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	12/22/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council regarding long call light wait times were acted upon to resolve the issue.Findings include:Review of the facility's policy titled Resident Council, dated as revised in February 2024, indicated the facility would establish and maintain an active Resident Council with the basic goal of promoting the highest Quality of Life for each resident. The process included Department Heads responding to grievances addressed in the minutes in writing before the next meeting. Review of the Resident Council Minutes, dated 7/16/25, indicated call lights continued to be monitored and when asked the residents responded that they could not get help or care without waiting a long time and call lights were not answered in a timely manner. Review of the Resident Council Minutes, dated 8/13/25, indicated call lights continued to be monitored, and the residents added that on weekends call lights were not answered in a timely manner; the residents requested and were in agreement to file a grievance. Review of the Resident Council Minutes, dated 9/17/25, indicated call lights continued to be monitored and residents asked for auditing of call lights on the second shift (3:00 P.M. to 11:00 P.M.) and when asked if call lights were answered in a timely manner the residents indicated not on the second shift. Review of the Resident Council Minutes, dated 10/15/25, indicated call lights continued to be monitored and a grievance was filed. Review of the Resident Council Minutes, dated 11/12/25, indicated call lights on weekends and second shift continue to be a work in progress. On 12/17/25 at 1:30 P.M., the surveyor held a group meeting with 13 residents in attendance. The residents said every month they bring up the concerns of call light wait times and said the problem continued on weekends and second shift. They said they can wait 45 minutes to an hour for a staff member to answer their call lights and did not feel the facility had followed up with the Resident Council on a plan. The surveyor requested Resident Council meeting follow-up from the Activity Director and was provided staff education sheets.Review of the staff education sheets indicated the following related to call lights:7/22/25: Review of answering call light policy signed by nine staff members9/18/25: Education on customer service including answering call lights provided to 50 staff members (7 who signed-in twice for a total of 43 staff members), 11 of which worked on the second shift.10/15/25: Education on customer service including answering call lights with the same signatures, in the same order, on the same pages as the training from 9/18/25. During an interview on 12/17/25 at 4:42 P.M., the Staff Development Coordinator said she was unable to find the original sign in sheets for the trainings from 9/18/25 and 10/15/25 and that although she felt the staff had been educated multiple times on call light response time she said the staff did not sign in on both 9/18/25 and 10/15/25. During an interview on 12/17/25 at 9:20 A.M., the Activity Director said the staff had been conducting audits on call lights, staff wearing name tags, and staff using headphones. She said the audit responses were provided to the Assistant Administrator and does not know what the follow up to the audits was. The Activity Director provided the surveyor with facility conducted audits for the month of December 2025. Review of the audits failed to indicate any audits were conducted on the weekends. The audits indicated call light response time for the second shift was observed on 2 out of 16 days. The audit forms inquired if call lights were answered timely and both second shift observations answered no. Observations on the first shift (7:00 A.M. to 3:00 (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M.) indicated on 12/2/25 one resident waited 25 minutes for the call light to be answered, one resident waited 20 minutes and for another resident a staff member had shut off the call light from the nurses' station without going to see the resident and on 12/3/25 one resident waited 25 minutes and one resident waited 20 minutes. During an interview on 12/17/25 at 3:20 P.M., the Activity Director said the residents in Resident Council had voiced concerns mostly about the call light response wait time on the second shift and weekends, she said the residents had noted there had been some improvement in the wait time during the first shift. She said she was not sure who audited the second shift or the weekends. She said there was a scheduled manager on duty during the weekends, but the audits were not part of the responsibilities. During an interview on 12/17/25 at 3:40 P.M., the Administrator said the audits had recently started and the management staff were responsible for conducting audits on call lights and to bring the results to the Assistant Administrator. He said he had not reviewed the December 2025 audits and had not realized the residents had waited 20 and 25 minutes for call lights to be answered. He said he did not know the residents from Resident Council had voiced they had waited 45 minutes to an hour and had not inquired how long they wait. The surveyor reviewed the grievance book with the Administrator which did not include the grievances from the August 2025 and October 2025 Resident Council meetings. The Administrator said he would have to look for these grievances and their resolutions. During an interview on 12/18/25 at 10:27 A.M., the Administrator said there were no grievance forms for the August 2025 or October 2025 Resident Council meetings and no follow up to the grievances. Refer to F865

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on document review and interviews, the facility failed to ensure residents had access to their personal funds. Specifically, the facility failed to make funds available for Resident #10 within three banking days for requests in the amount of $50 or more and failed to make funds available for same day requests for cash amounts less than $50.Findings include:Review of the facility's Resident Handbook, undated, indicated the facility could assist with the management of Personal Funds. The Handbook indicated Deposits into these accounts may be made by mail or in person during normal business office hours. For withdrawals from a resident's personal funds account after the Business Office hours, the resident may contact his/her unit supervisor who will assist the resident with the transaction. Review of the facility's Resident Handbook failed to indicate a process for withdrawals during business office hours, how much personal funds could be withdrawn at a time, or what the business office hours were. During an interview on 12/15/25 at 10:00 A.M., the Ombudsman said there were concerns with the Business Office distributing funds to all residents who were requesting their funds and it was on a first come first serve basis and that, in particular, Resident #10 could not access his/her personal funds to purchase clothing and had been told to purchase clothing from a catalog. On 12/17/25 at 1:30 P.M., the surveyor held a group meeting with 13 residents in attendance. During interviews at this time, five out of 13 residents said they had the facility manage their personal funds, while the other residents said they held their personal funds off site. The five residents said the Receptionist was responsible for distributing funds from their personal funds accounts from 10:00 A.M. to 2:00 P.M. and would often run out