STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 15203 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was alert and oriented, frequently incontinent and dependent on staff to meet his/her care needs, the Facility failed to ensure he/she was free from verbal abuse by staff members when, during the night shift (11:00 P.M. to 7:00 A.M.) on 03/09/25, Certified Nurse Aide (CNA) #1 and CNA #2 yelled at, made insulting and ridiculing comments to Resident #1, who said he/she was upset, humiliated and cried after the incident. Findings include: Review of the Facility Policy titled Abuse Investigation and Reporting, last revised February 2024, indicated that each resident has the right to be free from verbal, sexual, physical and mental abuse. Review of the Facility Policy titled Resident Rights, last revised January 2024, indicated employees shall treat all residents with kindness, respect and dignity. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 3/12/25, indicated that Resident #1 reported that Certified Nurse Aide (CNA) #1 and CNA #2 verbally abused him/her. Review of the Facility's Internal Investigation Report, undated, indicated that on 3/12/25, Resident #1 reported that at 2:00 A.M. on 3/09/25, he/she had diarrhea and CNAs (later identified as CNA #1 and CNA #2) yelled at him/her, said that he/she could have prevented the diarrhea and incontinence and said that he/she was lazy. Resident #1 was admitted to the Facility during October 2017 and his/her diagnoses included anxiety disorder, depression, and post-traumatic stress disorder. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 3/14/25, indicated his/her cognitive patterns were intact, he/she was frequently incontinent of bowel and bladder and he/she required assistance with hygiene and bathing. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1's Care Plan regarding Self-Care Deficit, dated as revised 2/23/25, indicated interventions which included total dependence on staff members for showers and personal hygiene and the assistance of two staff members with toileting needs. During an interview on 3/31/25 at 10:00 A.M., the Unit Manager said that on 3/12/25, Resident #1 reported that on 3/09/25 CNAs #1 and #2 yelled at him/her after he/she was incontinent in bed. The Unit Manager said that Resident #1 told her that CNAs #1 and #2 weren't very nice to him/her and had told him/her that he/she was lazy and should have gotten up to use the bathroom. During an interview on 3/31/25 at 10:25 A.M. Resident #1 said on 3/09/25 during the overnight shift, around 2:00 A.M., two CNA's came to his/her room to provide care, that it was dark but that he/she knew who the CNA's were by their voices, and said their names (identifying CNA #1 and CNA #2). Resident #1 said after finding he/she had been incontinent in the bed, that both CNA #1 and CNA #2 were verbally abusive to him/her. Resident #1 said CNA #1 and #2 told him/her to get his/her ass out of bed and get to the shower. Resident #1 said that CNA #1 and #2, without first helping to clean him/her up or remove his/her feces covered Johnny, told him/her to walk to the shower, and that he/she continued to be incontinent of diarrhea while walking to the shower. Resident #1 said that once in the shower room, CNA #1 and #2 told him/her to stop acting like an animal and, when he/she was incontinent again during the shower, he/she heard them say he/she's doing it again, shitting like a cow. Resident #1 said that he/she felt verbally abused, was humiliated and upset as a result of the incident, and that the CNA's treatment of him/her that night made him/her cry. Review of Resident #2's Minimum Data Set (MDS) assessment, dated 1/10/25, indicated he/she had a BIMS score of 15/15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, 13-15 suggests cognition intact. The MDS indicated Resident #2 was alert, oriented, able to make self understood and understood others. During an interview on 3/31/25 at 10:35 A.M., Resident #2, who shared a room with Resident #1, said that during the overnight shift on 3/09/25, he/she heard CNA #1 and #2 yell at Resident #1. Resident #2 said that CNA #1 and #2 yelled oh my God and what a mess when they found that Resident #1 had moved his/her bowels in bed. Resident #2 said CNA #1 and #2 made Resident #1 walk to the shower in a [NAME] which was soiled by feces and that he/she heard them yell at Resident #1 the whole way to the shower. Resident #2 said he/she heard CNA #1 and #2 say to Resident #1 that he/she wouldn't have been incontinent in his/her bed if he/she wasn't so lazy and if he/she didn't eat the foods that he/she ate. Resident #2 said that Resident #1 cried and apologized to CNA #1 and #2 for having been incontinent in the bed. Resident #2 said that he/she heard CNA #1 and CNA #2 tell Resident #1 that he/she ought to be sorry and he/she should stop acting like an animal. During a telephone interview on 4/01/25 at 2:50 P.M., CNA #1 said that she and CNA #2 assisted Resident #1 following an incident in which Resident #1 was incontinent of stool in bed. CNA #1 said on 3/09/25, she assisted CNA #2 that night, while they provided care to Resident #1, that CNA #2 yelled at Resident #1 and made insulting and ridiculing comments. