

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  11/12/2025
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)
F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was dependent on the assistance of staff for transfers, the Facility failed to ensure staff provided care consistent with professional standards of practice, when on 09/22/25 at 9:55 P.M., Resident #1 was transferred into bed with the assistance of two staff members, without the use of a gait belt (safety device used to assist individuals with mobility challenges during transfers) per facility policy, his/her knees buckled during the transfer, and staff had to grab Resident #1 by the waist band of his/her pants to try to prevent him/her from falling. Findings include: Review of the Facility Policy titled, Gait Belt Policy and Procedure, dated as revised March 2024, indicated that a gait belt should be used for all residents during functional transfers when physically assisted with transfers to provide a safe environment for all residents and staff. Review of the Facility Policy titled, Safe Lifting and Movement of Residents, dated as revised July 2017, indicated that the facility used appropriate techniques and devised to lift and move residents in order to protect the safety and well-being of staff and residents and to promote quality care. The Policy indicated that staff responsible for direct resident care will be trained in the use of gait belts. Resident #1 was admitted to the Facility in August 2025, diagnoses included acute kidney failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, depression, anemia and atrial fibrillation. Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 09/19/25, indicated Resident #1 was moderately cognitively impaired and was dependent on staff for transfers. Review of the Facility's Internal Investigation Report, dated 9/23/25, indicated that on 9/22/25, Resident #1 sustained a laceration during a 2-person transfer from wheelchair to bed. The Report indicated that a gait belt was not used during the transfer (per facility policy) and that nursing staff were educated on proper transfer techniques. During an interview on 11/12/25 at 2:30 P.M., (which also included review of her written witness statement, dated 9/22/25) Nurse #1 said that on 9/22/25 she was in another resident's room when a Certified Nurse Aide (CNA) (exact name unknown) entered the room and asked her to come see Resident #1. Nurse #1 said that when she entered Resident #1's room, he/she was lying sideways in the bed with a laceration to his/her left leg. Nurse #1 said that the laceration happened during a transfer from wheelchair to bed and said she was unsure if the CNA's used a gait belt during the transfer. Nurse #1 said that it is the Facility's policy for staff to use a gait belt during all resident transfers. During an interview on 11/12/25 at 2:50 P.M., (which also included review of her written witness statement, dated 9/22/25) CNA #1 said CNA #2 asked her to help transfer Resident #1 into bed on 9/22/25 sometime around 10:00 P.M. CNA #1 said that both of them stood him/her up from the wheelchair to pivot Resident #1 into bed. CNA #1 said that she was aware that it was the Facility's policy to use a gait belt but said they did not use a gait belt during Resident #1's transfer. CNA #2 said Resident #1's left leg caught the bed frame and that a piece of exposed metal from the bed frame caused him/her to get a laceration on his/her left leg. During a telephone interview on 11/17/25 at 9:35 A.M., (which also included review of her written witness statement, dated 9/22/25) CNA #2 said that on 9/22/25, Resident #1 was on her assignment and that around 10:00 P.M., she asked CNA #1 to help her transfer Resident #1 into bed. CNA #2 said that they both stood him/her up from the wheelchair to pivot Resident #1 into the bed, and that they did not use a gait belt during the transfer. CNA #2 said during the transfer, Resident #1 began letting go and his/her knees began to buckle so they grabbed onto the waist band of his/her pants and lifted him/her into bed. CNA #2 said that during the transfer, Resident #1's left leg bumped into the bed frame and a piece of metal was exposed caused him/her to get a laceration. CNA #2 said that she was aware that it was the Facility's policy to use a gait belt during all resident transfers and said that they should have used a gait belt during the transfer. Review of Certified Nurse Aide (CNA) #2's personnel file indicated the following: -On 2/13/24, CNA #2 signed a Gait Belt Policy &amp; Procedure acknowledgement which indicated that a gait belt should be used for all