of cash. They said they accessed funds on a first come first serve basis and most residents would request $50 at a time and then the funds would run out leading to times where they could not access their funds. They said on the weekends they only had access to funds if there was a receptionist working, which was not every weekend.During an interview on 12/17/25 at 11:15 A.M., Resident #10 said the process to withdraw money from his/her personal account at the facility was to request money from the Receptionist. Resident #10 said he/she could only take out $50 per day and there were days the facility did not have funds available to distribute to residents. Resident #10 said he/she had called down to the Receptionist this morning and was told there was no cash available to distribute for the residents. In addition, Resident #10 said he/she had wanted to buy new clothes and a friend was going to go shopping for the clothing. He/she said they had requested to withdraw $300 for clothing and were told they could not have $300 of their own money at once and they could either order clothing from a catalog (a particular clothing company the facility utilized) or the friend could purchase the clothing with their money, submit the receipt and be reimbursed. During an interview on 12/17/25 at 11:50 A.M., the Business Office Assistant said she had worked at the facility since July 2025 and did not handle anything regarding resident personal funds. She said the Receptionist was responsible for distributing money to residents from their personal needs accounts. During an interview on 12/17/25 at 11:51 A.M., the Business Office Manager said she had started working at the facility this month and was still in training. During an interview on 12/17/25 at 12:00 P.M., the Receptionist said she provided banking hours from 10:00 A.M. to 3:30 P.M. She said a lot of residents would request $50 at a time and the bank would run out of money. She said the process was for her to submit the information of money withdrawn from the bank each day and then the corporate office would respond by adding money to an ATM card, she would then go to the bank and withdraw the money. She said the maximum amount of money added to the ATM card was $480 and that was the amount she could withdraw. She said the resident bank would then only have $480 and she would tell the residents to come down early to withdraw their money because it was a first come first serve basis. She said if the first 10 residents were to request $50 each that was why the bank would run out of money and funds were not available for other residents. The Receptionist said when Resident #10 had called down earlier she had informed the Resident there was no money available because she had not had time to go to the bank yet, she added (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility bank had the money at the time of this interview. She said the maximum amount of funds a Resident could take out per day was $50. She said even if a resident were to request funds ahead of time they could not withdraw more than $50 per day from their own personal funds. She said Resident #10 could not have $300 from their personal funds account because that would take almost all of the $480 from the facility bank. She said the friend of Resident #10 could go shopping with their own money and submit a receipt to the facility for reimbursement from the Resident's personal funds. During an interview on 12/17/25 at 3:10 P.M., the Quality Assurance Liaison said the process for resident personal funds accounts was that the facility was provided with a global cash card to withdraw money from an external bank. She said when money was withdrawn by residents from the petty cash box (facility bank) the Receptionist submitted withdrawal slips and the corporation would add money to the global cash card for withdrawal. She said the facility was allowed to keep $1000 in cash in the petty cash box but that the ATM withdrawal limit was $480 per day. She said the Receptionist goes to the bank to withdraw money about once or twice a week and does not have time to go more. She said she was not aware that the petty cash box did not have $1000 in it and that residents were being told they could not access funds because the petty cash box (facility bank) was out of money. She said if a Resident has funds they can request more than $50 ahead of time. She said Resident #10 should have been provided with the money he/she requested and should not have been told no by the Receptionist.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, interview, and record review, the facility failed to evaluate and assess one Resident (#97), out of a total sample of 34 residents after an unplanned 11.29% significant weight loss in six months had been identified. Specifically, the facility failed to assess and evaluate the resident for more than two months after the significant weight loss had been identified. Findings include: Review of the facility's policy titled Weight Measurement, dated as last revised 11/2025, indicated but was not limited to the following:-Weights will be obtained monthly at the beginning of the month.-All residents with significant weight changes will be reweighed to ensure accuracy of the weight. If the reweight indicates significant weight change, the resident and/or representative and interdisciplinary team (IDT) will be notified, and plan of care will be revised as warranted. Resident #97 was admitted to the facility in April 2025 with diagnoses which include abnormal weight loss, muscle wasting and atrophy, and diabetes mellitus. Review of the Minimum Data Set (MDS) Assessment, dated 10/24/25, indicated Resident #97 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating he/she had severe cognitive impairment, and had undesired/unplanned weight loss of 5% in the last month or 10% in the last six months. During an interview on 12/16/25 at 10:00 A.M., Resident #97 said the food is terrible, poor quality, small portions, and odd pairings. Additionally, he/she said they were picky since admission because the food is weird and they have lost weight. Review of the Comprehensive Care Plan indicated but was not limited to the following:FOCUS: NUTRITION: Resident is at nutritional risk.GOAL: The resident will have no significant changes in weight through review date.INTERVENTIONS: Monitor/Record weights per facility protocol/MD orders; Diet Consult as needed. Review of the Physician's Orders indicated Resident #97's diet was Heart Healthy, CCHO (Controlled Carbohydrate for diabetic management). No nutritional supplements were ordered. Review of the Weight Summary for Resident #97 indicated but was not limited to the following:-4/9/25: 124 pounds (lbs.)-5/7/25: 118 lbs.-6/4/25: 118 lbs.-7/11/25: 117 lbs.-8/7/25: 115 lbs.-9/3/25: 115 lbs.-10/8/25: 110 lbs. Resident #97's weight was down 4.35% in one month; 5.98% in three months; and 11.29% in six months. Review of the Nurse Practitioner (NP) progress note, dated 9/19/25, indicated Resident #97 had a weight loss since admission, about 9 lbs., and they wanted the Dietitian to follow up.Review of the nursing progress note, dated 9/19/25, indicated the NP was in the facility, aware of weight loss, and ordered a Dietitian consult and the Registered Dietitian (RD) was made aware. Review of the Medical Nutrition Therapy Assessment, dated 10/7/25, indicated but was not limited to the following:-Assessment Type: Quarterly-Does the Resident have a recent weight: Yes: 115 lbs. on 9/3/25.