

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 01/14/2025
NAME OF PROVIDER OR SUPPLIER Brandon Woods of Dartmouth		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702</p> <p>Based on records reviewed and interviews, for one of three sampled residents, (Resident #1) whose Plan of Care related to Activities of Daily Living (ADLs) indicated interventions included that he/she required continual supervision (staff member to be with him/her during entire task) with meals, the facility failed to ensure staff consistently implemented and followed interventions, when on 12/21/24, staff assistance was not provided as required, Resident #1 was served his/her lunch tray, left alone in his/her room while eating his/her meal, he/she choked on food and required the Heimlich Maneuver.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled, Care Planning-Comprehensive, dated as revised May 2017, indicated the following:</p> <ul style="list-style-type: none"> -an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. -the Facility's Care Planning/Interdisciplinary Team (IDT) in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to maintain. -each resident comprehensive care plan incorporates identified problem areas, incorporates risk factors, builds on resident's strengths, identify the professional services that are responsible for each element of care, aid in preventing or reducing declines in the resident's functional status, enhance the optimal functioning of the resident, reflect currently recognized standards of practice. -care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. <p>Resident #1 was admitted to the Facility in October 2019, diagnoses included Senile degeneration of the brain (neurological disorder that causes a decline in cognitive function), Dysphagia (difficulty swallowing), Gastro-esophageal reflux disease, feeding difficulties, Hyperlipidemia (high cholesterol), and Anxiety.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], indicated he/she had severe cognitive impairment.</p> <p>Review of Resident #1's Self Care Deficit Care Plan related to ADLs, renewed and reviewed with his/her November 2024 MDS, indicated that he/she required continual supervision with meals.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/21/24, indicated that at approximately 12:00 P.M. a Certified Nurse Aide (CNA) observed Resident #1 to be choking on his/her food, and he/she required the Heimlich Maneuver to dislodge the food. The Report indicated Resident #1 had not received assistance (supervision) with his/her meal (as required).</p> <p>Review of Resident #1's Nurse Progress Note, dated 12/23/24 (as a late entry for 12/21/24 and written by Nurse #1), indicated that Resident #1 was found by a Certified Nurse Aide (CNA) in his/her room choking while he/she was eating and this writer performed the Heimlich Maneuver, expelling a small piece of meatball from Resident #1's mouth. The Note indicated Resident #1's vital signs were taken, he/she was encouraged to cough and clear his/her throat with good effect, and he/she was then allowed to rest.</p> <p>During an interview on 01/15/25 at 10:04 A.M., (which included review of her written employee statement), Certified Nurse Aide (CNA) #3 said on 12/21/24, she was walking towards Resident #1's room, heard him/her struggling to cough and went into his/her room. CNA #3 said Resident #1 was sitting on the side of the bed, his/her meal tray was in front of him/her, his/her face was red and turning purple in color and she realized that he/she was choking. CNA #3 said she yelled out help he/she is choking and CNA #2 came into the room while CNA #1 went to get Nurse #1. CNA #3 said that CNA #2 got behind Resident #1, she (CNA #2) started the Heimlich Maneuver as Nurse #1 entered the room. CNA #3 said Nurse #1 and CNA #2 stood Resident #1 up, Nurse #1 took over doing the Heimlich Maneuver, and a piece of a meatball came up into his/her mouth. CNA #3 said when she entered Resident #1's room, there were no staff member present in the room supervising him/her while he/she was eating.</p> <p>During an interview on 01/16/25 at 2:49 P.M., (which included review of her written employee statement), Nurse #1 said Resident #1 had an order for a house chopped diet and required supervision by staff when eating his/her meals. Nurse #1 said on 12/21/24, around 12:00 P.M. she heard a CNA yelling out for help, she ran into Resident #1's room and the CNA (exact name unknown) said he/she is choking. Nurse #1 said she saw Resident #1 sitting on the side of his/her bed in distress, his/her face was red, and he/she was struggling to breathe. Nurse #1 said she stood Resident #1 up, performed the Heimlich Maneuver on him/her and a piece of meat expelled from his/her mouth. Nurse #1 said she took Resident #1's vital signs, assisted him/her into bed to rest and she notified the Administrator. Nurse #1 said that one of the CNAs had given Resident #1 his/her meal tray in his/her room and left him/her alone with his/her meal.