

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Brandon Woods of New Bedford		STREET ADDRESS, CITY, STATE, ZIP CODE 397 County Street New Bedford, MA 02740	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who was cognitively impaired, the Facility failed to ensure staff implemented and followed their Policy related to Reporting Resident Abuse Policy, when on 5/22/25, the Hospice Certified Nurse Aide (CNA) reported an allegation of verbal abuse of a resident by a staff member (CNA #1 or CNA #2) to Nurse #1, and Nurse #1 did not immediately report the allegation to their direct Supervisor as required, and facility Administration was not made aware until the next day.</p> <p>Findings include:</p> <p>The Facility Policy titled Reporting Resident Abuse, last reviewed 2/2025, indicated that any staff member who believed that a resident of the Facility has been abused, mistreated or neglected, the individual is required to notify their direct supervisor who will notify the Executive Director or Director of Nursing.</p> <p>Resident #1's medical record indicated he/she was admitted to the Facility during February of 2024. Resident #2's most recent Minimum Data Set (MDS) Assessment, dated 4/07/25, indicated his/her short and long term memory and decision-making skills were impaired.</p> <p>During a telephone interview on 6/18/25 at 12:50 P.M., the Hospice CNA said that on 5/22/25 while caring for Resident #2 [who shared a room with Resident #1] two CNAs (later determined to be CNA #1 and CNA #2) were providing care to Resident #1 (in the next bed) behind a closed privacy curtain. The Hospice CNA said that at one point, one of the two CNAs providing care to Resident #1 told him/her to shut the fuck up.</p> <p>The Hospice CNA said that she called the Hospice Nurse, who was her direct supervisor, to report the allegation and the Hospice Nurse told her to call the nurse who was working on Resident #1's unit. The Hospice CNA said that she called Nurse #1 and told her that she heard one of the CNAs caring for Resident #1 tell him/her to shut the fuck up.</p> <p>During an interview on 6/12/25 at 11:45 A.M., Nurse #1 said that on 5/22/25 the Hospice CNA called her and told her that while two CNAs cared for Resident #1 behind a closed privacy curtain, one of the CNAs used the word fuck.</p> <p>Nurse #1 said that because the Hospice CNA told her that she reported the allegation to her supervisor at the Hospice Agency, that she did not report the allegation to her supervisor, the Executive Director or the Director of Nursing.</p> <p>(continued on next page)</p>		

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/12/25 at 11:15 A.M., the Unit Manager said that on 5/23/25 one of the CNAs told her that the Hospice CNA reported that on 5/22/25 there had been a situation with CNA #1 and CNA #2 while caring for Resident #1. The Unit Manager said that she spoke to CNA #2 and CNA #2 told her that CNA #1 swore while providing care to Resident #1. The Unit Manager said that she reported the allegation to the Executive Director.</p> <p>During an interview on 6/12/25 at 12:30 P.M., the Executive Director and Director of Nursing said that on 5/23/25, the Unit Manager reported to them an allegation that on 5/22/25 CNA #1 swore at Resident #1 when caring for him/her. The Executive Director and Director of Nursing said that they reported the allegation to the Department of Public Health and initiated an investigation.</p> <p>On 6/12/25, the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction that addressed the concern as evidence by:</p> <p>A. On 5/23/25, the Assistant Director of Nursing educated Nurse #1 on the timeframes for reporting allegations of abuse.</p> <p>B. Resident #1 was assessed for potential for adverse affects related to the use of profanity during care, he/she remains at baseline, will be supported by staff as needed. Social Services and nursing staff check with other residents on CNA #1's assignment, no other concerns were noted.</p> <p>C. On 5/23/25, the Assistant Director of Nursing initiated education of all Facility staff on the reporting requirements for allegations of abuse. Education included Policy review, and staff verbalization of understanding of reporting requirements.</p> <p>D. Since 5/23/25 and on-going, the Executive Director and Director of Nursing review all reported incidents and allegations for timeliness of reporting.</p> <p>E. Concern area was present at the facility's Quality Assurance Performance Improvement Committee (QAPI) meeting, along with corrective action plan and will be followed up on at next QAPI meeting to ensure continued compliance.</p> <p>F. The Executive Director/designee are responsible for overall compliance.</p>		