-Weight 30 days ago: (left blank)-% Weight Change in 30 days: (left blank)-Weight 90 days ago: 117-% Weight Change in 90 days: (left blank)-Weight 180 days ago: 124-% Weight Change in 180 days: (left blank)-Summary: Resident has maintained a stable weight, with gradual weight loss since their admission 3 months ago. No nutritional interventions at this time. The RD failed to ensure a recent weight was obtained and used in the evaluation for an accurate assessment of Resident #97's status. Review of the Nursing, RD, MD, and Nurse Practitioner (NP) progress notes failed to indicate Resident #97 had been assessed and evaluated regarding the weight loss since the significant weight loss had been identified on 10/8/25 (72 days). During an interview on 12/19/25 at 12:03 P.M., Nurse #4 said she was not sure of the facility policy on weights, reweights, and notifications. During an interview on 12/19/25 at 12:13 P.M., Unit Manager #2 said anytime the new weight is down or up three pounds from the previous weight, it should be rechecked to confirm accuracy of the loss or gain. She said the computer program should generate an alert for the RD to see, but if we (nursing) noticed the weight loss the RD would be notified to evaluate for interventions. She said with any significant weight loss, the resident should be discussed at risk, the RD usually makes recommendations and writes a note and/or the MD/NP. She said she was not sure why this weight loss was not addressed. During an interview on 12/19/25 at 1:35 P.M., the Wound Nurse said weights are done monthly and must be done before the 10th. She said (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if it is off by 3 lbs. then it should be rechecked by the next day to confirm, then resident representative, RD, MD/NP would all be notified, and he/she would be evaluated for additional interventions within a week by the RD and/or MD/NP. She said significant weight loss should be documented and addressed timely, and this was not. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said if the weight loss is 5% change in a month, they should recheck the weight to confirm. She said the RD is here regularly and there should be a provider response to address the weight loss within a week. Additionally, she said although the one-month weight loss is just under 5% the six-month weight loss was >10% so it should have triggered as significant weight loss in the system and been addressed. During an interview on 12/19/25 at 2:54 P.M., the Corporate Dietitian said the trigger for a reweight is 5%, and although the one-month weight loss (115 lbs. down to 110 lbs.) was just under 5%, the six-month weight loss (124 lbs. down to 110 lbs.) was over 10% so it automatically triggers an alert on the dashboard. She said the RD reviews the dashboard every day they are in the building, which is typically five days a week. She said the alert stays on the dashboard for 30 days unless it is cleared out. She said this alert was never cleared out, so it was on the dashboard for 30 days and then fell off. She said the previous RD left the first week of November which would have been around the time the alert fell off. She said she had been following the residents since then and Resident #97's weight has been stable at 110 lbs. for the last three months, so it is no longer triggering. When the significant weight loss was identified in October, it should have been addressed by the RD, and at the very minimum, a progress note should have been written and that did not happen.

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	225723	A. Building B. Wing	12/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and records reviewed, the facility failed to ensure it was free from a medication error rate of greater than 5% when one of three nurses observed during the medication pass made three errors out of 31 opportunities, resulting in a medication error rate of 9.68%. Those errors impacted two Residents (#77 and #62). Findings include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated and revised April 11, 2018, indicated but was not limited to the following: Nurses Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers.Review of the facility's policy titled Administering Medications, dated as revised September 2024, indicated but was not limited to the following:-Medications are administered in a safe and timely manner, and as prescribed.-Medications are administered in accordance with prescriber orders, including any required time frame.-Medications may be administered one (1) hour before or after the prescribed time, unless otherwise specified.A. Resident #77 was admitted to the facility in November 2024 with diagnoses which include hypertension (high blood pressure) and depression.On 12/17/25 at 8:30 A.M., the surveyor observed Nurse #1 prepare and administer medication for Resident #77. Prior to preparing medication, Nurse #1 obtained Resident #77's blood pressure, resulting in a result of 108/75. Nurse #1 said she would not administer Resident #77 his/her propranolol (used to lower blood pressure) because his/her blood pressure was below 110. Nurse #1 could not locate Resident #77s sertraline (antidepressant) in her medication cart and reported she could not administer the medication to Resident #77 because it was not available from the pharmacy.Review of the Physician's Orders indicated but were not limited to following:-propranolol 20 milligrams (mg) by mouth two times a day, scheduled for 9:00 A.M. and 9:00 P.M. (dated 8/18/25)-sertraline 100 mg by mouth in the morning for depression, scheduled for 9:00 A.M. (dated 12/16/25)Further review of the propranolol order failed to indicate a parameter was in place for the blood pressure to not be administered if his/her blood pressure was below 110.Review of the Medication Administration Record (MAR) indicated but was not limited to the following:-propranolol was not signed off as administered, and was marked with an 8, indicating other. -sertraline was not signed off as administered and was marked with an 8, indicating other.During an interview on 12/17/25 at 12:02 P.M., Nurse #1 said she did not administer Resident #77 propranolol because she did not want to drop his/her blood pressure. Nurse #1 said the order did not have a parameter indicating it should be held if his/her blood pressure was below a certain number; she just used her nursing judgment. Nurse #1 said she located Resident #77's sertraline, the surveyor asked to observe the card the dose was administered from and Nurse #1 said that although she had located the sertraline she had not administered it.B. Resident #62 was admitted to the facility in October 2017 with diagnoses which included hypertension and diabetes mellitus.On 12/17/25 at 8:46 A.M., the surveyor observed Nurse #1 prepare and administer Resident #62's medication. Nurse #1 prepared one capsule of the probiotic saccharomyces boulardii with the rest of Resident #62's medications and administered it.Review of Physician's Orders indicated but were not limited to the following:-Lactobacillus, give one capsule by mouth two times per day, (dated 9/24/25) Review of the MAR indicated but was not limited to the following:-Lactobacillus was signed off as administered on 12/17/25. During an interview on 12/17/25 at 12:04 P.M., Nurse #1 reviewed the probiotic bottle and said it does not indicate lactobacillus was an ingredient. Nurse #1 said she had administered Resident #62 the wrong probiotic. During an interview on 12/17/25 at 2:23 P.M., the Regional Director of Clinical Operations said physician's orders should be followed, and the correct medications should be administered.