</p> <p>During interviews throughout the day of the survey, on 01/14/25 with CNA #1 and CNA #2, and on 01/15/25 with CNA #3, CNA #4, and CNA #5, who all worked on Resident #1's unit, said that Resident #1 ate all meals in his/her room and required supervision by staff with eating.</p> <p>During an interview on 01/14/25 at 5:13 P.M., the Director of Nursing (DON) said her expectation is that residents that need assistance and/or supervision with meals that they be provided that assistance from staff and that staff did not follow Resident #1's plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an in-person interview on 01/14/25 at 5:23 P.M. and a telephone interview on 01/16/25 at 11:38 A.M., the Administrator said on 12/21/24 Nurse #1 informed him that Resident #1 had choked on his/her lunch meal and that a CNA had not assisted or stayed to supervise Resident #1 with his/her meal. The Administrator said during his investigation which included interviews with staff, he was unable to determine which staff member gave Resident #1 his/her lunch tray and left him/her unassisted in his/her room.</p> <p>On 01/14/25, 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:</p> <p>A. On 12/21/24, Resident #1 was assessed by the nurse, the physician and hospice nurse were notified, a new order was obtained for a chest X-ray, mechanical soft texture diet and nectar thick liquids.</p> <p>B. On 12/23/24, Resident #1's level of assistance with eating was updated on his/her ADL Care/Kardex Plan and indicated he/she required 1:1 with meals, (assistance of one staff member while eating, being fed).</p> <p>C. 12/23/24 through 12/31/24, the Unit Managers conducted house wide audits on all units and reviewed what was indicated as each resident's current level of feeding assistance on their Care Plans/Kardex, to ensure they were accurate and up to date.</p> <p>D. On 12/23/24, Nursing Management provided education to all Licensed Nursing Staff on meal tray accuracy, checking and ensuring the proper level of feeding assistance, Licensed nurses are required to check each tray before each meal service to ensure residents tray is accurate according to their meal ticket and CNAs must follow residents care plan regarding provision of the correct level of assistance.</p> <p>E. The Nursing Department staff will conduct daily audits on verifying tray accuracy and ensuring proper level of feeding assistance for one month, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.</p> <p>F. The results of the audits will be presented and reviewed at the quarterly QAPI meeting for a minimum of two quarters or until compliance is achieved.</p> <p>G. The Director of Nursing and/or designee are responsible for overall compliance.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702</p> <p>Based on records reviewed and interviews, for one of three sampled residents, (Resident #1) who had a diagnosis of Dysphagia (difficulty swallowing), required an altered textured diet and continual supervision (staff member to stay with resident during entire task) during meals, the Facility failed to ensure that he/she was provided with the necessary level of staff supervision during meals in an effort to maintain his/her safety to prevent an incident of choking. On 12/21/24, Resident #1 was served his/her lunch time meal tray in his/her room, however the staff member did not stay to provide supervision while he/she ate. Resident #1 was also served food items that were inconsistent with his/her diet orders. Resident #1 choked on the food and required the Heimlich Maneuver.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled Assisting the Resident with In-Room Meals, dated as revised December 2013, indicated the following:</p> <ul style="list-style-type: none"> -the purpose of this procedure is to provide appropriate assistance for residents who choose to receive meals in their rooms -check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow <p>Review of the Facility's Policy titled Food and Nutrition Services, dated as revised October 2017, indicated the following:</p> <ul style="list-style-type: none"> -food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident -if an incorrect meal is provided to a resident, nursing staff will report it to the Food Service Manager so that a new food tray can be issued <p>Resident #1 was admitted to the Facility in October 2019, diagnoses included senile degeneration of the brain (neurological disorder that causes a decline in cognitive function), dysphagia (difficulty swallowing), gastro-esophageal reflux disease, feeding difficulties, hyperlipidemia (high cholesterol), and anxiety.</p> <p>Review Resident #1's Annual Minimum Data Set (MDS), dated [DATE], indicated he/she had severe cognitive impairment.</p> <p>Review of Resident #1's Self Care Deficit Care Plan related to ADLs, renewed and reviewed with his/her November 2024 MDS, indicated that he/she required continual supervision with meals.