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said that CNA #2 asked Resident #1 why he/she hadn't called to use the bathroom and said that Resident #1 was fucking ridiculous and fucking disgusting. CNA #1 said however, that she did not know whether CNA #2 was calling Resident #1 ridiculous and disgusting or was talking about the condition of his/her bed. CNA #1 said that CNA #2 told her, while in Resident #1's presence and where he/she could hear, that Resident #1 was with it and had moved his/her bowels in bed on purpose. CNA #1 said that while CNA #2 walked Resident #1 to the shower room, CNA #2 muttered that Resident #1 was shitting like a cow. CNA #1 said that once Resident #1 was in the shower, CNA #2 continued to run her mouth and use foul language when Resident #1 had been incontinent of stool during the shower. CNA #1 said that she was present when CNA #2 yelled at and made insulting and ridiculing comments toward Resident #1. CNA #1 denied that she yelled at Resident #1 and denied making insulting or ridiculing statements to him/her. Although CNA #1 said it was CNA #2 that verbally abused Resident #1, CNA #1 also did not intervene to stop CNA #2 and did not report CNA #2's behavior to the nurse. During a telephone interview on 4/04/25 at 9:20 A.M., CNA #2 said that she and CNA #1 cared for Resident #1 following an episode of incontinence on 3/09/25 during the overnight shift. CNA #2 said that CNA #1 called her to Resident #1's room and said to her (CNA #2) look at this, referring to Resident #1 and his/her soiled bed. CNA #2 said she did ask Resident #1 why he/she didn't put on his/her call light so that they could have taken him/her to the bathroom, but denied saying it an abusive manner. CNA #2 said that CNA #1 suggested that they clean Resident #1 by taking him/her to the shower and Resident #1 agreed. CNA #2 said that she stood in the shower room door while CNA #1 and went into the shower assisted Resident #1. CNA #2 said CNA #1 made insulting and ridiculing comments toward Resident #1 during the shower. CNA #2 said that during the shower, CNA #1 said this was unacceptable. CNA #2 said she heard CNA #1 say in a frustrated and angry tome of voice, that Resident #1 should have put his/her call light on, that it was two o'clock in the morning and that she (CNA #1) and Resident #1 were not good. CNA #2 said that at one point when Resident #1 had diarrhea during the shower, CNA #1 said to him/her now you're going again and we are not good. CNA #2 said that Resident #1 explained to CNA #1 that he/she did not realize that he/she was moving his/her bowels in the shower and CNA #1 said, in an incredulous tone of voice, you don't know when you have to go? CNA #2 said that when Resident #1 told CNA #1 he/she was finished moving his/her bowels, CNA #1 responded back and said I thought you said you didn't know when you needed to go. You know, don't give me that, this is unacceptable. CNA #2 said that when the shower was completed, CNA #1 handed Resident #1 a towel and said dry yourself off, I'm not going to do it, I've done enough. CNA #2 said that she was present when CNA #1 yelled at and made insulting and ridiculing comments toward Resident #1. CNA #2 denied that she yelled at Resident #1 and denied making insulting or ridiculing statements to him/her. Although CNA #2 said it was CNA #1 that verbally abused Resident #1, CNA #2 also did not intervene to stop CNA #1 and did not report CNA #1's behavior to the nurse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Both CNA #1 and CNA #2 had initially denied that anyone yelled at Resident #1 or make insulting and ridiculing comments directly to him/her, or within his/her earshot. CNA #1 and #2's statements of denial seemed suspect given the consistent and corroborating statements of Resident #1 and Resident #2, who said that both CNA's were verbally abusive to Resident #1 that night. As a result, of the facility's and State Agency's investigations, CNA #1 and #2 changed their stories about the events that occurred on 3/09/25 and accused each other of having made the alleged abusive statements. During an interview on 3/31/25 at 2:00 P.M., with the Director of Nursing and the Administrator, they said that the Facility investigated Resident #1's report to the Unit Manager regarding the actions of CNA #1 and CNA #2. They said that although CNA #1 and CNA #2 initially denied that any disrespectful or verbally abusive comments were uttered toward Resident #1 during the incident on 3/09/25, that during subsequent interviews, CNA #1 and CNA #2 each, then changed their stories and accused the other of having made such comments. On 3/31/25 the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by: A. On 3/12/25, CNAs #1 and #2 were suspended pending the outcome of the Facility Investigation and were subsequently terminated. B. Resident #1 was seen by Social Services on 3/13/25, 3/19/25 and 3/26/25 for support related to the alleged incident and was seen by psychiatric services on 3/17/25. C. On 3/19/25, the Administrator attended Residents Council to provide education to residents on the Facility Abuse Policy and to ask resident about other potential concerns related to verbal abuse/resident rights. D. On 3/19/25, the Director of Clinical Compliance reviewed the 2025 Grievances for any concerns related to verbal abuse/resident rights. E. Between 3/19/25 and 3/21/25, the Director of Clinical Compliance and the Staff Development Coordinator trained all Facility staff using a new scenario-based training curriculum targeted toward identifying and responding to resident abuse/resident rights. F. Starting 3/15/25 and on-going, the Social Worker interviewed four Facility residents daily, five days each week, to ask about potential incidents of verbal abuse/resident rights violations. G. The Administrator and/or designee are responsible for overall compliance.