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	225723	A. Building B. Wing	12/22/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and menu review, the facility failed to ensure that menus posted were followed. Findings include:Review of the lunch menu for 12/17/25 indicated the residents should have received chicken cacciatore as a main entree. On 12/17/25 at 11:20 A.M., the surveyor observed the lunch tray line and a test tray was conducted. The surveyor along with a second surveyor observed the chicken cacciatore to be red in color and have no sauce or topping. The chicken had a cumin-like flavor. Review of the chicken cacciatore recipe included, but was not limited to, the following ingredients: yellow onions, green peppers, sliced mushrooms, diced tomatoes with juice, oregano, ground thyme, chicken stock, flour, and water. The recipe instructed to mix water and flour and add to boiling chicken and vegetable mixture, stir until thickened. Review of the lunch menu for 12/18/25 indicated residents should have received Harvard beets as a side dish. On 12/18/25 at 11:30 A.M., the surveyor observed the lunch tray line and a test tray was conducted. The surveyor and a second surveyor observed the beets to have no sauce or seasoning with a plain beet taste. Review of the Harvard beets recipe included, but was not limited to, the following ingredients: ground allspice, granulated sugar, cornstarch, and vinegar. During an interview on 12/18/25 at 11:30 A.M., the Food Service Director (FSD) said the food should be prepared according to the recipe in the recipe binder. REFER TO F804

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	225723	A. Building B. Wing	12/22/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and test tray results, the facility failed to ensure staff served palatable, attractive, and flavorful food for 2 out of 2 test trays conducted. Findings include:During the initial resident screening on 12/16/25, the residents expressed the following concerns about the food at the facility:-Taste of the food is not good; it's overcooked, dry, mushy vegetables;-Food is awful, does not taste good, no flavor;-Flavor is awful, I usually just ask for a peanut butter and jelly sandwich instead of the food;-Food sucks;-Food is not good, poor quality, odd pairings that don't go together;-Food is terrible;-Food is lousy;-Food is gross. On 12/17/25 at 11:20 A.M., the surveyor conducted Test Tray #1 (regular texture). The meal consisted of chicken cacciatore, penne pasta, cauliflower, chilled baked apples, milk, and juice. APPEARANCE: The chicken cacciatore was a red colored chicken thigh with no sauce; the penne pasta was white; and the cauliflower was white. TEXTURE: The cauliflower was overall mushy and could be easily crushed between the tongue and roof of the mouth. FLAVOR: The chicken cacciatore had a subtle cumin-type flavor and was not prepared or served with any sauce. The penne pasta tasted like plain, unseasoned penne pasta. The cauliflower tasted like plain, unseasoned cauliflower. During an interview on 12/17/25 at 11:20 A.M., the Food Service Director (FSD) said the flavor of the meal was subtle and had no concern with the taste or presentation of the test tray. On 12/17/25 at 12:20 P.M., the surveyor observed the meal posting on the 3rd floor had stated chicken cacciatore, penne pasta, and parslied cauliflower. On 12/17/25 at 1:30 P.M., the Resident Council meeting was conducted with 13 residents in attendance. During the meeting the residents collectively expressed the kitchen continues to be problematic, with specific complaints including the following:-Residents disliked the food;-A grievance was submitted that morning requesting the facility to reinstate the selective/alternate menu;-Today's chicken missing the cacciatore part. During an interview on 12/18/25 at 11:53 A.M., the FSD said one of the sides served for yesterday's lunch should have had parsley sprinkled on top. The FSD said food items should be prepared according to the recipe and if there was a change in the menu, then the meal postings on the units would reflect the change and residents would be notified. On 12/18/25 at 12:02 P.M., the surveyor conducted Test Tray #2 (regular texture). The meal consisted of beef tips with gravy, rice, Harvard beets, mandarin oranges with a dollop of whipped cream, milk, and juice. APPEARANCE: The beef tips were extremely tender causing them to lose shape and appear as a mound of beef, unable to fork a shaped beef tip. The beets were cubed and had no sauce, appeared to have been steamed. FLAVOR: The beets tasted like plain beets, no sweet or acidic flavor. The rice tasted like plain rice, unseasoned. The FSD was present for the Test Tray and had no concerns with the appearance or flavor. The results of the test tray and identification of not following the recipes validates the residents' concerns with the food.

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	225723	A. Building B. Wing	12/22/2025

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained for five Residents (#97, #106, #17, #46, and #6), out of a total sample of 34 residents. Specifically, the facility failed:1. For Resident #97, to:a) ensure medications and treatments were accurately documented during a leave of absence (LOA), and tob) ensure the percentage of lunch consumed was accurately documented after the meal was provided and consumed on 17 of 31 days reviewed; 2. For Resident #106, to ensure the percentage of lunch consumed was accurately documented after the meal was provided and consumed on 16 of 31 days reviewed; 3. For Residents #17 and #46, to ensure volumes of tube feeding and water flushes being administered to the Residents were accurately documented in the Medication Administration Record (MAR); and4. For Resident #6, to accurately document wound care provided on the TAR per the physician's orders. Findings include:Review of the facility's policy titled Charting and Documentation dated as last revised November 2024 indicated but was not limited to the following: -Documentation in the medical record may be electronic, manual, or a combination. -The following information is to be documented in the resident medical record as warranted: objective observations, medications administered, treatments or services performed, changes in the resident condition, events, incidents, or accidents, and progress toward or changes in the care plan goals and objectives. -Documentation in the medical record will be objective, complete, and accurate. 