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	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interview, the facility failed to ensure the Health Care Proxy (HCP: health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) was notified of the benefits, risks, and alternatives for the medication prior to providing psychotropic medication for one Resident (#3), out of 31 sampled residents.Findings include:Review of the facility's policy titled Psychotropic Medication, dated as revised 7/2023, indicated but was not limited to:-A written informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychotropic medicationResident #3 was admitted to the facility in October 2024 with diagnoses that include dementia and depression.Review of the Minimum Data Set (MDS) assessment, dated 6/27/25, indicated Resident #3 received antidepressant medication.Review of Resident #3's Physician's Orders indicated but were not limited to:-invoked HCP, dated 10/30/24-Sertraline (antidepressant) 25 milligrams (mg) by mouth daily, dated 6/22/25Review of Resident #3's June and July 2025 Medication Administration Record (MAR) indicated he/she received Sertraline as ordered.Review of Resident #3's electronic and paper records failed to indicate his/her representative was notified of the benefits, risks, and alternatives of Sertraline.During an interview on 7/28/25 at 3:12 P.M., Nurse #7 said before a psychotropic medication is started the resident or resident representative must be notified of the risks, benefits and side effects. Nurse #7 said the facility completes a consent form indicating the notification had occurred.During an interview on 7/28/25 at 3:08 P.M., Unit Manager #3 said the initiation of psychotropic medication requires consent from the resident or his/her representative, as indicated. Unit Manager #3 said the resident/resident representative should be aware of the benefits, risks, and alternative options prior to initiation of the medication. Unit Manager #3 said to indicate acceptance, the facility completes a consent form that is signed by the resident/resident representative. Unit Manager #3 reviewed Resident #3's medical record and could not locate a consent form. Unit Manager #3 said Resident #3 was not his/her own person and their HCP had been activated and should have signed a consent for Sertraline prior to it being initiated.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure the state agency responsible for Preadmission Screening and Resident Review (PASRR) was notified following psychiatric hospital admissions for one Resident (#155), in a total sample of 31 residents.Findings include:Review of Nursing Facility Bulletin 186: Updates to Nursing Facility Regulations: Preadmission Screening and Resident Review (PASRR) for Intellectual Disability, Developmental Disability, and Serious Mental Illness (SMI) indicated the following:-PASRR Portal: An online portal that is required for the submission of all Level I Screening forms -A nursing facility must ensure an individual who has or is suspected of having SMI is referred to the state PASRR Unit, for a post-admission Level II Evaluation (i.e. a Resident Review) in the following instances: When an individual who resides in a nursing facility has experienced a Significant Change; including but not limited to: The resident is transferred, admitted , or readmitted to a nursing facility following an inpatient psychiatric stay or equally intensive treatment. Resident #155 was admitted to the facility in May 2024 with diagnoses of schizoaffective disorder, bipolar disorder, and anxiety disorder. Review of the medical record indicated Resident #155 was admitted to psychiatric hospitals in August 2024 and March 2025. Review of the medical record indicated the most recent PASRR was dated 7/12/24, prior to the psychiatric hospital admissions. During an interview on 7/23/25 at 12:05 P.M., Social Worker #1 said he checked the PASRR portal and the last PASRR submitted for Resident #155 was in July 2024. He said there were no additional PASRRs submitted for the Resident. He said he can see in the medical record that Resident #155 had psychiatric admissions in August 2024 and March 2025. He said a Resident Review should have been submitted in the PASRR portal following the psychiatric admissions.