</p> <p>Review of Resident #1's Physician's Orders, dated December 2024, indicated he/she required a House regular, with foods to be chopped diet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/21/24, at approximately 12:00 P.M. a Certified Nurse Aide (CNA) observed Resident #1 to be choking on his/her food, and he/she required the Heimlich Maneuver to dislodge the food. The Report indicated that Resident #1's lunch meal was not prepared by the cook according to his/her diet, nursing staff did not check his/her meal tray for accuracy according to his/her meal ticket, he/she was served the incorrect meal texture, and he/she did not receive assistance (staff supervision) with his/her meal.</p> <p>Review of Resident #1's Lunch meal ticket, dated 12/21/24, indicated that he/she required a House Chopped diet and noted under his/her preferences was that all meals were to be chopped.</p> <p>Review of Resident #1's Nurse Progress Note, dated 12/23/24 as a late entry for 12/21/24, (written by Nurse #1), indicated that Resident #1 was found by a Certified Nurse Aide (CNA) in his/her room choking while he/she was eating and Nurse #1 performed the Heimlich Maneuver, expelling a small piece of meatball from Resident #1's mouth. The Note indicated Resident #1's vital signs were taken, he/she was encouraged to cough and clear his/her throat with good effect, and he/she was then allowed to rest.</p> <p>During an interview on 01/15/25 at 10:04 A.M., (which included review of her written employee statement), Certified Nurse Aide (CNA) #3 said on 12/21/24 she was walking towards Resident #1's room, heard him/her struggling to cough and went into his/her room. CNA #3 said Resident #1 was sitting on the side of the bed, his/her meal tray was in front of him/her, his/her face was red and turning purple in color and she realized that he/she was choking. CNA #3 said she yelled out help he/she is choking and CNA #2 came into the room while CNA #1 went to get Nurse #1. CNA #3 said that CNA #2 got behind Resident #1, she (CNA #2) started the Heimlich Maneuver as Nurse #1 entered the room, and CNA #3 said Nurse #1 and CNA #2 stood Resident #1 up, Nurse #1 took over doing the Heimlich Maneuver on him/her and a piece of a meatball came up into his/her mouth. CNA #3 said when she entered Resident #1's room, there were no staff member in the room supervising him/her while he/she was eating.</p> <p>During an interview on 01/14/25 at 2:45 P.M., (which included review of her written employee statement), CNA #2 said on 12/21/24 she heard CNA #3 yell out Nurse help, Resident #1 is choking. CNA #2 said she ran to Resident #1's room and saw that he/she was in distress, his/her face was red, and he/she was not speaking. CNA #2 said Resident #1 was sitting on the side of the bed, she got behind him/her, did the Heimlich Maneuver and Resident #1 coughed up some food as Nurse #1 came into the room. CNA #2 said Nurse #1 took over and continued the Heimlich Maneuver on Resident #1 and he/she started coughing. CNA #2 said she did not see what type of food Resident #1 coughed up.</p> <p>During an interview on 01/16/25 at 2:49 P.M., (which included review of her written employee statement), Nurse #1 said she worked the 6:00 A.M. to 2:30 P.M. shift on 12/21/24. Nurse #1 said Resident #1 had a house chopped diet order and required staff supervision when eating meals. Nurse #1 said around 12:00 P. M. she heard a CNA yelling out for help, she ran into Resident #1's room and the CNA (exact name unknown) said he/she is choking. Nurse #1 said she saw Resident #1 sitting on the side of his/her bed in distress, his/her face was red, and he/she was struggling to breathe. Nurse #1 said she stood Resident #1 up, performed the Heimlich Maneuver on him/her and a piece of meat expelled from his/her mouth. Nurse #1 said she took Resident #1's vital signs, assisted into his/her bed to rest and said she notified the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/14/25 at 3:51 P.M., the Unit Manager said when the food trucks are delivered to the units, the Nurses are responsible for checking all resident's meal tickets against the meal provided on their tray, prior to them being served to the residents, to make sure that residents are receiving the proper diet (food consistency).</p> <p>During interviews throughout the day of the survey, on 01/14/25 with CNA #1 and CNA #2, and on 01/15/25 with CNA #3, CNA #4, and CNA #5, who all worked on Resident #1's unit, said that Resident #1 ate all meals in his/her room and required supervision by staff with eating.</p> <p>During an interview on 01/14/25 at 5:13 P.M., the Director of Nursing (DON) said prior to meal trays being served to the residents, nurses are responsible for checking meal trays against resident's meal tickets to make sure they receive the correct meal. The DON said it is her expectation that all nurses check residents' meal trays before being passed to them. The DON said it is also her expectation that residents that need assistance/supervision with meals are provided the level of assistance they require from staff.