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	06/29/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required transfer to the Hospital Emergency Department for an evaluation, the Facility failed ensure they sent a copy of their Notice of Intent to Discharge him/her to a representative of the Office of the Long-Term Care Ombudsman, as required. Findings include: The Facility Transfer or Discharge Notice Policy, last revised 11/2024, indicated that a resident and/or his/her representative, will be given a thirty-day written notice of an impending transfer or discharge from the Facility. The Policy indicated that a copy of the notice would be sent to the Office of the State Long-Term Care Ombudsman. Review of Resident #1's clinical record indicated he/she was admitted to the Facility during July 2025 and his/her diagnoses included multiple sclerosis, major depressive disorder, anxiety disorder and tobacco use. Resident #1's Care Plan related to resident's wish to discharge to the community, dated as initiated 7/16/25, indicated that Resident #1 would communicate an understanding of the discharge plan and interventions included preparing and giving him/her the contact information for community referrals as needed. During a telephone interview on 6/29/26 at 9:03 A.M., the Ombudsman said that the Facility does not send them a copy of each individual resident discharge notice but only provided them [Ombudsman office] with a Weekly Report entitled Ombudsman Notification of Facility Initiated Transfer/Discharge. The Ombudsman said that the Weekly Report indicates which residents had been discharged during the prior week and provides a generic location, such as home or to hospital. The Ombudsman said the Report also does not indicate the specific address where the Facility planned to discharged residents. During an interview on 6/29/26 at 3:40 P.M., the Director of Social Service provided the surveyor with a copy of the Ombudsman Notification of Facility Initiated Transfer/Discharge Reports, dated as having been faxed to the Ombudsman on 6/08/26 and 6/19/26. The Reports did not indicate the specific addresses where residents had been discharged . The Director of Social Service said that she faxed the Report to the Ombudsman's office instead of faxing each resident's discharge or transfer notice because that was what had been done by her predecessor. The Director of Social Services said she was not aware that the Ombudsman Office required additional information, or that the regulations required they were sent a copy of discharge notices.

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
	225723	A. Building B. Wing	06/29/2026

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 an atypical antipsychotic medication for major depressive disorder and anxiety disorder, the Facility failed to ensure he/she was free from a significant medication error, when upon re-admission to the facility following a hospitalization, his/her medication orders were not accurately reconciled by nursing resulting in him/her being administered four extra doses of his/her antipsychotic in error. Findings include: Review of the Reconciliation of Medication on admission Policy, dated 11/20/24, indicated that the purpose of the procedure was to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. The Guidelines for the Policy indicated that medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/19/26, indicated Resident #1 was hospitalized on [DATE] following an incident in which he/she intentionally drove his/her electric wheelchair into a staff member's leg. Review of Resident #1's medical record indicated he/she was initially admitted to the Facility in July 2025, diagnoses include multiple sclerosis, major depressive disorder, and anxiety disorder. Review of Resident #1's Physician's Orders for June 2026 indicated that at the time of his/her transfer to the hospital on 6/05/26, his/her medication orders included risperidone (atypical antipsychotic medication used to rebalance neurotransmitters in the brain to help stabilize mood, thoughts, and behaviors) 0.25 milligrams (mg) once a day in the evening. Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that upon return to the Facility, he/she should continue risperidone 0.5 mg tablet daily. Further review of the Hospital Discharge Summary indicated that there were no recommendations, instruction or order for Resident #1 related to risperidone 0.25 mg. There was no documentation in Resident #1's medical to support that upon his/her readmission to the facility that nursing clarified the risperidone orders with the physician. Review of Resident #1's Facility Physician's Orders, dated 06/25/26, indicated he/she had orders to be administered risperidone 0.5 mg in the morning and risperidone 0.25 mg at bedtime. Review of Resident #1's Medication Administration Record (MAR), dated 06/25/26 through 06/29/26, indicated Resident #1 received risperidone 0.5 mg every morning and from 6/26/26 through 6/29/26 he/she received risperidone 0.25 mg at bedtime. During an interview on 06/30/26 at 2:10 P.M., the Director of Nurses (DON) said she was unaware of Resident #1's significant medication error until being questioned about Resident #1's medications by the Surveyor on 6/29/26. The DON said when she reviewed Resident #1's Hospital Discharge Record, she discovered there had been a transcription error with Resident #1's risperidone medication, upon his/her readmission to the facility. The DON said that she spoke with the Resident #1's physician on 6/30/26 who said he wanted Resident #1 to receive risperidone 0.25 mg in the evening, and that Resident #1 should not have been receiving risperidone 0.5 mg.