 20 out of 20 residents were started on antibiotics. -The January 2026 line listing 31 out of 31 residents met McGeer criteria for infection and 31 out of 31 residents were started on antibiotics. -The February 2026 line listing 27 out of 27 residents met McGeer criteria for infection and 27 out of 27 residents were started on antibiotics. -The March 2026 line listing 26 out of 26 residents met McGeer criteria for infection and 26 out of 26 were started on antibiotics. Review of Resident #59's progress notes indicated on 3/23/26, he/she had complaints of dysuria (pain on urination), recently completed course of antibiotics for Urinary Tract Infection (UTI), and to obtain a follow up urine. Urinalysis resulted on 3/27/26 with less than 10,000 units of bacteria, and the Resident was not started on antibiotics. Further review of the March 2026 line listing failed to include Resident #59's concern for illness. Further review of the line listing sheets failed to indicate any tracking or trending of illnesses, not prescribed antibiotics, for surveillance of the potential spread of illnesses. During an interview on 4/7/26 at 1:38 P.M., the IP said she gathers information about illnesses from resident records and in morning report. She completes surveillance sheets for COVID-19 and Influenza outbreaks but does not keep track of illnesses on a day-to-day basis that do not require the use of antibiotics. 2. Review of the facility's policy titled [Corporate Name], undated, indicated but was not limited to the following: -Standard precautions are used for all patient care when exposure to blood, body fluids, non-intact skin or mucous membranes is possible. -Infection Control Measures for Standard precautions include: -Enhanced Barrier Precautions was implemented by Centers for Disease Control and Prevention (CDC) in 2019 to prevent the risk of targeted MDROs. Enhanced precautions to be used for infection of colonization of MDROs when contact precautions do not apply (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enhanced Barrier Precautions include: Standard precautions for infection control measures and PPE, gowns and gloves for high-contact care activity which includes dressing, transferring, wound care or device care. -Transmission Based Precautions are the second tier of basic infection control and are used in addition to standard-based precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed. -They may include Extended-Spectrum B-lactamase (ESBL: enzymes produced by bacteria making them resistant to many common antibiotics and spread through contaminated surfaces, food, or person-to-person contact). Review of the CDC Enhanced Barrier Precautions sign indicated the following: -Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Transferring Wound Care: any skin opening requiring a dressing Review of the CDC Contact Precautions sign indicated the following: -Everyone must: Clean their hands, including before entering and when leaving the room. -Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. A. Resident #11 was admitted to the facility in November 2025 with diagnoses including history of vancomycin resistant enterococci (VRE – bacteria that have developed resistance to vancomycin, a powerful antibiotic), pressure ulcer of left buttocks and heel, gastrostomy tube (G-tube: a device surgically inserted through the abdomen directly into the stomach to provide nutrition, fluids, and medications) and urinary retention with an indwelling urinary catheter in place. Review of Resident #11's active Physician's Orders indicated, but was not limited to, the following: -Maintain Enhanced Barrier Precautions related to history of VRE, G-Tube, Foley (urinary catheter), wounds every shift – start date 12/4/25 On 4/02/26 at 10:19 A.M., the surveyor observed an orange CDC Enhanced Barrier Precautions sign (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	posted on the wall over the room number plaque outside of the Resident's room and PPE was available in a cart below the sign. The surveyor observed Certified Nursing Assistant (CNA) #2 and CNA #3 rolling the Resident side to side on his/her bed, placing a cloth pad underneath the Resident. The CNAs then hooked the cloth pad to the Hoyer lift (a medical device designed to safely transfer patients) and transferred the Resident to his/her chair. CNA #2 and CNA #3 were not wearing gowns or gloves during the transfer. During an interview on 4/2/26 at 10:31 A.M., CNA #3 said Resident #11 is on EBP because he/she has a catheter. She said she only needs to use PPE for direct care, not for putting the Resident in his/her chair. B. Resident #23 was admitted to the facility in March 2025 with diagnoses including ESBL in urine. Review of Resident #23's active Physician's Orders indicated, but was not limited to, the following: -Maintain Contact Precautions related to ESBL in the urine every shift – start date 3/30/25 On 4/7/26 at 8:21A.M., the surveyor observed a yellow CDC Contact Precautions sign posted on the wall over the room number plaque outside of the Resident's room and PPE was available in a cart below the sign. The surveyor observed Nurse #1 seated on Resident #23's bed and the Resident was seated beside her in a chair, with his/her bedside table placed in