1. Resident #97 was admitted to the facility in April 2025 with diagnoses which include heart disease, abnormal weight loss, muscle wasting and atrophy, and diabetes mellitus. Review of the Minimum Data Set (MDS) Assessment, dated 10/24/25, indicated Resident #97 took antiplatelet medication (to prevent blood clots) and hypoglycemic medication (to lower blood sugar) and had undesired/unplanned weight loss of 5% in the last month or 10% in the last six months. a. Review of the medical record indicated Resident #97 had been on a leave of absence (LOA) from approximately 10/17/25 (afternoon/early evening) through 10/19/25 (midday). Review of the Medication Administration Report (MAR) and Treatment Administration Report (TAR) indicated but were not limited to the following: -Friday, 10/17/25 at 8:00 P.M., Medications were signed off as administered. -Friday, 10/17/25 NIGHT SHIFT documented a Temperature of 97.2 with no cold symptoms. -Saturday, 10/18/25 4:30 P.M., Blood Sugar was documented with a reading of 147 and 5:00 P.M., Medications were documented as administered. -Saturday, 10/18/25 NIGHT SHIFT documented a Temperature of 97.4 with no cold symptoms, additionally, Check Placement of Wanderguard on left wrist was documented as completed (+) indicated the wanderguard was on the left wrist. (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing progress note dated 10/17/25 (LATE ENTRY), indicated This nurse did not witness the residents departure and was not informed during the shift that the resident had left the facility. Therefore, no departure was documented or reported by this nurse at that time. Medication administration prior to departure cannot be confirmed by this nurse. Supervisor notified. During an interview on 12/19/25 at 1:35 P.M., the Wound Nurse said the MAR/TAR should accurately reflect what was administered and/or not administered. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said she was unaware of the specifics surrounding the incident but believes it was determined Resident #97 was out with family and it should have been documented as such. During an interview on 12/19/25 at 4:00 P.M., the Assistant Administrator said it was determined Resident #97 left the building with their son on 10/17/25 in the evening and returned midday on Sunday and the medical record should have reflected that. b. Review of the Meal Percentage Task report for 11/19/25 through 12/18/25 indicated but was not limited to the following: -17 of 31 days reviewed the percentage of lunch consumed was documented prior to meal service being completed. Specifically, the intake was documented between 10:30 A.M. and 12:00 P.M. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said meals should not be documented prior to them being served and consumed. 2. Resident #106 was admitted to the facility in December 2022 with diagnoses which include diabetes mellitus, above the knee amputation, and obesity. Review of the Meal Percentage Task report for 11/19/25 through 12/18/25 indicated but was not limited to the following: -16 of 31 days reviewed the percentage of lunch consumed was documented prior to meal service being completed. Specifically, the intake was documented between 10:30 A.M. and 12:00 P.M. During an interview on 12/18/25 at 10:14 A.M., Unit Manager (UM) #2 said the first lunch truck doesn't leave the kitchen until at least 11:30 A.M. During an interview on 12/19/25 at 12:03 P.M., Nurse #4 said lunch should be documented after they eat not before. During an interview on 12/19/25 at 12:13 P.M., UM #2 said meals should only be documented after they eat. She said these meals were documented prior to lunch and they should not have been. During an interview on 12/19/25 at 12:57 P.M., Certified Nursing Assistant (CNA) #3 said meals should be documented after they eat and before the end of the shift. She said lunch should not be documented before lunch, but honestly the documentation is done when we have time. She said she knows the residents and they usually eat the same amount every day, so sometimes it is documented before lunch. (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/25 at 1:35 P.M., the Wound Nurse said lunch should only be documented after it is eaten. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said meals should not be documented prior to them being served and consumed. 3A. Resident #17 was admitted to the facility in May 2025 with diagnoses which included brain stem stroke, stage four sacral pressure ulcer, type two diabetes, quadriplegia, locked-in state, and gastrostomy. Review of Resident #17's MDS assessment, dated 12/8/25, indicated the Resident received tube feeding formula via gastrostomy tube feeding (TF) and hydration via TF, which provided the Resident 51% or more of his/her nutrition and hydration from TF and water flushes. The surveyor made the following observations of the Resident's tube feeding and water flushes: 12/16/25 at 3:00 P.M. – Glucerna 1.2 TF formula hung and running at 80mL/hour with total TF value in the tens of thousands indicated on the TF pump; a bag of water for flushes hung at bedside with the pump set to administer 225mL free water every six hours. 12/17/25 at 8:45 A.M. – Glucerna 1.2 TF formula hung and running at 80mL/hour with a total TF value in the tens of thousands indicated on the TF pump; a bag of water for water flushes hung at bedside with the pump set to administer 225mL free water every six hours. 12/17/25 at 2:30 P.M. – Glucerna 1.2 TF formula hung and running at 80mL/hour with total feed equaling 42,861mL; a bag of water for water flushes hung at bedside with pump set to administer 225mL free water every six hours. 12/18/25 at 8:33 A.M. – Glucerna 1.2 TF formula hung and running at 80mL/hour; a bag of water for water flushes hung at bedside with pump set to administer 225mL free water every six hours. Review of Physician's Orders indicated, but was not limited to, the following: -NPO (Latin for nothing by mouth), for tube feeding, 4/22/24; -Enteral Feed Order, every shift, Glucerna 1.2 at 80mL per hour (total volume 1920mL), 5/28/24; -Enteral Feed Order, every shift, Total Intake of formula and water every shift, 5/6/24; -Enteral Feed Order, four times a day, give free water 225mL every 6 hours, 2/27/25. (Of note: 225mL every six hours equals 900mL total) Review of Resident #17's MAR indicated, but was not limited to, the following: December 2025: Enteral Feed Order, every shift, Total Intake of formula and water every shift: 12/1- hospitalized (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2– Formula 1280mL, water 600mL; 12/3– Formula 1780mL, water 850mL; 12/4, 12/5, 12/6– Formula 1500mL, water 750mL; 12/7– Formula 1400mL, water 750mL; 12/8, 12/9– Formula 1200mL, water 750mL; 12/10, 12/11, 12/12, 12/23, 12/14, 12/15, 12/16– Formula 1470mL, water 450mL; 12/17– Formula 1770mL, water 600mL. Based on the December MAR, Resident #17 received less than the prescribed volume of TF and free water per physician's orders. During an interview on 12/17/25 at 2:54 P.M., Nurse #5 reviewed Resident #17's TF and water flush orders against the MAR and said the MAR values were not accurate; based on the orders the Resident should receive a total of 1920mL of Glucerna 1.2 TF per day and 900mL of water flushes per day. Nurse #5 said the recorded values did not add up to those totals. During an interview on 12/17/25 at 3:20 P.M., Unit Manager #1 said Resident #17 received continuous TF and water flushes and while it's common to hold TF and water flushes to provide care, Resident #17 was bedbound and rarely had his/her TF and water flushes held on a consistent basis or for extended lengths of time unless he/she was being transferred out of the facility or it was warranted to hold them. She said the Resident typically received TF and water flushes during the full 24 hours. Unit Manager #1 reviewed Resident #17's physician's orders for TF and water flush orders against the Resident's December MAR and said the recorded volumes administered did not add up to the total volume. B. Resident #46 was admitted to the facility in October 2024 with diagnoses which included catatonic disorder, diabetes, muscle wasting, and gastrostomy. Review of Resident #46's MDS assessment, dated 10/24/25, indicated the Resident received tube feeding formula via gastrostomy TF and hydration via TF, which provided the Resident with 51% or more of his/her nutrition and hydration from TF and water flushes. The surveyor made the following observations of the Resident's tube feeding and water flushes: 12/16/25 at 8:58 A.M. – Glucerna 1.2 TF hung and running at 70mL per hour with total feed reading of 6822mL. Water bag hanging and set for 150mL every three hours for 17 hours. 