STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225233	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of Dartmouth	567 Dartmouth Street South Dartmouth, MA 02748

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 0658 Level of Harm - 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 required the use of a splint to secure a fracture he/she sustained to his/her right elbow, the Facility failed to ensure he/she was provided care and treatment that met professional standards for quality of care, when after a follow-up appointment, Resident #1's orthopedic Physician Assistant (PA) made recommendations on the consult form for Nursing to remove the splint and change his/her right elbow dressing daily, until healed. However, the recommendations were not followed up on or implemented by Nursing, the dressing changes were not completed and at his/her next orthopedic follow-up appointment is was discovered that Resident #1 had developed a pressure injury to his/her right elbow. Findings include: Standard Reference: Standard of Practice Reference: 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 and practical nurse incorporated into the plan of care and implement prescribed medical regimens. The rules and regulations 9.03 defined 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. Resident #1 was admitted to the Facility in February 2024, diagnoses included displaced fracture of lateral end of right clavicle (collarbone), unspecified fall, chronic kidney disease stage 3, diabetes mellitus, Bell's palsy and a displaced fracture of olecranon (elbow) process intraarticular extension of right ulna (long bone in the forearm). Review of Resident #1's Norton Scale Predicting Risk of Pressure Ulcer, dated 03/04/24, indicated he/she was assessed by nursing to be at high risk for the development of pressure injuries. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 03/07/24, indicated that Resident #1 had moderate cognitive impairments and he/she was at increased risk for the development of pressure injuries. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Brandon Woods of Dartmouth		STREET ADDRESS, CITY, STATE, ZIP CODE 567 Dartmouth Street South Dartmouth, MA 02748	

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Orthopedic Report of Consultation, dated 03/18/24, indicated their recommendations included the following: -Continue with posterior (used to immobilize the elbow) splint -May remove splint for gentle Active Range of Motion (AROM) and Passive Range of Motion (PROM) -Non-weight bearing of right upper extremity -Change right elbow skin tear dressing daily until healed -Follow-up in 3 weeks Review of Resident #1's Weekly Skin Assessments, dated 03/08/24, 03/19/24, 03/26/24, and 04/05/24, indicated that nursing documented that he/she did not have any skin impairments other than multiple bruised areas that were previously identified due to a fractured right clavicle and right olecranon. Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 04/08/24, indicated that on 03/18/24, Resident #1 had an orthopedic appointment with orders to change right elbow skin tear dressing daily. The Report indicated that on 4/08/24 Resident #1 had another orthopedic appointment where he/she was noted to have 1 centimeter (cm) x 1 cm x 0.3 cm stage 4 (full-thickness skin loss with extensive destruction, tissue death or damage to muscle, bone or supporting structures) wound to his/her right elbow. The Report indicated Resident #1 had previously had an order for the splint to be worn on his/her right arm which stated not to remove or get the splint wet. The Report indicated that the nurse who had Resident #1 on her assignment on 3/18/24 did not follow up on the new orders {recommendations} given from the orthopedic appointment. Review of Resident #1's Nurse Progress Note, dated 3/18/24, (written by Nurse #2), indicated that he/she had a splint placed to the right arm, positive Circulation Sensation Motion (CSM) and ortho appointment. Review of Nurse #2's Written Witness Statement, dated 4/10/24, (provided to the Surveyor on the date of the survey), indicated that Resident #1 returned from an orthopedic appointment {on 3/18/24} and the consultation report was placed on the nursing desk. The Statement indicated that Nurse #2 forgot to look at the report for new orders. Review of Nurse #2's second Written Witness Statement, dated 4/11/24, (copy provided via fax to the Surveyor on 5/07/24), indicated that Resident #1 was at an orthopedic appointment {on 3/18/24} and the consultation report was placed on the unit desk. The Statement indicated that she (Nurse #2) was doing her medication pass when Resident #1 arrived back on the unit from the appointment. The Statement indicated that at the end of her (Nurse #2) shift while giving report to the overnight nurse, that her report included that Resident #1 went to an orthopedic appointment, and that she (Nurse #2) had verbalized to the overnight nurse that she had not looked at the paperwork from the orthopedic appointment. The Statement indicated that the overnight nurse agreed to review Resident #1's orthopedic consult paperwork. The Statement indicated that Nurse #2 showed the overnight nurse where the orthopedic consult paperwork was and placed the orthopedic consult paperwork in front of the computer. (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 - Actual harm Residents