from of them with their breakfast tray placed on top of the table. Nurse #1 was feeding the Resident breakfast. Nurse #1 was not wearing a gown or gloves. During an interview on 4/7/26 at 8:24 A.M., Nurse #1 said she was not required to wear a gown or gloves when feeding the Resident. She said PPE is needed only when providing direct care. Surveyor and Nurse #1 reviewed the contact precaution sign together and she said she should have had a gown and gloves on and did not. Nurse #1 said she made a mistake. During an interview with an observation on 4/7/26 at 8:35 A.M., the surveyor observed Nurse #3 enter Resident #23's room, without donning (putting on) PPE. Nurse #3 removed the Resident's breakfast tray and exited the room. Nurse #3 and the surveyor reviewed the contact precaution sign together and she said she should have put on PPE prior to entering the Resident's room, but she usually does not work on this unit and was unaware. C. Resident #5 was admitted to the facility in August 2025 with diagnoses including pressure ulcers of the right heel, sacral region (base of the spine) and neuropathic bladder with indwelling urinary catheter. Review of Resident #5's active Physician's Orders indicated, but was not limited to, the following: -Maintain Enhanced Barrier Precautions related to wounds and Foley every shift – start date 2/5/26 On 4/2/26 at 12:27 P.M., the surveyor observed an orange CDC Enhanced Barrier Precautions sign posted on the wall over the room number plaque outside of the Resident's room and PPE was available in a cart below the sign. Nurse #6 was assisted by a CNA completing a dressing change to Resident #5's right heel. Nurse #6 and the CNA were not wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/7/26 at 9:51 A.M., Nurse #6 said she should have had a gown on to do the dressing change because the Resident is on EBP for their wounds. During an interview on 04/07/26 at 2:44 P.M., the surveyor reviewed observations of PPE breaches with the IP and Director of Nursing (DON). The IP said her expectations were for the staff to follow the guidelines that were posted outside of the Residents' room. She said transferring a resident and completing a dressing change is considered high contact care and the staff should have been wearing gowns and gloves; it is the standard of practice. The IP said residents on contact precautions require PPE to be donned prior to entering the room. The DON said the line listings should include all illnesses in the facility, even without antibiotic use for accurate tracking and trending of infections. 3. Review of the facility's policy titled Nebulizer Therapy, dated last revised 12/2025, indicated but was not limited to the following: - It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. Review of the facility's policy titled Oxygen Administration, dated last revised January 2025, indicated but was not limited to the following: - If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated. - Keep delivery devices covered in plastic bag when not in use. Resident #15 was admitted to the facility in September 2022 with diagnoses including Parkinson's disease and chronic obstructive pulmonary disease (COPD). Review of Resident #15's Minimum Data Set (MDS) assessment, dated 2/10/26, indicated he/she had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15. Review of Resident #15's Physician's Orders indicated but were not limited to the following: - 9/10/25: change nebulizer/tubing every week; every night shift every Tuesday and as needed; label and date tubing when changed. - 1/29/26: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligrams)/ 3 ML (milliliters); 3 ML inhale orally two times a day for COPD; 9 A.M. and 9 P.M. - 2/10/26: Formoterol Fumarate Inhalation Nebulization Solution 20 MCG (micrograms)/2 ML; 2 ML inhale orally two times a day related to COPD; 8 A.M. and 8 P.M. Review of Resident #15's April Medication Administration Record (MAR) indicated his/her nebulizer medications/treatments were administered as ordered. On the following dates/times, the surveyor observed Resident #15's nebulizer mask and tubing left (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open to air on top of the nebulizer machine on his/her bedside nightstand: - 4/2/26 at 9:06 A.M. and 9:28 A.M. - 4/2/26 at 12:26 P.M. and 3:02 P.M. - 4/3/26 at 7:31 A.M. and 10:15 A.M. During an interview on 4/3/26 at 10:23 A.M., Nurse #1 said if a resident utilizes nebulizer treatment equipment, such as the mask and/or tubing, it should be placed in a bag when not in use. Nurse #1 said nebulizer masks and/or tubing should not be left open to air. During an interview on 4/3/26 at 10:25 A.M., Nurse #2 said Resident #15 utilizes nebulizer treatments. Nurse #2 said Resident #15's nebulizer equipment should be stored in a bag at his/her bedside when it is not in use. Nurse #2 and the surveyor entered Resident #15's room to observe the nebulizer mask and tubing. Nurse #2 took the nebulizer mask, which was resting on the nebulizer machine, and placed it into a bag she had brought into the room. During an interview on 4/3/26 at 10:42 A.M., the DON said nebulizer equipment, including masks and tubing, should be changed weekly. The DON said when nebulizer equipment is not in use it should be stored in a bag and not left open to air.