</p> <p>During an in-person interview on 01/14/25 at 5:23 P.M. and a telephone interview on 01/16/25 at 11:38 A.M., the Administrator said on 12/21/24 Nurse #1 informed him that Resident #1 had choked on his/her lunch meal, and he started his investigation right away. The Administrator said he observed Resident #1's leftover lunch tray which contained one whole meatball still on his/her plate and his/her meal ticket on the tray indicated a house, chopped diet. The Administrator said Nurse #1 told him she had not checked Resident #1's meal tray or any of the other residents' trays at lunch prior to them being passed to residents and that a CNA had not assisted/stayed to supervise Resident #1 while he/she was eating.</p> <p>The Administrator said during his investigation which included interviews with staff, he was unable to determine which staff member gave Resident #1 his/her lunch tray and left him/her unassisted in his/her room. The Administrator said nurses are supposed to check all meal trays for accuracy prior to being served to residents, and that each meal is accurate according to the resident's meal ticket.</p> <p>On 01/14/25, 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:</p> <p>A. On 12/21/24, Resident #1 was assessed by the nurse, the physician and hospice nurse were notified, a new order was obtained for a chest X-ray, mechanical soft texture diet and nectar thick liquids.</p> <p>B. On 12/23/24, Resident #1's level of assistance with eating was updated on his/her ADL Care/Kardex Plan and indicated he/she was a 1:1 feed.(assistance of one staff member to be fed).</p> <p>C. 12/23/24 through 12/31/24, the Unit Managers conducted a house wide audits on all units and reviewed what was indicated on each resident's current level of feeding assistance on their Care Plans/Kardex to ensure they were accurate and up to date.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 12/23/24, Nursing Management provided education to all Licensed Nursing Staff on meal tray accuracy, checking and ensuring the proper level of feeding assistance: Licensed nurses are required to check each tray before each meal service to ensure residents tray is accurate according to their meal ticket and CNAs must follow residents care plan regarding provision of the correct level of assistance.</p> <p>E. On 12/23/24, the Assistant Food Service Director provided education to all Dietary staff on meal tray accuracy: all resident meal trays are to be checked for complete accuracy according to their meal tickets prior to the trays leaving the kitchen to be delivered.</p> <p>F. On 12/23/24, the Dietary Department management started daily audits on all resident's meal trays for accuracy according to their meal tickets prior to the trays leaving the kitchen to be delivered.</p> <p>G. On 01/02/25, the Dietician provided education to all Dietary Staff cooks on meal service/texture modifications: description of textures and how to properly prepare and serve texture modified food to residents with swallowing difficulties or dexterity issues.</p> <p>H. The Nursing Department staff will conduct daily audits on verifying tray accuracy and ensuring proper level of feeding assistance for one month, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.</p> <p>I. The Dietary Department management will conduct daily audits on resident's diet orders on the meal tickets is accurate to the meal being served for one month, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.</p> <p>J. The results of the audits will be presented and reviewed at the quarterly QAPI meeting for a minimum of two quarters or until compliance is achieved.</p> <p>K. The Director of Nursing, Food Service Director, and/or designees are responsible for overall compliance.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>40702</p> <p>Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who had a history of dysphagia (difficulty swallowing) and required an altered texture diet, the Facility failed to ensure meals prepared and served to him/her met his/her individual needs and physicians orders for diet. On 12/21/24 dietary staff preparing his/her lunch time meal tray did not put the correct texture of food on his/her tray, Resident #1 was observed choking on his/her food and required the Heimlich Maneuver to dislodge the food.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled Food and Nutrition Services, dated as revised October 2017, indicated the following:</p> <ul style="list-style-type: none"> -each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs -food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident -if an incorrect meal is provided to a resident, nursing staff will report it to the Food Service Manager so that a new food tray can be issued <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/21/24, indicated that on 12/21/24, at approximately 12:00 P.M. a Certified Nurse Aide (CNA) observed Resident #1 to be choking on his/her food, and he/she required the Heimlich Maneuver to dislodge the food. The Report indicated that Resident #1's lunch meal was not prepared by the cook according to his/her diet, nursing staff did not check his/her meal tray for accuracy according to his/her meal ticket and he/she was served the incorrect meal texture.</p> <p>Resident #1 was admitted to the Facility in October 2019, diagnoses included senile degeneration of the brain (neurological disorder that causes a decline in cognitive function), dysphagia (difficulty swallowing), gastro-esophageal reflux disease, feeding difficulties, hyperlipidemia (high cholesterol), and anxiety.</p> <p>Review of Resident #1's Physician's Orders, dated December 2024, indicated he/she required a House regular diet, food to be chopped.</p> <p>Review of Resident #1's Nutrition/Dietary Progress Note, dated 11/04/24, indicated that his/her diet order was a house regular chopped with thin liquids.</p> <p>During an interview on 01/14/25 at 4:14 P.M., the Dietician said Resident #1 had a diagnosis of Dysphagia and on a house chopped with thin liquid diet order. The Dietician said on 12/21/24 Resident #1 was served whole Swedish meatballs for lunch which was not appropriate for him/her because the meatballs should have been chopped up.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility's Dietary Menu, dated 12/21/24, indicated the following meal was on the menu to be served for lunch:</p> <p>-Swedish meatballs, egg noodles, and carrots.</p> <p>Review of Resident #1's Lunch meal ticket, dated 12/21/24, indicated that he/she required a House Chopped diet and noted under his/her preferences all meals were to be chopped.</p> <p>During an interview on 01/14/25 at 1:03 P.M., Dietary Aide #2 said he worked 6:00 A.M. to 2:30 P.M. on 12/21/24 and called out all the residents' lunch diet orders to the Cook. Dietary Aide #2 said the lunch meal was Swedish meatballs, egg noodles, carrots and he remembered calling out Resident #1's diet order as being house chopped from his/her meal ticket to the Cook.</p> <p>Dietary Aide #2 said when the [NAME] handed him Resident #1's plate, he saw that the meatballs on his/her plate were whole, not chopped up and said he asked the [NAME] if the meal was appropriate for Resident #1 who had a chopped diet. Dietary Aide #2 said the [NAME] told him that it was okay to give the meal to Resident #1 and he put the plate on his/her tray in the food truck and covered it.</p> <p>During an interview on 01/14/25 at 1:30 P.M., the [NAME] said the Dietary Aide that is assigned to the food truck calls out resident's diets, any allergies, preferences and dislikes from their meal tickets to the Cook, the [NAME] prepares the appropriate meal plate according to the diet order called out by the Dietary Aide, and the Dietary Aide is supposed to double check the resident's meal ticket to ensure the diet order is correct prior to placing the meal plate on the tray.</p> <p>The [NAME] said on 12/21/24 she prepared the lunch meal which was Swedish meatballs over egg noodles with diced carrots and that Dietary Aide #2 called out the resident's diet orders to her. The [NAME] said Dietary Aide #2 did call out Resident's #1's diet as a house chopped and she told Dietary Aide #2 that chopped and regular diets would be the same set-up for the lunch meal.</p> <p>The [NAME] said she had been directed in the past to serve the Swedish meatballs with egg noodles meal as a regular diet and that the meatballs are not chopped up. The [NAME] said she made the decision to serve the lunch meal as a regular diet to Resident #1 and that Dietary Aide #2 that was going by her directive. The [NAME] said Resident #1's meal ticket indicated under preferences all meals chopped and that the meatballs should have been chopped up.</p> <p>During an interview on 01/14/25 at 4:47 P.M., the Assistant Food Service Director (AFSD) said a Dietary Aide calls out all resident's diet orders to the Cook, the [NAME] prepares the meal plate, and hands the plate back to the Dietary Aide. The AFSD said the Dietary Aide is supposed to check the meal on the plate to the resident's meal ticket to make sure the meal is correct, then places the plate on the tray in the food truck. The AFSD said Resident #1 had a house chopped diet order and on 12/21/24 he/she received whole meatballs that should have been chopped according to his/her diet order.</p> <p>(continued on next page)</p>		

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 01/14/2025