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the standard of nursing practice was followed for one Resident (#55), out of a total sample of 31 residents. Specifically, the facility failed to ensure physician's orders for bolus tube feedings (TF) were administered by nursing as written and the Resident was assessed for competency to self-administer his/her own bolus tube feeding (TF) and had a physician's order to do so. Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice.Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.-In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber.Review of the facility's policy titled Self-Administration of Medications, dated as revised 9/2024, indicated but was not limited to the following: Residents have the right to self-administer if the interdisciplinary team has determined it is clinically appropriate and safe for them to do sofollowing an evaluation the staff will document their findings Resident #55 was admitted to the facility in July 2025 with diagnoses including: malignant neoplasm of the mandible, mouth, pharynx and overlapping sites; dysphagia (difficulty swallowing); gastrostomy status (presence of a surgically created opening with a tube into the stomach for the purpose of nutrition- G-tube).Review of the Brief Interview for Mental Status score, dated 7/16/25, indicated the Resident was cognitively intact with a score of 15 out of 15. Review of the current orders for Resident #55, as of 7/23/25, indicated but were not limited to the following: Regular diet, easy to chew texture, thin liquid consistency (7/16/25)Enteral Feed order: Jevity 1.5 calories, 500 milliliters (mls) bolus three times a day, may hold if eats greater than 50% of by mouth meals (7/19/25)Enteral Feed order: Give 200 mls free water four times a day (7/16/25)During an interview on 7/22/25 at 12:45 P.M., the surveyor observed Resident #55's room. In front of their bureau there were numerous TF supplies including: one sealed 237ml box of Jevity 1.5cal, 3 small bottles of sterile water, 2 piston syringes, a notebook, and a large 1500 ml bottle of Jevity 1.5ml that was sealed. Resident #55 said he/she provides him/herself with bolus feedings of Jevity about three times a day. Resident #55 said he/she is concerned that the facility may run out of the small individual boxes (containing 237 mls each) and he/she may have to try to use a large bottle (containing 1500 mls) which he/she is unsure if he/she can manage that independently. Resident #55 said he/she had just provided him/herself a bolus about 20 minutes prior and showed the surveyor their G-tube. The surveyor observed the G-tube to have what appeared to be residual tube feeding in the tube from insertion to the clamp. The Resident said he/she keeps a notebook record of when he/she provides him/herself the bolus, how much he/she takes and at what time, but said he/she does not consistently take the bolus three times a day or more than one 237 ml box at one time. Review of the progress notes for Resident #55 indicated but were not limited to the following: 7/16/25: Physician progress note: Concerns with G-tube dysfunction, G-tube in place and Jevity 1.5 - 500ml three times a day ordered and tolerated plus free water flushes. Plan: G-tube care, continue feeds and monitor tolerance7/19/25: G-tube patent and pt does feeds and flushes on own7/23/25: G-tube is patent and pt independent with water flushes and bolus feedings if by mouth intake is not adequateFurther review of the medical record failed to indicate an order for the Resident to self-administer their tube feeding or flushes or an evaluation to determine if the Resident was capable or could demonstrate the ability to provide themselves G-tube feedings and flushes as ordered in the progress notes, or a resident education evaluation or self-administration evaluation.Review of the Resident #55's personal notebook of GT feedings indicated but was not limited to the following: 7/17/25: took 1 (237ml box) three times7/18/25: took 1 box in the A.M., two boxes in the afternoon, and an unknown amount from a large bottle in the evening7/19/25: took 2 boxes in the morning and afternoon, but couldn't finish 2 boxes in the evening having taken an unknown amount7/20/25: took 2 boxes in the A.M., took one in the afternoon and two in the evening7/21/25: took 2 boxes in the A.M. and afternoon and an unknown

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview and record review, the facility failed to arrange for an audiology appointment for one Resident (#155), out of 31 sampled residents, to address the Resident's hearing loss.Findings include:Review of the facility's policy titled Ancillary Physician Services, last revised March 2025, indicated routine Audiology services were available to meet the resident's health needs. The policy indicated the services could be available through a contract agreement with an Audiologist that comes to the facility, or referral to community Audiologists. Resident #155 was admitted to the facility in May 2024 with a diagnosis of hearing loss. Review of the Minimum Data Set (MDS) assessment indicated the following for Resident #155:5/22/24: moderate difficulty with hearing; no hearing aid or other hearing appliance9/5/24: moderate difficulty with hearing; no hearing aid or other hearing appliance12/4/24: highly impaired hearing; no hearing aid or other hearing appliance5/23/25: highly impaired hearing; no hearing aid or other hearing appliance; Brief Interview for Mental Status score 10 out of 15, indicating the Resident had a moderate cognitive impairment. During an interview on 7/22/25 at 9:05 A.M., Resident #155 said he/she could not hear the surveyor, and their left ear was better than the right ear. Review of a care plan, initiated on 5/16/24, indicated Resident #155 had a communication problem related to moderate hearing impairment and deficits in understanding and making self understood