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program.Findings include:Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance.- Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.- The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.- Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of the facility's policy titled Antibiotic Stewardship Program, dated as revised September 25, 2023, indicated but was not limited to the following:Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program.-The purpose of our Antibiotic Stewardship Program is to improve the use of antibiotics in our facility to protect residents and reduce the threat of antibiotic resistance to monitor the use of antibiotics in our residents.-When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the provider as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.Review of the facility's policy titled Infection Surveillance, dated as reviewed/revised December 2025, indicated but was not limited to the following: -The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility.-Updated McGeer criteria (surveillance-based definitions used to track confirmed infections) or other nationally recognized surveillance criteria will be used to define infections.-The facility will communicate via written reports to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated.-All resident infections will be tracked. Review of the facility's policy titled Infection Prevention and Control Program (IPCP), undated, indicated but was not limited to the following:Antibiotic Stewardship-Antibiotic usage is evaluated and practitioners are provided with feedback on reviews. During an interview on 4/2/26 at 1:26 P.M., the Infection Preventionist (IP) said the facility utilizes McGeer criteria to determine if an illness meets the criteria for an infection requiring use of antibiotics. The IP said she completes the McGeer criteria on paper and keeps the completed documents in her office. Review of the Revised McGeer Criteria for Infection Surveillance Checklist, indicated but was not limited to the following: Urinary Tract Infection (UTI) Surveillance Definitions UTI without indwelling catheter: Must fulfill both 1 and 2 1. At least one of the following signs or symptoms:-Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate-Fever or leukocytosis, and 1 or more of the following: -Acute costovertebral angle pain or tenderness-Suprapubic pain-Gross hematuria-New or marked increase in incontinence, urgency, frequency-If no fever or leukocytosis, then one or more of the following:-Suprapubic pain-Gross hematuria-New or marked increase incontinence, urgency 2. At least one of the following microbiologic criteria:- greater than or equal to 102 colony forming units (cfu)/milliliters (mL of no more than 2 species of organisms in a voided urine sample)- greater than or equal to 102 cfu/mL of any organism(s) in a specimen collected by an in-and-out-catheter UTI with indwelling catheter: Must fulfill both 1 and 2 1. At least one of the following signs or symptoms:-Fever, rigors, or new-onset hypotension, with no alternate site of infection.-Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis-New-onset suprapubic pain or costovertebral angle pain or tenderness-Purulent discharge from around the catheter or acute pain, (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	swelling, or tenderness of the testes, epididymis, or prostate2. Urinary catheter specimen culture with greater than or equal to 105 cfu/mL of any organism(s) Review of the facility's Surveillance Sheets for February 2026 indicated but were not limited to the following: Resident #11 had a urinary catheter in place with a concern for a UTI with an onset date of 2/23/26 and was placed on Ceftriaxone (antibiotic). The surveillance stated it was for empiric treatment due to signs/symptoms, no lab services were completed due to weather, and a 48-hour time out (review of therapy 48-72 hours after initiation to ensure proper use) was completed and did meet criteria for infection (although it did not meet criteria per documentation). Review of Resident# 11's McGeer criteria, dated 2/25/26, indicated the concern fulfilled only one criteria (new-onset suprapubic pain or costovertebral angle pain or tenderness), no urine specimen completed, and the concern met criteria for infection (although it did not meet criteria due to no urine specimen completed).Review of the medical record failed to indicate a 48-hour time out had been completed even though the symptoms did not meet criteria for infection.Resident #59 did not have a urinary catheter and a concern for a UTI with an onset date of 2/22/26 and was placed on Bactrim (antibiotic). The surveillance stated it was for empiric treatment due to signs/symptoms, no lab services were completed due to weather, and a 48-hour time out was completed and did meet criteria for infection. Review of Resident# 59's McGeer criteria, dated 2/25/26, indicated the concern fulfilled both 1 and 2 criteria and did meet criteria for infection (although it did not meet criteria due to no urine specimen completed). Review of the medical record failed to indicate a 48-hour time out had been completed even though the