12/17/25 at 2:35 P.M. – Glucerna 1.2 TF hung and running at 70mL per hour. Water bag hung and running, set for 150mL every three hours for 17 hours. Review of Physician's Orders indicated, but was not limited to, the following: -NPO, 10/24/24; (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral Feed Order, every shift, Glucerna 1.2 at 70mL/hour for 17 hours, up at midnight and down at 5 P.M., total TF of 1190mL per day, 1/24/25; -Water flush, 150mL every 3 hours via pump for 17 hours for total of 750mL, every shift, 1/24/25. Review of the Resident's MAR indicated, but was not limited to the following: December 2025: Enteral Feed Order, every shift, Glucerna 1.2 at 70mL/hour for 17 hours, up at midnight and down at 5 P.M., total TF of 1190mL per day: 12/1 – Formula 1680mL; 12/2 – Formula 1720mL; 12/3 – Formula 860mL; 12/4 through 12/6 – Formula 420mL per day; 12/7 – Formula 360mL; 12/8 – Formula 570mL with evening shift recording the volume as Other; 12/9 – Formula 910mL; 12/10 – Formula 0mL; 12/11 – Formula 280mL with day shift recording 0 volume administered; 12/12 – Formula 420mL; 12/13 through 12/17 – Formula 1680mL per day. Water flush, 150mL every 3 hours via pump for 17 hours daily for a total volume of 750mL: 12/1 – water 440mL; 12/2 – water 450mL; 12/3 – water 500mL; 12/4, 12/5 – water 600mL per day; 12/6 – water 700mL; 12/7 – water 750mL; 12/8 – water 300mL with evening shift recording the volume as Other; 12/9 through 12/16 – water 450mL per day; (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/17 – water 750mL. During an interview on 12/17/25 at 2:54 P.M., Nurse #5 reviewed Resident #46's TF and free water orders against the December MAR and said the MAR values were not accurate. Nurse #5 said the Resident received TF and water flushes for 17 hours per day which included only two hours on the evening shift (3 P.M. to 11 P.M.), yet the MAR indicated the Resident received over 500mL of TF for seven of the 17 evening shifts and that value should be 140mL. Nurse #5 also said the night shift (11 P.M. to 7 A.M.) values should be around 490mL but none of the values were close and seemed to reflect the value of the previous shift. Additionally, Nurse #5 said the total water flush values did not add up to 750mL for 15 of the 17 days in December. During an interview on 12/17/25 at 3:20 P.M., Unit Manager #1 reviewed Resident #46's physician's orders for TF and water flushes against the Resident's December MAR and said the recorded volumes administered did not reflect the physician's orders despite the pumps being programmed appropriately and the Residents receiving the total amounts of TF and water flushes. Unit Manager #1 said staff should be documenting the appropriate values of TF and water flushes being administered. 4. Resident #6 was admitted to the facility in March 2024 with diagnoses which include morbid obesity, Diabetes Mellitus, Peripheral Vascular Disease (PVD), Osteomyelitis of Right Ankle and Foot, and muscle wasting and atrophy. Review of the Minimum Data Set (MDS) Assessment, dated 10/3/25, indicated Resident #6 was at risk for skin breakdown, had a venous/arterial ulcer, an open foot lesion, Moisture Associated Skin Damage (MASD) and had ointments and wound care treatment provided. Review of the Wound Physician progress notes from July 2025 through October 2025 indicated he/she had multiple wounds and was being followed for wound care management. Review of the MAR and TAR from July 2025 through October 2025 indicated but were not limited to the following: JULY 2025: Site: Left Toe: 6 of 31 opportunities treatment not signed off as administered. Site: Groin: 6 of 31 opportunities treatment not signed off as administered. Site: Left Buttock: 4 of 15 opportunities treatment not signed off as administered. Site: Right Lower Leg: 4 of 15 opportunities treatment not signed off as administered. Site: Left Lower Leg: 5 of 16 opportunities treatment not signed off as administered. Site: Scrotum: 14 of 47 opportunities treatment not signed off as administered. Site: Buttocks/Groin: 7 of 31 opportunities treatment not signed off as administered. AUGUST 2025: (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Site: Left Toe: 5 of 20 opportunities treatment not signed off as administered. Site: Right Lower Leg: 3 of 7 opportunities treatment not signed off as administered. Site: Left Lower Leg: 2 of 16 opportunities treatment not signed off as administered. Site: Scrotum: 10 of 39 opportunities treatment not signed off as administered. Site: Buttocks/Groin: 4 of 20 opportunities treatment not signed off as administered. Site: Right Plantar Foot: 5 of 18 opportunities treatment not signed off as administered. SEPTEMEBER 2025: Site: Left Toe: 7 of 30 opportunities treatment not signed off as administered. Site: Right Lower Leg: 6 of 20 opportunities treatment not signed off as administered. Site: Scrotum: 5 of 60 opportunities treatment not signed off as administered. Site: Buttocks/Groin: 6 of 30 opportunities treatment not signed off as administered. Site: Right Plantar Foot: 6 of 30 opportunities treatment not signed off as administered. OCTOBER 2025: Site: Left Toe: 5 of 31 opportunities treatment not signed off as administered. Site: Left Buttock: 2 of 15 opportunities treatment not signed off as administered. Site: Right Lower Leg: 1 of 1 opportunities treatment not signed off as administered. Site: Left Lower Leg: 2 of 15 opportunities treatment not signed off as administered. Site: Scrotum: 6 of 62 opportunities treatment not signed off as administered. Site: Buttocks/Groin: 3 of 31 opportunities treatment not signed off as administered. Site: Right Plantar Foot: 2 of 22 opportunities treatment not signed off as administered. Site: Sacrum: 1 of 13 opportunities treatment not signed off as administered. Review of the medical record failed to indicate why the above treatments were not administered as ordered. During an interview on 12/19/25 at 12:13 P.M., Unit Manager #2 said treatments should be done per the physician's orders. During an interview on 12/19/25 at 1:35 P.M., the Wound Nurse said treatments should be done per (continued on next page)

