

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Fall River Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1748 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had an unwitnessed fall on 11/21/24, and was noted on 11/22/24 and 11/23/24 to have a change in status that included left hand/wrist edema, bruising, and pain, the Facility failed to ensure his/her Provider was notified timely of the change, when the Nurse Practitioner (NP) was not made aware of the changes until 11/25/24, at which time the NP ordered an X-ray for Resident #1 and he/she was diagnosed with a left wrist fracture.</p> <p>Findings include:</p> <p>Review of the Facility's policy, titled Change in Resident's Condition or Status, dated as revised July 2024, indicated that the nurse will notify the resident's provider or on call provider when there has been a change in resident condition which includes (but not limited to):</p> <ul style="list-style-type: none"> -accident or incident involving resident, -adverse reaction to medication, -significant change in the resident's physical condition, -need to transfer the resident to hospital/treatment center, or -discharge without proper medical authority. <p>Resident #1 was admitted to the Facility in August 2024, diagnoses included dementia and anxiety disorder.</p> <p>Review of the report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 11/27/24, indicated that on 11/21/24, Resident #1 was found on the floor in his/her room. The Report indicated that nursing assessed Resident #1, noted a hematoma on the left side of his/her head, no other visible injuries, and he/she was transferred to the Hospital Emergency Department (ED) for evaluation. The Report indicated that after being notified on 11/25/24 that Resident #1's left hand/wrist was painful, the NP saw him/her and ordered an X-ray. The Report indicated that the X-ray showed Resident #1 had an acute (new) distal radial (wrist) fracture with soft tissue swelling, and Resident #1 was transferred to the Hospital (ED).</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 0580</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: 20 P.M., Nurse #1 said she found Resident #1 on the floor on 11/21/24, noted that he/she had a hematoma on his/her head, so she notified the NP and the Resident #1 was sent to the Hospital Emergency Department (ED) for evaluation. Nurse #1 said Resident #1 did not have any other visible injuries at the time of his/her fall.</p> <p>Review of a Nurse Progress Note, dated 11/22/24 at 6:32 A.M., indicated that Resident #1 returned to the facility on [DATE] at 1:00 A.M. with no abnormal findings. The Note also indicated that the bruise on the left side of Resident #1's head was intact.</p> <p>Per the Nurse Progress Note referenced above and the Hospital's ED documentation, there was no indication that Resident #1 had left wrist/hand bruising, edema, or pain when he/she was sent to the Hospital ED on 11/21/24, or when he/she returned on 11/22/24, to the Facility.</p> <p>Review of a Nurse Progress Note (written by Nurse #3), dated 11/22/24, indicated that Resident #1 had left hand edema and bruising [which was new].</p> <p>During a telephone interview on 12/12/24 at 3:19 P.M., Nurse #3 said she was aware Resident #1 had had a fall on 11/21/24, and had been evaluated at the Hospital. Nurse #3 said that when she noticed Resident #1 had swelling and bruising on his/her left wrist, she did not check the Hospital's ED documentation to see if Resident #1 had wrist pain, bruising, or swelling upon discharge back to the Facility. Nurse #3 said she did not notify the NP when she noticed Resident #1's left wrist swelling and bruising, because he/she did not complain of pain. Nurse #3 said she figured the swelling and bruising were from his/her fall on 11/21/24.</p> <p>Review of a Nurse Progress Note (written by Nurse #2), dated 11/23/24, indicated that Resident #1 refused to use his/her walker [to ambulate] due to left hand pain.</p> <p>During a telephone interview on 12/12/24 at 1:35 P.M., Nurse #2 said that on 11/23/24 she noticed Resident #1's left hand and wrist were swollen. Nurse #2 said when Resident #1 stood to use his/her walker, he/she refused because of left wrist/hand pain. Nurse #3 said she did not notify the on-call Provider because she was not sure who to call.</p> <p>Review of a Nurse Progress Note, dated 11/25/24, indicated that Resident #1 complained of left hand discomfort, and his/her hand was swollen and bruised. The Note indicated that Resident #1 was seen by NP #1 who ordered an x-ray.</p> <p>Nurse #3 said Resident #1 complained of wrist pain on 11/25/24, so she called the Nurse Practitioner to report it. When the Surveyor asked why she had not reported the swelling and bruising on Resident #1's wrist to the NP on 11/22/24, she said she had not reported it because he/she had not complained of pain.</p> <p>Review of an X-ray Report, dated 11/25/24, indicated Resident #1 had an acute distal radial (wrist) fracture with moderate soft tissue swelling.</p> <p>Review of a Nurse's Note, dated 11/26/24, indicated that the X-ray results showed that Resident #1 had an acute distal radial fracture with moderate soft tissue swelling. The Note indicated that Resident #1's NP was notified and he/she was sent to the Hospital's Emergency Department.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 12/12/24 at 12:32 P.M., the NP said that after being notified on 11/25/24 that Resident #1 had left wrist pain, edema, and bruising, she saw Resident #1. The NP said she ordered an X-ray which showed a left distal radial fracture, and she sent Resident #1 to the Hospital's ED. The NP said she was unaware of Resident #1's left wrist pain, edema, and bruising, until she was notified on 11/25/24.</p> <p>During an interview on 12/12/24 at 1:57 P.M., the Director of Nurses (DON) said she knew that Resident #1 had had a fall on 11/21/24 and was sent to the Hospital's ED due to a hematoma on the left side of his/her head. The DON said there was no documentation at the time of the fall to suggest that Resident #1 had injured his/her left wrist.</p> <p>The DON said on Monday (11/25/24), she reviewed the Nurse's Notes while she investigated Resident #1's fall, and noticed progress notes about left wrist pain, edema, and bruising. The DON said she told Nurse #3 to notify the NP immediately. The DON said Nurse #3 should have notified the NP or on call Provider when she noticed bruising and edema on Resident #1's left wrist on 11/22/24, but did not. The DON also said that Nurse #2 should have notified the NP or on call provider when she noticed that Resident #1 had left wrist edema, bruising, and pain on 11/23/24, but did not.</p>		