NAME OF PROVIDER OR SUPPLIER Brandon Woods of Dartmouth		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/16/25 at 2:49 P.M., (which included review of her written employee statement), Nurse #1 said she worked the 6:00 A.M. to 2:30 P.M. shift on 12/21/24. Nurse #1 said she had not checked Resident #1's lunch meal tray against his/her meal ticket before he/she received his/her tray. Nurse #1 said she had not been trained and was unaware at that time (12/21/24) that it was the nurses' responsibility to check all resident's meal trays before they received them. Nurse #1 said Resident #1 had a house chopped diet order and required continual supervision with eating his/her meals.</p> <p>Nurse #1 said around 12:00 P.M. she heard a CNA yelling out for help, she ran into Resident #1's room and the CNA (exact name unknown) said he/she is choking. Nurse #1 said she saw Resident #1 sitting on the side of his/her bed in distress, his/her face was red, and he/she was struggling to breathe. Nurse #1 said she stood Resident #1 up, performed the Heimlich Maneuver on him/her and a piece of meat expelled from his/her mouth. Nurse #1 said she took Resident #1's vital signs, put him/her into his/her bed to rest and said she notified the Administrator.</p> <p>During an interview on 01/14/25 at 5:13 P.M., the Director of Nursing (DON) said nurses are responsible for checking meal trays against resident's meal tickets to make sure they receive the correct meal and that it is her expectation that all nurses check residents' meal trays before being passed to them.</p> <p>During an in-person interview on 01/14/24 at 5:23 P.M. and a telephone interview on 01/16/25 at 11:38 A.M., the Administrator said on 12/21/24 Nurse #1 informed him that Resident #1 had choked on his/her lunch meal, and he started his investigation right away. The Administrator said he observed Resident #1's leftover lunch tray which contained one whole meatball still on his/her plate and his/her meal ticket on the tray indicated a house, chopped diet. The Administrator said Nurse #1 told him she had not checked Resident #1's meal tray or any of the other residents' trays at lunch prior to them being passed to residents.</p> <p>The Administrator said the [NAME] told him she had served Resident #1 the Swedish meatballs whole because it was her understanding that was how they should be served, and she (the Cook) said the meatballs should have been chopped according to Resident #1's diet order. The Administrator said his expectation is that Dietary staff should be verifying resident's prepared meal plates to the resident's meal ticket to ensure all residents receive the correct diet order.</p> <p>On 01/14/25, 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:</p> <p>A. On 12/21/24, Resident #1 was assessed by the nurse, the physician and hospice nurse were notified, a new order was obtained for a chest X-ray, mechanical soft texture diet and nectar thick liquids.</p> <p>B. On 12/23/24, the Assistant Food Service Director provided education to all Dietary staff on meal tray accuracy: all resident meal trays are to be checked for complete accuracy according to their meal tickets prior to the trays leaving the kitchen to be delivered.</p> <p>(continued on next page)</p>		

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 01/14/2025
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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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C. On 12/23/24, Nursing Management provided education to all Licensed Nursing Staff on meal tray accuracy, checking and ensuring the proper level of feeding assistance: Licensed nurses are required to check each tray before each meal service to ensure residents tray is accurate according to their meal ticket and CNAs must follow residents care plan regarding provision of the correct level of assistance.</p> <p>D. On 12/23/24, the Dietary Department management started daily audits on all resident's meal trays for accuracy according to their meal tickets prior to the trays leaving the kitchen to be delivered.</p> <p>E. On 01/02/25, the Dietician provided education to all Dietary Staff cooks on meal service/texture modifications: description of textures and how to properly prepare and serve texture modified food to residents with swallowing difficulties or dexterity issues.</p> <p>F. The Dietary Department management will conduct daily audits on resident's diet orders on the meal tickets are accurate to the meal being served for one month, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.</p> <p>G. The Nursing Department staff will conduct daily audits on verifying tray accuracy by checking each tray before each meal service to ensure resident's trays are accurate according to their meal tickets for one month, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.</p> <p>H. The results of the audits will be presented and reviewed at the quarterly QAPI meeting for a minimum of two quarters or until compliance is achieved.</p> <p>I. The Director of Nursing, Food Service Director, and/or designees are responsible for overall compliance.</p>		