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	225723	A. Building B. Wing	12/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the orders, there should not be blanks on the TAR. She said sometimes they refuse care but that should be coded as refused and not left blank if that is the case. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said Resident #6 is followed by the wound care team and expects all treatments to be done per the physician's orders and signed off. She said there should not be blanks on the TARs. She said if they refused care, it should be documented as refused.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) program that had a systematic analysis and action plan to rectify identified issues. Specifically, after repeated concerns brought forward by the Resident Council regarding long call light response times the facility failed to implement their policy and procedures to include the Resident Council concerns as a QAPI project. Findings include:Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI), dated as revised in June 2019 indicated:-the purpose of the Steering Committee was to review and analyze facility related data and direct appropriate actions for the facility response-the appointment of a QAPI team may be necessary to explore the depth of the issue and identify the root cause so that interventions are appropriately resolved-the QAPI plan will address Quality of Life through resident/family concerns brought up at Resident or Family Committee meetings-Center leadership, including, but not limited to Administrator, Director of Nurses, Social Services, and Activity Director meet monthly to address life concerns. Review of the Resident Council Minutes, dated 7/16/25, indicated call lights continued to be monitored and when asked the residents responded that they could not get help or care without waiting a long time and call lights were not answered in a timely manner. Review of the Resident Council Minutes, dated 8/13/25, indicated call lights continued to be monitored, and the residents added that on weekends call lights were not answered in a timely manner; the residents requested and were in agreement to file a grievance. Review of the Resident Council Minutes, dated 9/17/25, indicated call lights continued to be monitored and residents asked for auditing of call lights on the second shift (3:00 P.M. to 11:00 P.M.) and when asked if call lights were answered in a timely manner the residents indicated not on the second shift. Review of the Resident Council Minutes, dated 10/15/25, indicated call lights continued to be monitored and a grievance was filed. Review of the Resident Council Minutes, dated 11/12/25, indicated call lights on weekends and second shift continue to be a work in progress. On 12/17/25 at 1:30 P.M., the surveyor held a group meeting with 13 residents in attendance. The residents said every month they bring up the concerns of call light wait times and said the problem continued on weekends and second shift. They said they have waited 45 minutes to an hour for a staff member to answer their call lights.During an interview on 12/17/25 at 3:20 P.M., the Activity Director said the residents in Resident Council had voiced concerns mostly about the call light response wait time on the second shift and weekends. She said management staff were completing audits during the day shifts, but she was not sure who audited the second shift or the weekends. She said there was a scheduled manager on duty during the weekends, but the audits were not part of the responsibilities. During an interview on 12/17/25 at 3:40 P.M., the Administrator said the audits had recently started and the management staff were responsible for conducting audits on call lights and bringing the results to the Assistant Administrator. He said the staff responsible for conducting the audits provided just-in time education to staff regarding answering call lights and there was no formal education noted at these times. He said he had not reviewed the December 2025 audits and had not realized the residents had waited 20 and 25 minutes for call lights to be answered. He said he did not know the residents from Resident Council had voiced they had waited 45 minutes to an hour. He said he has previously attended Resident Council meetings and had not inquired how long the residents wait. The Administrator said he started working at the facility at the end of September and he could not be sure if there had been a QAPI initiated to improve the call light wait times. He reviewed the QAPI projects and said there was not a current project to address the Resident Council concerns regarding long call light wait times. During an interview on 12/17/25 at 4:00 P.M., the Assistant Administrator said she had been working at the facility through the changes in Administration and there was not a QAPI project to address Resident Council concerns of long call light wait times.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the Physician (MD)/ Nurse Practitioner (NP) or Resident Representative of an 11.29% significant weight loss in six months for one Resident (#97), out of a total sample of 34 residents. Findings include: Review of the facility's policy titled Change in a Resident's Condition or Status, dated as last revised July 2024, indicated but was not limited to the following:-The nurse will notify the resident's provider or on call provider when there has been a change in resident condition, including a significant change in resident's physical condition.-The nurse/designee shall notify the resident's representative when there is a significant change in the resident's condition.-The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Resident #97 was admitted to the facility in April 2025 with diagnoses which include abnormal weight loss, muscle wasting and atrophy, and diabetes mellitus. Review of the Minimum Data Set (MDS) Assessment, dated 10/24/25, indicated Resident #97 had undesired/unplanned weight loss of 5% in the last month or 10% in the last six months. Review of the Comprehensive Care Plan indicated but was not limited to the following:FOCUS: NUTRITION: Resident is at nutritional risk.GOAL: The resident will have no significant changes in weight through review date.INTERVENTIONS: Monitor/Record weights per facility protocol/MD orders; Diet Consult as needed. Review of the Physician's Orders indicated his/her diet was Heart Healthy, CCHO (Controlled Carbohydrate for diabetic management). No nutritional supplements were ordered. Review of the Weight Summary for Resident #97 indicated but was not limited to the following:-4/9/25: 124 pounds (lbs.)-5/7/25: 118 lbs.-6/4/25: 118 lbs.-7/11/25: 117 lbs.-8/7/25: 115 lbs.-9/3/25: 115 lbs.-10/8/25: 110 lbs. Resident #97's weight was down 11.29% in six months (April to October). Review of the Nursing, MD, and NP progress notes failed to indicate the resident representative, MD/NP were notified of the significant weight loss and failed to indicate the weight loss had been addressed since it had been identified on 10/8/25 (72 days). During an interview on 12/19/25 at 12:03 P.M., Nurse #4 said she was not sure of the facility policy on weights and notifications. During an interview on 12/19/25 at 12:13 P.M., Unit Manager #2 said the MD/NP and resident representative should be notified of significant weight loss. During an interview on 12/19/25 at 1:35 P.M., the Wound Nurse said the resident representative, MD/NP should all be notified if a significant weight loss was identified, and he/she would be evaluated for additional interventions within a week by the RD and/or MD/NP. During an interview on 12/19/25 at 2:29 P.M., the Regional Director of Clinical Operations said when weight loss is identified the resident representative, MD/NP should all be notified and weight loss addressed and she did not see in the record that that occurred.