with a goal of being able to communicate simple concrete needs. The interventions included: discuss with resident/family concerns or feelings regarding communication difficulty, allow time to respond and a new intervention on 7/2/25 for ear drops every night for five days. Review of the active Physician's Orders for Resident #155 indicated to consult Audiology as needed. During an interview on 7/24/25 at 1:17 P.M., the Health Care Proxy (HCP) of Resident #155 said the Resident had increased difficulty hearing over the last year. He said he had attended a care plan meeting the previous month where they had discussed the increased hearing loss. He said he was not sure if the Resident had ever seen an Audiologist, but believed the facility was working on it. Review of the Care Plan Meeting notes, dated 6/12/25, failed to indicate any information regarding the HCP's request for assistance with the Resident's hearing. Review of the nursing progress notes indicated on 7/2/25 Resident #155 complained he/she could not hear out of their right ear; the right ear was noted with wax build-up and an order for ear drops was obtained. During an interview on 7/23/25 at 11:26 A.M., Nurse #5 said Resident #155 had received the five days of ear drops to the right ear, following a flush on the sixth day. The Nurse said the ear flush was successful, and the Resident cannot hear at baseline. The Nurse said every day the Resident will say he/she cannot hear. During an interview on 7/24/25 at 1:43 P.M., Unit Manager #3 said the Audiologist was at the facility in June 2025 and Resident #155 was not on the list of residents who were seen. She said she started working at the facility at the end of June 2025 and was not aware Resident #155 could not hear at baseline. During an interview on 7/25/25 at 8:46 A.M., the Medical Records staff said Resident #155's consent for ancillary services was sent over to the consultant ancillary service company on 6/6/25. She said she had sent the consent form for Resident #155 so the Resident could be seen by the dentist. She said she had not requested for Resident #155 to be seen by the consultant Audiologist. She said she had never been asked to have Resident #155 be seen by an Audiologist. She said the consultant Audiologist visits the facility approximately every quarter and was at the facility on 6/16/25 and did not see Resident #155. During an interview on 7/25/25 at 9:00 A.M., the Director of Clinical Operations said the Unit Manager and the Social Worker who attended the care plan meeting for Resident #155 on 6/12/25 no longer worked at the facility. She said she could not speak to why the Resident had not been referred to Audiology services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and records reviewed, the facility failed to ensure one Resident (#6), out of a total sample of 31 residents, received care and treatment to promote healing of a pressure ulcer. Specifically, the facility failed for Resident #6, to implement treatments from the wound consultant physician for a chronic Stage 4 pressure ulcer (full-thickness skin and tissue loss) on the ischium (lower buttocks). Findings include: Resident #6 was admitted to the facility in August 2023 with a chronic stage 4 pressure ulcer on the ischium. Review of the care plans indicated Resident #6 had a stage 4 pressure ulcer and could be non-compliant with offloading (not bearing weight on an area) and dietary recommendations with a goal to improve skin integrity by signs and symptoms of healing. The care plan interventions included but were not limited to: consult and treatment by wound physician; follow orders for skin care and treatments. Review of the Consultant Wound Physician Encounter Form, dated 6/17/25, indicated Resident #6's Stage 4 pressure ulcer measured 3.7 centimeters (cm) in length, by 3.0 cm in width, by 0.2 cm in depth and had a large amount of serous exudate (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage). The following treatment plan was indicated: antibacterial wound cleanser, Alginate (made of fibers that absorb wound fluid and promote healing), and followed by foam to the left ischium wound twice daily and as needed. Review of the June 2025 Treatment Administration Record (TAR) indicated this treatment was completed as ordered, twice daily. Review of the Consultant Wound Physician Encounter Form, dated 7/1/25, indicated Resident #6's Stage 4 pressure ulcer measured 4.0 cm in length by 3.5 cm in width by 0.4 cm in depth and had a moderate amount of serous exudate. The following treatment plan was indicated: Primsa/Puracol/Dermacol (or similar collagen dressing (a dressing with the collagen protein, used to promote healing), Alginate, and followed by foam to the left ischium once daily. Review of the nursing progress, dated 7/1/25 and written by Nurse #9, indicated Resident #6 was seen by the Consultant Wound Physician with a treatment of antibacterial wound cleanser, pat dry, apply collagen dressing and foam to the left buttock daily. Review of the Physician's Orders and July 2025 TAR on 7/23/25 failed to indicate the treatment had been updated to include the collagen dressing. Review of the Consultant Wound Physician Encounter Form, dated 7/15/25, indicated Resident #6's Stage 4 pressure ulcer measured 3.7 cm in length by 3.5 cm in width by 0.2 cm in depth and had a moderate amount of serous exudate. The following treatment plan was indicated: Primsa/Puracol/Dermacol (or similar collagen dressing (a dressing with the collagen protein, used to promote healing), Alginate, and followed by foam to the left ischium once daily. Review of the nursing progress, dated 7/16/25 and written by the Assistant Director of Nurses (ADON), indicated Resident #6 was seen by the Consultant Wound Physician with a treatment of antibacterial wound cleanser, pat dry, apply collagen dressing and foam to the left buttock daily. During an interview on 7/24/25 at 2:05 P.M., Nurse #4 said she had completed the dressing change for Resident #6 that morning. She said the treatment she completed was for the antibacterial wash, followed by Alginate, followed by a foam dressing. During an interview on 7/25/25 at 10:53 A.M., Nurse #6 said she had completed the dressing change for Resident #6 that morning. She said the treatment she provided was for antibacterial wash, followed by Alginate, followed by a foam dressing and demonstrated the products to the surveyor. During an interview on 7/25/25 at 11:27 A.M., Nurse Practitioner #1 said the in-house Consultant Wound Physician saw residents weekly and determined the treatments needed for managing the wounds. She said the facility defers to the Consultant Wound Physician on wound treatment orders. During an interview on 7/25/25 at 11:35 A.M., Nurse #9 said she was previously the ADON at the facility and that was why she was conducting weekly wound rounds. She said she had conducted wound rounds with the Consultant Wound Physician on 7/1/25. She said the process was that at the end of the visit the Consultant Wound Physician provides a copy of the Encounter Form and the ADON will document in a progress note and make changes to the treatment orders. She reviewed the medical record with the surveyor and said the changes to the treatment on 7/1/25 were not made in the electronic medical record and did not reflect the accurate order from the Consultant Wound Physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Properly label and date food products and maintain safe/clean equipment in three of four nourishment kitchenettes; and2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another). Findings include:1. Review of the facility's policy titled Food Brought into Facility, revised 4/2019, indicated but was not limited to the following:- It is the policy of the Company that visitors or family members are permitted to bring food to a resident and are encouraged to limit foods to those that meet patient's meal plan and safe food handling practices.- Visitors and family members should take all food to the nurse's station before it is provided to the resident.- Perishable foods must be stored and identified with resident's name, food item and use by date.- Nursing staff is responsible for discarding perishable foods on or before the use by date. On 7/22/25 at 11:44 A.M., the surveyor made the following observations in the River 2 Kitchenette:- The inside of the microwave had orange/brown residue and food splatter covering the tops and sides.- A white plastic bag containing a loaf of bread was labeled only with a resident name and had no use by date. On 7/22/25 at 12:05 P.M., the surveyor made the following observations in the [NAME] 2 Kitchenette:- The inside of the microwave had orange/brown residue and food splatter covering the tops and sides.- The refrigerator contained two clear plastic containers with food product, labeled with a resident name but no use by date. There were visible moisture/water droplets inside each of the containers.- The refrigerator contained one clear plastic container with a small salad, labeled with a resident name and a use by date of 7/20/25. There were moisture/water droplets inside of the container. The lettuce and vegetables were noted to be browning.- The bottom right drawer of the refrigerator had a bag of red [NAME] apples and a container of red grapes. Both items were not labeled with any resident identification or use by dates. On 7/22/25 at 12:47 P.M., the surveyor made the following observations in the River 1 Kitchenette:- The inside of the microwave had a gray residue covering the top/sides.- A white plastic bag was inside the freezer containing five individual ice cream cups (in plastic cups) with no lids as well as three Bizcocho cakes. Neither the bag nor the individual ice cream cups/cakes were labeled with resident identification or a use by date. The ice cream cups were freezer burned with discoloration to the top. On 7/23/25 at 11:11 A.M., the surveyor made the following observations in the River 2 Kitchenette:- The inside of the microwave had orange/brown residue and food splatter covering the tops and sides.- A white plastic bag containing a loaf of bread was labeled only with a resident name and had no use by date. On 7/23/25 at 11:15 A.M., the surveyor made the following observations in the [NAME] 2 Kitchenette:- The inside of the microwave had orange/brown residue and food splatter covering the tops and sides.- The bottom right drawer of the refrigerator had a bag of red [NAME] apples and a container of red grapes. Both items were not labeled with any resident identification or use by dates. On 7/23/25 at 11:21 A.M., the surveyor made the following observations in the River 1 Kitchenette:- The inside of the microwave had a gray residue covering the top/sides.- A white plastic bag was inside the freezer containing five individual ice cream cups (in plastic cups) with no lids as well as three Bizcocho cakes. Neither the bag nor the individual ice cream cups/cakes were labeled with resident identification or a use by date. The ice cream cups had freezer burn and discoloration to the top.During an interview on 7/24/25 at 1:20 P.M., the Food Service Director (FSD) said dietary staff are responsible for stocking unit refrigerators and ensuring items in the refrigerators and freezers are properly labeled and dated. The FSD said the dietary staff are also responsible for making sure the microwaves and refrigerators/freezers are clean. The FSD and the surveyor reviewed the observations made in the unit kitchenettes throughout the survey. The FSD said all items should have proper labels including resident identification and use by dates. The FSD said microwaves, refrigerators and freezers should be clean from any food residue or spills.2. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:- 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing