

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Sacred Heart Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 359 Summer 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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>15203</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was alert and oriented, frequently incontinent but able to made his/her needs known, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 03/18/24, Certified Nurse Aide (CNA) #1 spoke to Resident #1 in degrading and insulting manner</p> <p>Findings include:</p> <p>Review of the Facility Resident Rights Policy, undated, indicated residents had the right to reasonable accommodation of their needs and preferences.</p> <p>Resident #1 was admitted to the Facility in July 2021, diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or paralysis on one side of the body) following a non-traumatic intracranial hemorrhage.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 2/20/24, indicated he/she had intact cognitive function, was able to make his/her care needs known and was frequently incontinent.</p> <p>Review of Resident #1's Point of Care History, dated 3/01/24 through 3/31/24, indicated Resident #1 had episodes of being both continent and incontinent of bowel. The Point of Care History indicated Resident #1 was continent of bowel 20 days during the month of March 2024.</p> <p>Review of the Facility's Internal Investigation Summary, dated 3/20/24, indicated that on 3/18/24, in response to Resident #1's request to be put on the bedpan, CNA #1 told Resident #1 just go in your pants and I'll change you later.</p> <p>During a telephone interview on 04/24/24 at 10:15 A.M., CNA #2 said that around 3:30 P.M. on 3/18/24, she approached Resident #1, who was in bed, to provide incontinence care. CNA #2 said that Resident #1 told her that during the prior (7:00 A.M. to 3:00 P.M.) shift that guy (later identified as CNA #1) told him/her to shit in his/her pants and he would come back and clean him/her up. CNA #2 said that CNA #1 was the only male CNA who worked the previous shift and that CNA #1 had been assigned to care for Resident #1.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 said that Resident #1's bed was completely soiled with urine and feces and she had to completely change the linen on Resident #1's bed to clean him/her. CNA #2 said feces had dried onto Resident #1's skin, that it had to be scrubbed off and his/her skin was red and irritated.</p> <p>CNA #2 said that Resident #1 told her that he/she did not ring his/her call light again during the prior shift because he/she did not want to get CNA #1 in trouble. CNA #2 said Resident #1 cried when he/she talked with her about the incident with CNA #1 and complained that he/she paid a lot of money to get this type of treatment. CNA #2 said she reported Resident #1's statement and condition to Nurse #1.</p> <p>During a telephone interview on 4/18/24 at 2:30 P.M., Nurse #1 said that on 3/18/24 around 8:30 P.M., CNA #2 told her that Resident #1 had complained to her about care that he/she received during the 7:00 A.M. to 3:00 P.M. shift.</p> <p>Nurse #1 said she spoke to Resident #1 and he/she told her that when he/she asked CNA #1 to put him/her on the bedpan, CNA #1 told him/her to shit in his/her pants and he would come back and clean him/her later. Nurse #1 said Resident #1 told her that CNA #1 never came back to clean him/her.</p> <p>Nurse #1 said she reported Resident #1's allegation to Nurse #3, who was the supervisor that night.</p> <p>During a telephone interview on 04/17/24 at 1:10 P.M., CNA #1 said on 3/18/24 while he/she was passing lunch trays, Resident #1 asked to use the bedpan. CNA #1 said that he told Resident #1 that he/she was going to have to wait until after lunch to be put on the bedpan and Resident #1 said oh man.</p> <p>The Surveyor asked CNA #1 about statements Resident #1 reported to staff (CNA #2 and Nurse #1) that he (CNA #1) told him/her to shit in his/her pants and CNA #1 acknowledged that he had said that to Resident #1.</p> <p>During an interview on 04/16/24 at 12:55 P.M., the Administrator said that she spoke to CNA #1 on 3/20/24 about Resident #1's allegation and CNA #1 told her that on 3/18/24 when Resident #1 asked to use the bedpan, he told Resident #1 to move his/her bowels in his/her incontinence brief.</p> <p>During a telephone interview on 04/24/24 at 10:30 A.M., the Assistant Director of Nurses said that she spoke to CNA #1 on 3/20/24 about Resident #1's allegation and CNA #1 told her that on 3/18/24 when Resident #1 asked to use the bedpan, he told Resident #1 to shit in his/her pants.</p> <p>On 4/16/24, the Facility was found to be in past non-Compliance and presented the Surveyor with a plan of correction that addressed the area(s) of concern as evidenced by:</p> <p>A) On 3/20/24, Resident #1 was interviewed about the alleged incident by the Administrator, the Assistant Director of Nursing and the Director of Social Service and an investigation of his/her allegation was initiated.</p> <p>B) On 3/20/24, the Director of Social Service initiated a plan for offering Resident #1 on-going support.</p> <p>C) On 3/25/24, the Facility terminated CNA #1.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D) On 03/20/24, the Assistant Director of Nursing and the Director of Social Service interviewed alert and oriented residents who resided on Resident #1's unit to surveil for other unreported allegations of potential abuse or neglect.</p> <p>E) On 03/20/24, the Administrator and Director of Nursing provided education to Nurse #1 and Nurse #3 regarding timelines and procedures for reporting allegations of abuse and neglect.</p> <p>F) Between 3/20/24 and 3/26/24, the Facility Administrator, Director of Nursing and Staff Development Coordinator educated all staff on the Facility Patient Abuse Policy and timelines of and mechanisms for reporting allegations of abuse and neglect.</p> <p>G) The Corrective Action Plan will be reviewed during the April 2024 QAPI meeting.</p> <p>H) The Administrator and/or designee are responsible for overall compliance.</p>