symptoms did not meet criteria for infection. During an interview on 4/7/26 at 1:38 P.M., the IP said when a resident is prescribed an antibiotic, she uses the McGeer criteria to collect data, and she files them in her office. The IP said she gathers information about illnesses from resident records and in morning report. The IP said the facility began conducting 48-hour timeouts in January 2026, and it consists of her reviewing the medication with the provider within 48 to 72 hours, but she does not document the information in the resident record. She said she only makes a notation on her surveillance sheet. The IP said she has not been reviewing all antibiotic use with the providers. The surveyor and IP reviewed the completed McGeer criteria for Resident #11 and Resident #59 together and the IP said both McGeer criteria documents were completed inaccurately and the concern did not meet the criteria for infection. She said her surveillance was incorrect.During an interview on 4/7/26 at 2:44 P.M., the Director of Nursing (DON) said the IP should be communicating with the physician regarding any antibiotics that do not meet criteria, and document the communication in the medical record. She said the McGeer criteria should be completed accurately to ensure proper tracking of infections and antibiotic usage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, records reviewed, and interviews, the facility failed to ensure it was free from a medication error rate of 5% or greater when two out of three nurses observed during a medication pass made two errors out of 39 opportunities, resulting in a medication error rate of 5%. Those errors impacted two Residents (#33 and #64), out of five residents observed.Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to, the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to:- Medications are administered in accordance with prescriber orders, including any required time frame.- The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.1. For Resident #33, Nurse #5 administered:-The incorrect formula of a probiotic (live microorganisms that provide health benefits when consumed, generally by improving or restoring the microbiota in the gut).On 4/6/26 at 8:45 A.M., the surveyor observed Nurse #5 prepare and administer medications to Resident #33 including:-Lactobacillus acidophilus (a bacteria-based probiotic that produces lactic acid, making the environment unfavorable to other bacteria by increasing the pH) 1 capsuleReview of Resident #33's Physician's Orders indicated but was not limited to: -Lactobacillus rhamnosus (a bacteria-based probiotic that does not produce lactic acid and does not make the environment unfavorable to other bacteria) 1 capsule by mouth in the morningDuring an interview on 4/6/26 at 9:55 A.M., Nurse #5 said the facility supplies Lactobacillus acidophilus, not Lactobacillus rhamnosus, and Resident #33's order should be changed. 2. For Resident #64, Nurse #6 administered:- An anti-nausea medication ordered to be given before meals and scheduled at 7:30 A.M., late and at least one hour after breakfast.On 4/6/26 at 9:11 A.M., the surveyor observed Nurse #6 prepare and administer medications to Resident #64, including:- Zofran (or Ondansetron, a medication used to prevent/treat nausea and vomiting) 4mg 1 tabletReview of Resident #64's Physician's Orders indicated, but was not limited to, the following:-Zofran 4 mg by mouth before meals for nauseaDuring an interview on 4/6/26 at 12:41 P.M., Nurse #6 said Resident #64 was taking anti-nausea medication because he/she had been hospitalized for nausea. Nurse #6 said Resident #64's Zofran should be scheduled earlier so it can be given before breakfast and not administered late.During an interview on 4/7/26 at 11:12 A.M., the Director of Nursing said it was her expectation that nurses in the facility follow physician's orders during medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in a safe and secure manner as required. Specifically, the facility failed to ensure:1. Licensed staff locked one of two treatment carts, which contained numerous topical treatments and biologicals, when it was not in use and left in the hallway where it could be accessed by residents or passersby on the Oak Grove unit; and2. Medications were dated once opened, and discarded according to manufacturer's guidelines, in one of three medication carts observed.Findings include:Review of the facility's policy titled Storage of Medications, undated, indicated, but was not limited to, the following:-Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 1. On 4/6/26 on the Oak Grove unit, the surveyor made the following observations of the Oak Grove treatment cart:-3:06 P.M. - The treatment cart was unlocked against the wall in the hallway beside the nurse's station. Residents and unlicensed staff were in the general area of the treatment cart but no nurse was visible in the area.-3:11 P.M. - The treatment cart remained unlocked against the wall in the hallway near, but not visible from, the nurse's station. Nurse #6, the nurse who was assigned to the cart, returned to the unit via the elevator. -3:22 P.M. - The treatment cart remained unlocked against the wall in the hallway near, but not visible from, the nurse's station. The surveyor approached the treatment cart and was able to open all drawers. The treatment cart was found to contain prescription creams and ointments and other treatment supplies. Residents remained in the hallway in the vicinity of the unlocked treatment cart.