Affected - Few	During a telephone interview on 05/06/24 at 2:35 P.M., Nurse #2 said that Resident #1 returned from an Orthopedic appointment on 03/18/24 with paperwork from his/her Orthopedic Consult during her shift (3:00 P. M. to 10:00 P.M.). Nurse #2 said that she placed the paperwork on the nurse's desk near the Unit Managers computer. Nurse #2 said that she was too busy at that time to review the Orthopedic Consult paperwork. Nurse #2 said that she told the overnight nurse (later identified as Nurse #1 who worked the 10:00 P.M. to 6:00 A.M. shift on 03/18/24 into 03/19/24) that Resident #1 had returned from an Orthopedic appointment, that the paperwork was at the nurse's desk and that she did not have time to review the paperwork for any new recommendations. Nurse #2 said that the next shift nurse (Nurse #1) told her that she would review the Orthopedic Consult paperwork because she had to do the 24-hour checks (reconciliation of past 24-hour physician's orders) anyway. Nurse #2 said that on 4/10/24, facility staff kept pressuring her to write a witness statement that indicated that she forgot to look at Resident #1's 03/18/24 orthopedic consult paperwork for any new orders. Nurse #2 said that the next day, on 04/11/24, she wrote another witness statement that detailed the events that occurred on 03/18/24 during her shift and gave it to a nurse manager at the facility. During an interview on 4/30/24 at 1:30 P.M., Nurse #1 (who was the overnight nurse on 03/18/24 into 03/19/24 and worked 10:00 P.M. to 6:00 A.M. and was assigned to Resident #1) said that she was not aware that Resident #1 had an orthopedic appointment the previous shift. Nurse #1 said that she was not aware that Resident #1 had an Orthopedic Consult on 3/18/24 until his/her 4/08/24 orthopedic appointment in which it was discovered that he/she had orders from the 3/18/24 appointment that were never implemented. Nurse #1 said that she did not get any report from the previous shift nurse (Nurse #2) that Resident #1 had been seen by the Orthopedic on 3/18/24. Nurse #1 said the only physician's orders that Resident #1 had prior to the 4/08/24 Orthopedic Consult was not to remove the right elbow splint, not to get the right elbow splint wet, monitor CSM and skin integrity (health of the skin). Nurse #1 said that after Resident #1 went to his/her 4/08/24 Orthopedic Follow-up Consult, she was told that he/she had recommendation orders from the 3/18/24 Orthopedic Consult that were never implemented and was told that Resident #1 had a Stage 4 pressure injury that was noted during the 4/08/24 Orthopedic visit. Review of Resident #1's Physician Interim Orders, dated 3/18/24 through 4/07/24, indicated there was no documentation to support that an order was obtained from the Physician regarding the recommendations from the Orthopedic PA related to his/her right elbow and transcribed onto his/her Treatment Administration Records (TAR). Review of Resident #1's TAR, dated 3/18/24 through 4/07/24, indicated there was no documentation to support Nursing removed his/her right arm splint and that the right elbow skin tear dressing was changed daily until healed. Further review of Resident #1's Medical Record, dated 3/18/24 through 4/07/24, indicated there were no Nursing Progress Notes with documentation to support Nursing removed his/her right arm splint and that the right elbow skin tear dressing was changed daily until healed. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Orthopedic Report of Consultation, dated 4/08/24, indicated he/she was seen for a healing displaced right olecranon fracture with noted pressure sore to his/her right elbow and had recommendations for the following: -Begin AROM and PROM to right elbow -Non-weight bearing to right elbow -Wound Clinic referral for right elbow pressure injury -Wound care for right elbow pressure injury: wet to dry dressing, change twice daily until seen by wound clinic -Follow-up with orthopedic in one week Review of Nurse Progress Note, dated 04/09/24, indicated that Resident #1's right elbow wound presented with purulent (thick discharge that usually implies an infection) substance, Nurse Practitioner (NP) was notified and Kelfex (antibiotic) 500 milligrams (mg) twice a day for 5 days was ordered. Review of Resident #1's Physician's Interim Telephone Order, dated 04/09/24, indicated to start Keflex 500 mg. twice a day, for 5 days. Review of a Physician Progress Note, dated 04/12/24, indicated that Resident #1 was currently on Keflex 500 mg. twice a day, monitor patient clinically and continue with medications as prescribed. Review of Resident #1's Orthopedic Report of Consultation, dated 4/15/24, indicated he/she was seen for a right olecranon fracture with a pressure injury present to his/her right elbow and had recommendations for the following: -AROM and PROM as tolerated -Wound Care for right elbow pressure injury: Continue wet to dry dressing and use Allevyn (foam dressing used to absorb wound exudate (drainage) dressing -Wound clinic referral and wound care per wound clinic physician -Follow-up with orthopedic in two weeks During a telephone interview on 5/06/24 at 8:40 A.M., the Orthopedic Physician Assistant (PA) said that Resident #1 was seen on 3/18/24 for a right elbow fracture. The Orthopedic PA said that Resident #1's right elbow was in a posterior splint, that a skin tear was noted, and he recommended that the splint be removed daily for AROM and PROM and for a dressing to be applied to the skin tear daily and a follow-up appointment was scheduled in 3 weeks. The Orthopedic PA said that there was no pressure injury noted to his/her right elbow at that time. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	The Orthopedic PA said that on 4/08/24, Resident #1 returned for his/her follow-up appointment, and it was discovered that he/she had a Stage 4 pressure injury to his/her right elbow. The Orthopedic PA said that he recommended that the splint be removed for AROM and PROM and he made recommendations for the treatment of the right elbow pressure injury which included a wound clinic consultation and a follow-up in 1 week. The Orthopedic PA said that on 4/15/24, Resident #1 returned for his/her follow-up appointment, and he made treatment changes to the right elbow pressure injury and recommended a wound clinic consultation and a follow-up appointment in 2 weeks. Review of Resident #1's Wound Clinic Report, dated 4/18/24, indicated that he/she was seen for a stage 4 pressure injury to his/her right elbow which measured 0.3 cm x 0.4 cm x 0.5 cm with undermining (erosion under the wound edges, resulting in a large wound with small opening), serosanguinous (containing both blood and serous fluid), exposed subcutaneous tissue and bone. The Report indicated that the pressure injury had a medium amount of necrotic (dead cells) tissue with a small amount of granulation (new connective tissue) and epithelialization (restoration of the damaged epithelium). The Report included recommendations for treatments and follow-up. During a telephone interview on 05/02/24 at 1:21 P.M., the Unit Manager said that Resident #1 had an orthopedic consultation on 03/18/24 that included recommendations that were not implemented. The Unit Manager said it was the responsibility of the nurse who was assigned to Resident #1 to review the consultation for any recommendations and to ensure that the recommendations were implemented. The Unit Manager said that she was not aware of any new recommendations that were made on the 03/18/24 orthopedic visit and said that she did not review Resident #1's 03/18/24 Orthopedic Consultation Report. The Unit Manager said that Resident #1 went for a follow-up orthopedic consultation on 04/08/24 and that was when she was made aware that he/she had developed a stage 4 pressure injury to his/her right elbow, and she was made aware that on 03/18/24 there were orthopedic consultation recommendations that were not implemented. The Unit Manager said that the facility did not have any specific policy and procedure on consultations. During an in-person interview on 04/30/24 at 2:35 P.M. and a follow-up telephone interview on 05/07/24 at 12:13 P.M., the Administrator said that Resident #1 was seen by the Orthopedic on 03/18/24 for his/her right elbow fracture, that recommendations were made and somehow the recommendations were missed and not implemented. The Administrator said that Resident #1 saw the Orthopedic again on 04/08/24 and it was discovered that he/she had developed a Stage 4 pressure injury to his/her right elbow. The Administrator said that it was his expectation that all consultations are reviewed by the nurse and the Unit Manager to ensure that any recommendation is implemented. The Administrator said it was the responsibility of the Unit Manager to follow up on all consultations to ensure that recommendations were implemented. On 04/30/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by: A. On 04/08/24, Resident #1 was seen by the Orthopedic with new orders for daily dressing changes to right elbow stage 4 area, posterior splint with orders to remove splint for AROM and PROM, a follow-up Orthopedic Consultation and wound clinic consultation. B. On 4/08/24, the Facility developed a Policy and Procedure on the Clinical Protocol for diagnostic test results and consultations. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	C. On 04/08/24 and 04/12/24, the Staff Development Coordinator educated Licensed Nursing Staff on the new Policy and Procedure - Clinical Protocol for diagnostic test results, Consultations and notification of the physician of any new orders, reviewing consultation forms, transcribing any new orders and updating the facility physician with any new order recommendations. D. On 04/12/24, a whole house audit was conducted by the Unit Managers of all resident consultation appointments since January 2024 to verify that all recommendations were followed through on by Nursing. E. On 04/12/24, Resident #1's Plans of Care were reviewed and updated with interventions related to his/her right elbow wound interventions. F. On 04/15/24, Resident #1 was seen by Orthopedic, consultation recommendations were reviewed, physician was notified, and new orders were implemented. G. On 04/18/24, Resident #1 was seen at the Wound Clinic, recommendations were reviewed, physician was notified, and new orders were implemented. H. Unit Managers and/or their Designee will conduct daily audits x 90 days, then weekly thereafter on Consultations, New Orders, Physician notification and Implementation of any new orders. I. The results of the audits will be brought to QAPI meeting quarterly x 3 or until the committee determines compliance. J. The Director of Nursing and/or Designee are responsible for overall compliance.