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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>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>15203</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was cognitively intact, the Facility failed to ensure staff implemented and followed their Abuse Policy when on 3/18/24, Resident #1 told Certified Nurse Aide (CNA) #2 and Nurse #1 that CNA #1 had made an inappropriate and insulting statement to him/her, and although Nurse #1 told her supervisor (Nurse #3), about Resident #1's allegation and provided Nurse #3 with a written statement about the allegation, Nurse #3 did not immediately notify the Administrator and/or Director of Nurses (DON), but instead placed Nurse #1's written statement in the DON's mailbox where it was not seen or brought to Administration's attention for around 36 hours.</p> <p>Findings include:</p> <p>Review of the Facility Abuse Prohibition Policy and Procedure, dated as last reviewed 1/2024, indicated that allegations of abuse will be immediately reported to the Administrator and Director of Nurses.</p> <p>Resident #1 was admitted to the Facility in July 2021 and his/her diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or paralysis on one side of the body) following a non-traumatic intracranial hemorrhage.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 2/20/24, indicated he/she had intact cognitive function, was able to make his/her needs known and was frequently incontinent.</p> <p>Review of Resident #1's Point of Care History, dated 3/01/24 through 3/31/24, indicated Resident #1 had episodes of being both continent and incontinent of bowel. The Point of Care History indicated Resident #1 was continent of bowel 20 days during the month of March 2024.</p> <p>Review of the Facility's Internal Investigation Summary, dated 3/20/24, indicated that on 3/18/24, in response to Resident #1's request to be put on the bedpan, CNA #1 told Resident #1 just go in your pants and I'll change you later.</p> <p>During a telephone interview on 04/24/24 at 10:15 A.M., CNA #2 said that around 3:30 P.M. on 3/18/24, she approached Resident #1, who was in bed, to provide incontinence care. CNA #2 said that Resident #1 told her that during the prior shift that guy (later identified as CNA #1) told him/her to shit in his/her pants and he would come back and clean him/her up. CNA #2 said that CNA #1 was the only male CNA who worked the 7:00 A.M. to 3:00 P.M. shift and that CNA #1 had been assigned to care for Resident #1.</p> <p>CNA #2 said that when Resident #1 told her about the incident, he/she cried and complained about being treated in that way. CNA #2 said she reported Resident #1's statement to Nurse #1 on 3/18/24.</p> <p>(continued on next page)</p>		

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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 a telephone interview on 4/18/24 at 2:30 P.M., Nurse #1 said that on 3/18/24, CNA #2 told her that Resident #1 had complained to her about care that he/she received during the 7:00 A.M. to 3:00 P.M. shift. Nurse #1 said she spoke to Resident #1 and he/she told her that when he/she asked CNA #1 to put him/her on the bedpan, CNA #1 told him/her to shit in his/her pants and he would come back and clean him/her.</p> <p>Nurse #1 said she reported Resident #1's statement to Nurse #3, who was the supervisor, on 3/18/24.</p> <p>During a telephone interview on 4/24/24 at 10:40 A.M., Nurse #3 said that she worked during the 3:00 P.M. to 11:00 P.M. shift on 3/18/24 and was the supervisor. Nurse #3 said that around 10:30 P.M., Nurse #1 reported to her that Resident #1 alleged that during the prior shift, when he/she asked CNA #1 to assist him/her to the bathroom, CNA #1 told him/her to go in his/her incontinence brief and CNA #1 would clean him/her later, but never returned.</p> <p>Nurse #3 said that Nurse#1 provided her with a written statement documenting Resident #1's allegation and she (Nurse #3) placed the written statement in the Director of Nurse's mailbox.</p> <p>During an interview on 04/16/24 at 12:55 P.M., the Administrator and Director of Nurses (DON) said that because the DON did not work on 3/19/24 or 3/20/24, Nurse #1's written statement about Resident #1's allegation was not brought to the attention of Administration until later in the morning on 3/20/24 (about the 36 hours after Resident #1 initially reported the allegation).</p> <p>On 4/16/24, the Facility was found to be in past non-Compliance and presented the Surveyor with a plan of correction that addressed the area(s) of concern as evidenced by:</p> <p>A) On 3/20/24, Resident #1 was interviewed about the alleged incident by the Administrator, the Assistant Director of Nursing and the Director of Social Service and an investigation of his/her allegation was initiated.</p> <p>B) On 3/20/24, the Director of Social Service initiated a plan for offering Resident #1 on-going support.</p> <p>C) On 3/25/24, the Facility terminated CNA #1.</p> <p>D) On 03/20/24, the Assistant Director of Nursing and the Director of Social Service interviewed alert and oriented residents who resided on Resident #1's unit to surveil for other unreported allegations of potential abuse or neglect.</p> <p>E) On 03/20/24, the Administrator and Director of Nursing provided education to Nurse #1 and Nurse #3 regarding timelines and procedures for reporting allegations of abuse and neglect.</p> <p>F) Between 3/20/24 and 3/26/24, the Facility Administrator, Director of Nursing and Staff Development Coordinator educated all staff on the Facility Patient Abuse Policy and timelines of and mechanisms for reporting allegations of abuse and neglect.</p> <p>G) The Corrective Action Plan will be reviewed during the April 2024 QAPI meeting.</p> <p>H) The Administrator and/or designee is responsible for overall compliance.</p> <p>(continued on next page)</p>		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	