-3:32 P.M. - The treatment cart remained unlocked against the wall in the hallway near, but not visible from, the nurse's station. Residents from the [NAME] and Oak Grove units were congregated in the area by the nurse's station waiting to go downstairs. -3:40 P.M. - The treatment cart remained unlocked against the wall in the hallway near, but not visible from, the nurse's station. Nurse #6 walked from the Oak Grove unit to the [NAME] unit, then returned to the Oak Grove unit and went downstairs via the elevator.-3:53 P.M. - The treatment cart remained unlocked against the wall in the hallway near, but not visible from, the nurse's station. Five residents remained in the general vicinity of the treatment cart.On 4/7/26 at 11:19 A.M., the surveyor observed the Oak Grove unit Float Assignment medication cart unlocked in the hallway across from the nurse's station. Two residents were sitting in wheelchairs beside the medication cart. The nurse was observed in the unit dining room administering medication to a resident with her back to the dining room door and out of line of sight of the medication cart.During an interview on 4/7/26 at 11:45 A.M., Nurse #6 said the treatment cart should always be locked when not in use.During an interview on 4/8/26 at 10:32 A.M., the Director of Nursing said medication and treatment carts should be locked when the nurse is not at the cart.2. During observation of the Oak Grove medication cart with Nurse #6 on 4/7/26 at 11:34 A.M., the surveyor observed two opened bottles of Latanoprost eye drops for Resident #69 in the medication cart. Neither bottle was marked with the date opened. Per the manufacturer's instructions, Latanoprost eye drops should be discarded six weeks after opening.The surveyor also observed one bottle of ProStat (a liquid protein supplement) labeled with a date opened of 12/15/25. Per the manufacturer's instructions, ProStat should be discarded three months after opening.During an interview on 4/7/26 at 11:45 A.M., Nurse #6 said Latanoprost bottles should be labeled with the date opened and medications should be discarded per the manufacturer's instructions.During an interview on 4/8/26 at 10:32 A.M., the Director of Nursing said eye drops should be dated when opened and discarded per the manufacturer's instructions.

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	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove at Carvalho	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure the main kitchen floor tile was maintained in a sanitary and safe condition and was free of standing, pooled water. Findings include:Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following: 1-2 Definitions 1-201 Applicability and Terms Defined1-201.10 Statement of Application and Listing of Terms.Easily Cleanable.(1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use. Smooth means:(3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean. 6-201.12 Floors, Walls, and Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized. 6-101.11 Surface Characteristics. Floors, walls, and ceilings that are constructed of smooth and durable surface materials are more easily cleaned. Floor surfaces that are graded to drain and consist of effectively treated materials will prevent contamination of foods from dust and organisms from pooled moisture. Review of the facility's policy titled Environment from the Dining Services Policy and Procedure Manual, last revised 9/2017, indicated but was not limited to:-The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.-The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. On the following dates and times, the surveyor observed, in the dishwashing room and in front of the 3-bay sink of the main kitchen, several missing tiles and/or partial/cracked tiles, with pooled gray colored standing water:-4/2/26 at 8:20 A.M.-4/7/26 at 11:26 A.M.-4/8/26 at 9:05 A.M. During an interview on 4/8/26 at 9:02 A.M., the Food Service Director (FSD) said he is aware of the broken/missing tiles and has entered a work request with maintenance for them to be fixed. The FSD said staff do use a dry mop after the dishes are done to clean the areas of pooled water. The FSD said the kitchen is routinely cleaned according to a schedule that is kept in a binder that staff sign off daily. The FSD said he expected the main kitchen floor to be easily cleanable with no missing or broken tiles. During an interview on 4/8/26 at 9:10 A.M., the Maintenance Director said he did not have any current open work requests for the tile floor in the main kitchen, and the tiles in the kitchen were last updated about two years ago. The Maintenance Director said he has discussed with the FSD the difficulty of replacing the tiles in this area due to the area being consistently wet and he has tried some different solutions that have failed. During an interview on 4/8/26 at 9:15 A.M., the Administrator stated he expected the tile floor of the kitchen to be in good repair, easily cleanable, and free of pooled water.