STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225264	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had intact cognition and was dependent on staff to meet his/her care needs, the Facility failed to ensure staff implemented and followed their Abuse Policy when on 08/13/25, Family Member #1 (Resident #1's Health Care Agent) informed the Unit Manager that Resident #1 had alleged that CNA #1 was rough during the provision of care on 08/10/25, and the Executive Director was not notified until the next day (08/14/25). Findings include:Review of the Facility's Abuse Policy, titled Abuse Prevention Policies and Procedure, dated as revised November 2024, indicated that the Facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after an allegation is made, if the events that cause the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury, to the Executive Director and to officials (including the State Survey Agency) in accordance with state law. Resident #1 was admitted to the Facility in April 2025, diagnoses included stroke. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 07/14/24, indicated he/she had intact cognition and was dependent on staff to meet his/her care needs. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/14/25, indicated that during morning meeting on 08/14/25, the Unit Manager reported that she had received a call from Family Member #1 (Resident #1's HCA) on 08/13/25 who said that Resident #1 told her that on 08/10/25, CNA #1 had been rough when she washed his/her (Resident #1's) private area, even after he/she had asked CNA #1 to stop. Review of the Facility's Internal Investigation Report, undated, indicated that on 08/14/25, the Unit Manager reported to the Executive Director during their interdisciplinary daily meeting, that she received a call from Resident #1's family member alleging that CNA #1 had been rough during pericare after Resident #1 told CNA #1 that it was painful. During an interview on 09/16/26 at 12:58 P.M. (which included a review of her written witness statement), the Unit Manager said Resident #1's HCA called her on 08/13/25 to report that Resident #1 told her that on 08/10/25, CNA #1 gave him/her a shower and was very rough when she washed his/her private area. The Unit Manager said she immediately reported the allegation to the Director of Nurses and then reported it to the Executive Director the next day (08/14/25). However, the Unit Manager said she thought the Executive Director was already aware since she told the DON the previous day. During an interview on 09/16/25 at 1:34 P.M., the Director of Nurses (DON) said she was not aware of the allegation of rough care involving Resident #1 until 08/14/25, when the Unit Manager talked about the allegation during their interdisciplinary daily meeting. During an interview on 09/16/25 at 2:17 P.M., the Executive Director said that on 08/14/25, during their interdisciplinary daily meeting, the Unit Manager discussed Resident #1's allegation of rough care and that the Unit Manager assumed that he (Executive Director) was aware since she (Unit Manager) had she reported the allegation to the DON on 08/13/25. The Executive Director said he had not been made aware of the allegation until the meeting (08/14/25). The Executive Director said that either the DON or the Unit Manager should have immediately notified him of the allegation, but they had not. The Executive Director said once he was aware, he then immediately reported the allegation to the State Agency and Police as required and conducted a full investigation.