STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carvalho Grove Health and Rehabilitation Center	273 Oak Grove Avenue Fall River, MA 02723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had an activated Health Care Proxy (HCP) and had been admitted on to Hospice Services, the Facility failed to ensure nursing immediately notified his/her Health Care Agent (HCA), when on 08/21/24, Resident #1 was found lying in a bathtub, with his/her clothes on, cold water was running out from the tub faucet, and he/she was noted to be surrounded in about three inches of cold water. Resident #1's HCA as not made aware of the incident until close to six hours later, when the Hospice Nurse notified her. Findings include: Review of the Facility's policy, titled Notification of Changes, dated as revised March 2024, indicated the following: -the facility will promptly contact and consult the resident's physician, notify the resident's representative when there is a change requiring notification; -circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status; -for resident's incapable of making decisions, the representative would make any decisions that have to be made. Review of the Facility's policy, titled Incidents and Accidents, dated as revised March 2024, indicated that the nurse will contact the resident's practitioner to inform them of the incident and any other findings and the resident's family or representative will be notified of the incident. Resident #1 was admitted to the Facility in December 2021, diagnoses included: Alzheimer's disease with late onset, psychotic disorder with delusions, muscle weakness, hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, generalized anxiety disorder and unspecified dementia with psychotic disturbance. Review of Resident #1's medical record indicated Resident #1's Health Care Proxy was permanently invoked on December 06, 2021. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Resident Incident Report, dated 08/21/24, indicated that at approximately 6:35 A.M., Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. Further review of the Report and medical record indicated there was no documentation to support Resident #1's HCA was immediately notified of the incident. Review of a Nurse Progress Note, dated 08/21/24, (written by Nurse #1) indicated that Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. Further review of the Progress Note indicated there was no documentation to support that Resident #1's HCA was notified of the incident, by Nurse #1. During a telephone interview on 09/11/24 at 06:37 A.M., Nurse #1 said that on 08/21/24 at approximately 06:30 A.M., she was in the middle of medication administration when a Certified Nurse Aide (CNA), (later identified as CNA #1) called her into Resident #1's room. Nurse #1 said that she went into Resident #1's bathroom and found him/her lying in the bathtub fully clothed in three inches of cold water in the bathtub with the water running. Nurse #1 said that the cold water was running, and that Resident #1 was visibly cold and cold to the touch. Nurse #1 said that she reported the incident to the Director of Nurses and to the Physician. Nurse #1 said that she did not notify Resident #1's HCA and did not notify the Hospice Agency of Resident #1's incident. During a telephone interview on 09/10/24 at 1:46 P.M., (which included review of her written witness statement dated 08/21/24), Certified Nurse Aide (CNA) #1 said that on 08/21/24 at approximately 6:30 A.M., she found Resident #1 lying in the bathtub fully clothed in three inches of very cold water. CNA #1 said that Resident #1 was cold to the touch and was shivering. CNA #1 said that she immediately notified the nurse. During a telephone interview on 09/10/24 at 11:53 A.M., Resident #1's HCA said she was not notified by the Facility of Resident #1's incident of being found in the bathtub in cold water. Resident #1's HCA said that the Hospice nurse notified her on 08/21/24 around 12:30 P.M. (approximately six hours later) that Resident #1 was found fully clothed in the bathtub in cold water with the water running. Resident #1's HCA said that she expected that the facility staff should notify her right away of the incident. Resident #1's HCA said that when she went to the facility around 4:00 P.M. that day, Resident #1 was gray, pale, lethargic with his/her eyes sunken in. Resident#1's HCA said she requested that Resident #1 be evaluated at the Hospital Emergency Department (ED) and said he/she was transferred to the ED. During an interview on 09/10/24 at 1:18 P.M., the Hospice Nurse said that on 08/21/24 she went to the facility after lunch at approximately 12:30 P.M. and Nurse #3 notified her that Resident #1 was found lying in the bathtub fully clothed with three inches of cold water earlier that morning during the 11:00 P.M. to 7:00 A.M. shift. The Hospice Nurse said that she was the one who notified Resident #1's HCA of the incident. The Hospice Nurse said the facility should have notified the Hospice Agency and the family immediately after the incident occurred. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/12/24 at 9:36 A.M., Nurse #3 said that she was the nurse who took care of Resident #1 during the 7:00 A.M. to 3:00 P.M. shift on 08/21/24. Nurse #3 said that the overnight nurse reported the incident with Resident #1 to her and said that the incident happened at 6:30 A.M. Nurse #3 said she did not report the incident to Resident #1's HCA and said when the Hospice nurse came into the facility after lunch, approximately 12:30 P.M., that she reported the incident to the Hospice nurse at that time. Nurse #3 said that it was Nurse #1's responsibility to report Resident #1's incident to the HCA and Hospice. During a telephone interview on 09/11/24 at 12:49 P.M., the Physician said the facility had notified him that Resident #1 was found in the bathtub. The Physician said however, that he was unaware that Resident #1 had been found lying in the bathtub fully clothed in three inches of cold water and that the faucet was running. During an in-person interview on 09/10/24 at 3:40 P.M. and a subsequent telephone interview on 09/16/24 at 08:17 A.M., the Assistant Director of Nurses (ADON) said that she did not notify Resident #1's HCA or the Hospice Nurse of Resident #1's incident that occurred on 08/21/24. The ADON said that the HCA was notified of the incident later in the day by the Hospice Nurse. The ADON said it was her expectation that the facility nurse immediately notify the residents HCA of any incidents that occurred and Hospice of any incidents that occurred with residents on their caseload. The ADON said it was her expectation that nurses immediately report all details of an incident to the physician. During a telephone interview on 09/18/24 at 4:47 P.M., the former Director of Nurses (DON) said that it was her expectation that nurses immediately report all of the details of an incident to the physician. The DON said that it is her expectation that the HCA be notified immediately by a facility nurse of any incident that occurred to the resident.

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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. 37183 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was found lying in a bathtub in three inches of cold water with his/her clothes on, was observed by staff to be visibly cold, was shivering and cold to the touch, the Facility failed to ensure that he/she was provided with nursing services that met acceptable standards of practice related to nursing assessment of his/her vital signs (indicators of body's basic functions and help assess the general physical health) immediately after the incident. Findings include: Review of the Facility Policy titled, Nursing Examination and Assessment, undated, indicated the following: -examine and assess the resident for any abnormalities in health status; -physical examination, obtain vital signs: blood pressure, pulse, respirations and temperature; -document all assessment data obtained in the resident's medical record; -notify the physician of any abnormalities such as abnormal vital signs. -report other information in accordance with facility policy and professional standards of practice. Review of the Facility Policies titled, Documentation in Medical Record, dated as revised March 2024, indicated the following: -licensed staff shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy; -documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service rendered. Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. (continued on next page)

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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	Resident #1 was admitted to the Facility in December 2021, diagnoses included: Alzheimer's disease with late onset, psychotic disorder with delusions, muscle weakness, hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, generalized anxiety disorder and unspecified dementia with psychotic disturbance. Review of the Facility Resident Incident Report, dated 08/21/24, indicated that at approximately 6:35 A.M., Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. Further review of the Report indicated there was no documentation to support that a set of vital signs were obtained by nursing. Review of a Nurse Progress Note, dated 08/21/24, (written by Nurse #1) indicated that Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. During a telephone interview on 09/11/24 at 06:37 A.M., Nurse #1 said that on 08/21/24 at approximately 06:30 A.M., she was in the middle of medication administration when a Certified Nurse Aide (CNA), (later identified as CNA #1) called her into Resident #1's room. Nurse #1 said that she went into Resident #1's bathroom and found him/her lying in the bathtub fully clothed, that there was around three inches of cold water in the bathtub and that the water running. Nurse #1 said that just the cold water was running, and that Resident #1 was visibly cold and cold to the touch. Nurse #1 said that she did not recall if she obtained a set of vital signs after the incident but said if she had, she would have documented the vital signs in her nurse progress note and on the resident incident report. Further review of Nurse #1's Progress Note, for Resident #1, dated 8/21/24, indicated there was no documentation to support he/she was assessed by nursing (Nurse #1), and that at a minimum a set of vital signs were obtained. This was not consistent with the Facility's Nursing Examination, Assessment and Documentation in Medical Record Policies. During a telephone interview on 09/10/24 at 1:46 P.M., (which included review of her written witness statement dated 08/21/24), Certified Nurse Aide (CNA) #1 said that on 08/21/24 at approximately 6:30 A.M., she found Resident #1 lying in a bathtub fully clothed in three inches of very cold water. CNA #1 said that Resident #1 was cold to the touch and was visibly shivering. CNA #1 said that she immediately notified the nurse (Nurse #1). During an interview on 09/10/24 at 2:00 P.M., CNA #2 said that on 08/21/24 at approximately 6:30 A.M., she was notified by CNA #1 that Resident #1 was in the tub, and she saw him/her lying in the bathtub fully clothed in three inches of very cold water, he/she was cold to the touch and was visibly shivering. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/24 at 3:40 P.M., the Assistant Director of Nurses (ADON) said that Nurse #1 should have obtained vital signs as part of her nursing assessment after Resident #1's incident and then documented the vital signs in the medical record. The ADON said it was her expectation that nurses obtain vital signs after any incident and record the assessment data in the resident 's medical record. During a telephone interview on 09/11/24 at 12:49 P.M., the Physician said that it was his expectation that nurses obtain a set of vital signs as part of their assessment after any incident and document the vital signs in the medical record. During a telephone interview on 09/18/24 at 4:47 P.M., the former Director of Nurses (DON) said that it was her expectation that nurses obtain a set of vital signs as part of the nursing assessment after any incident and that they document the vital signs in the medical record. The DON said that vital signs are a basic standard of nursing practice and should be obtained after any incident.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had been admitted on to Hospice Services, the Facility failed to ensure nursing immediately communicated to the Hospice an incident that occurred with a need to potentially alter his/her plan of care, when on 08/21/24, Resident #1 was found lying in a bathtub, fully clothed, with the cold water faucet running, he/she was surrounded by three inches of cold water, was observed by staff to be visibly cold, was shivering, and was cold to the touch, however the Hospice Agency was not notified of the incident until six hours later, when the Hospice Nurse arrived at the facility. Findings include: Review of the Facility's policy, titled Coordination of Hospice Services, dated as revised March 2024, indicated the following: -the facility will coordinate and provide care in cooperation with hospice staff; -the facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility; -the facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations. Resident #1 was admitted to the Facility in December 2021, diagnoses included: Alzheimer's disease with late onset, psychotic disorder with delusions, muscle weakness, hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, generalized anxiety disorder and unspecified dementia with psychotic disturbance. Review of the Facility Resident Incident Report, dated 08/21/24, indicated that at approximately 6:35 A.M., Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. Further review of the Report indicated there was no documentation to support the Hospice agency was notified of the incident. Review of a Nurse Progress Note, dated 08/21/24, (written by Nurse #1) indicated that Resident #1 was found lying in the bathtub fully clothed with the water running from the faucet and that there was three inches of water in the bathtub. Further review of the Progress Note indicated there was no documentation to support that Hospice was notified of the incident. (continued on next page)

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/11/24 at 06:37 A.M., Nurse #1 said that on 08/21/24 at approximately 06:30 A.M., she was in the middle of medication administration when a Certified Nurse Aide (CNA), (later identified as CNA #1) called her into Resident #1's room. Nurse #1 said that she went into Resident #1's bathroom and found him/her lying in the bathtub fully clothed in three inches of cold water in the bathtub with the water running. Nurse #1 said that just the cold water was running, that Resident #1 was visibly cold and cold to the touch. Nurse #1 said that she reported the incident to the Director of Nurses and to the Physician. Nurse #1 said that she did not notify the Hospice Agency of Resident #1's incident. During an interview on 09/10/24 at 1:18 P.M., the Hospice Nurse said that on 08/21/24 she came to the facility after lunch at approximately 12:30 P.M. and Nurse #3 notified her that Resident #1 was found lying in the bathtub fully clothed with three inches of cold water earlier that morning during the 11:00 P.M. to 7:00 A. M. shift. The Hospice Nurse said that the facility should have notified Hospice immediately after the incident occurred. During a telephone interview on 09/12/24 at 9:36 A.M., Nurse #3 said that she was the nurse who took care of Resident #1 during the 7:00 A.M. to 3:00 P.M. shift on 08/21/24. Nurse #3 said that the overnight nurse reported the incident with Resident #1 to her and said that the incident happened at 6:30 A.M. Nurse #3 said she did not report the incident to the Hospice Agency that morning, but had reported it to the Hospice Nurse until she came into the facility after lunch, at approximately 12:30 P.M. on 08/21/24. Nurse #3 said it was Nurse #1's responsibility to report the incident to the Hospice Agency. During an in-person interview on 09/10/24 at 3:40 P.M. and a subsequent telephone interview on 09/16/24 at 08:17 A.M., the Assistant Director of Nurses (ADON) said that she did not notify the Hospice nurse of Resident #1's incident that occurred on 08/21/24. The ADON said it was her expectation that the facility nurse immediately notify Hospice of any incidents that occurred with residents on their caseload. During a telephone interview on 09/18/24 at 4:47 P.M., the former Director of Nurses (DON) said that it was her expectation that nurses immediately notify Hospice of any incident that occurred with any resident on their caseload.