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	12/22/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for one Resident (#4), out of a total sample of 34 residents. Specifically, the facility failed to implement physician's orders for Foley catheter (medical device used to drain urine from the bladder) care. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, 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 prescribers 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. Resident #4 was admitted to the facility in September 2024 with diagnoses including dementia, Parkinson's disease, urinary tract infection (UTI), and obstructive and reflux uropathy. Review of Resident #4's medical record indicated he/she had a hospital admission from 11/23/25 through 11/30/25 due to altered mental status. Resident #4 was re-admitted to the facility on [DATE]. Review of Resident #4's Minimum Data Set (MDS) assessment, dated 12/6/25, indicated he/she had an indwelling catheter and was always incontinent. Review of Resident #4's Hospital Discharge summary, dated [DATE], indicated but was not limited to the following:- Resident #4 was diagnosed with a UTI during hospitalization.- Urology recommended to discharge the Resident with a Foley catheter with a voiding trial in the community. Review of Resident #4's Physician's Orders indicated but were not limited to the following:- 12/4/25 through 12/9/25: Foley catheter care, every shift- 12/4/25 through 12/9/25: may irrigate Foley catheter with 50cc (cubic centimeter) of normal saline for sediment or blockage- 12/6/25: DC (discharge) Foley catheter Review of Resident #4's medical record indicated he/she had a Foley catheter on re-admission to the facility on [DATE] and it was discharged on 12/6/25 following review by the Nurse Practitioner. Review of Resident #4's December 2025 Treatment Administration Record (TAR) indicated the facility failed to provide 11 Foley catheter care treatments between 12/1/25 through 12/4/25. During an interview on 12/19/25 at 12:55 P.M., Unit Manager (UM) #2 said Resident #4 had recently been hospitalized and returned to the facility with a Foley catheter. UM #2 said Foley catheter care orders should have been implemented on admission and not delayed until 12/4/25. During an interview on 12/19/25 at 1:03 P.M., the Director of Nursing (DON) said any resident admitted to the facility with a Foley catheter should have orders implemented for its care. The DON and the surveyor reviewed the findings from Resident #4's TAR. The DON said orders should have been implemented for Foley catheter care when Resident #4 was re-admitted to the facility.

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	12/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to adhere to infection prevention and control standards of practice to prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to:1a. Ensure that sanitary practices were used by nursing while preparing and administering medications,b. Clean and disinfect shared equipment before and/or after use; and 2. [NAME] (put on) gloves prior to obtaining Resident #3's blood sugar. Findings include: Review of the facility's policy titled Administering Medications, dated as revised September 2024, indicated but was not limited to:-Staff follows established facility infection control procedures for the administration of medications, as applicable. Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, dated as revised July 2024, indicated but was not limited to:-Standard precautions are the minimum infection prevention practices that apply to all resident care. These practices are designed to both protect the health care provider and prevent the health care provider from spreading infections among residents. Standard precautions include: hand hygiene and sharps safety.-The nurse should clean multi-use equipment between resident use with the appropriate cleaning solution based on manufacturer's guidelines. 1. On 12/17/25 at 8:46 A.M., the surveyor observed Nurse #1 prepare and administer Resident #62 his/her medications as follows:a. -Nurse #1 prepared an over-the counter-medication and poured two tablets into the cap of the medication bottle. -Nurse #1 used an ungloved finger to secure one tablet to the top of the cap and attempted to drop the other tablet into the medication cup. -Nurse #1 dropped both tablets into the medication cup and then used a spoon to scoop one of the tablets out and put it back into the bottle. -Nurse #1 returned the medication bottle into the top drawer of her medication cart. -Nurse #1 administered the other tablet to Resident #62. b. -Nurse #1 removed the facility glucometer from her medication cart and brought it into Resident #62's room.-Nurse #1 used the glucometer to obtain his/her blood sugar. -After obtaining the blood sugar she placed the glucometer on Resident #62's overbed table. -Upon completion of medication administration, Nurse #1 exited the Resident's room and placed the glucometer on top of her medication cart and then into her medication cart. -Nurse #1 failed to sanitize the glucometer before and after use and returned the potentially contaminated glucometer to the medication cart. 2. On 12/17/25 at 11:54 A.M., the surveyor observed the following:- Nurse #1 remove the glucometer from the top of her medication cart and walk into the unit dining room.- Nurse #1, with ungloved hands, obtained Resident #3's blood sugar.-Nurse #1 returned to the medication cart and placed the glucometer on the top of her medication cart.-Nurse #1 failed to sanitize the glucometer after use and returned the potentially contaminated glucometer to the medication cart. During an interview on 12/17/25 at 12:04 P.M., Nurse #1 said medications should not be touched with ungloved hands. She said glucometers should be cleaned after every use and gloves should have been worn to check Resident #3's blood sugar. During an interview on 12/17/25 at 2:23 P.M., the Regional Director of Clinical Operations said infection control practices should be followed. She said medications should not be touched with ungloved hands, and shared equipment should be cleaned after use and gloves should be worn when obtaining a blood sugar.