residents during physically assisted functional transfers to provide a safe environment for all residents and staff. The Policy further indicated that noncompliance with use of gait belt will result in disciplinary action. -On 8/16/24, CNA #2 signed an Orientation Form acknowledgement which indicated that she was aware of the Facility's Gait Belt Policy and Procedure. -On 4/13/25, CNA #2 signed an Annual Competency Review which indicated that she demonstrated competence with the Facility's Gait Belt Policy and Procedure. Review of CNA #2's Text Message, sent to the Administrator, undated, indicated that no gait belt was used [on 9/22/25] during the transfer with Resident #1. During an interview on 11/12/25 at 3:30 P.M., the Director of Nurses (DON) said that two CNA's transferred Resident #1 into bed, said his/her left leg</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was dependent on the assistance of staff for transfers, the Facility failed to ensure his/her environment was free from potential hazards as is possible when on 09/22/25 sometime around 10:00 P., as Resident #1 was being transferred into bed with the assistance of two staff members, his/her left lower extremity scraped up against an exposed piece of metal on the bed frame joint and he/she sustained a 10-centimeter (cm) laceration to his/her left lower extremity that required 10 sutures to close. Findings include:Review of the Facility Policy titled, Equipment Management Plan, dated as reviewed January 2025, indicated the following:-all equipment, including beds, is functional and safe for use by all residents and is maintained appropriately by qualified individuals;-equipment is checked for functionality and safety in order to foster a safe environment;-the Facility will conduct yearly inspections or sooner as per manufacturer recommendations of all medical equipment and all equipment will be inspected and maintained in safe reliable operation.Review of the Report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 09/23/25, indicated that on 9/22/25 around 10:00 P.M., Resident #1 sustained a laceration to his/her left outer calf during a transfer into bed, was transferred to the Hospital Emergency Department (ED) and required 10 sutures to repair the laceration. The Report indicated that upon sitting down onto the bed, Resident #1's left leg scraped up against the exposed metal bed frame joint, and he/she sustained a laceration to his/her left lower outer calf. The Report indicated that as a corrective measure, Resident #1's bed frame joints were covered with (protective plastic) end caps.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she presented to the Hospital ED with a laceration of the left leg. The Summary indicated that Resident #1 sustained a 10 cm semilunar (involving the skin and underlying tissue and cause significant bleeding) laceration along the lateral aspect of his/her left leg, had a small amount of arterial bleeding and required 10 sutures to repair the laceration.Resident #1 was admitted to the Facility in August 2025, diagnoses included acute kidney failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, depression, anemia and atrial fibrillation.Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 09/19/25, indicated Resident #1 was moderately cognitively impaired and was dependent on staff for transfers.During an interview on 11/12/ 25 at 2:30 P.M., (which also included review of her written witness statement, dated 9/22/25) Nurse #1 said that on 9/22/25 she was in another resident's room when a Certified Nurse Aide (CNA) (exact name unknown) entered the room and asked her to come see Resident #1. Nurse #1 said that when she entered Resident #1's room, he/she was lying sideways in the bed, and he/she had a large wide-open laceration to his/her left leg that was actively bleeding.Nurse #1 said that the laceration happened during Resident #1's transfer by the CNAs from the wheelchair to bed. Nurse #1 said that Resident #1's left leg got caught on a piece of exposed metal on the bed frame and that she saw blood and fragments of skin on the piece of exposed metal on the bed frame. Nurse #1 said that she put a pressure dressing on the laceration, called 911 (Emergency Medical Services) and Resident #1 was transferred to the Hospital ED for treatment of his/her laceration. Nurse #1 said that Resident #1 returned from the Hospital ED with 10 sutures to his/her left leg.During an interview on 11/12/25 at 2:50 P.M., (which also included review of her written witness statement, dated 9/22/25) CNA #1 said that CNA #2 asked her to help she transfer Resident #1 into bed on 9/22/25 sometime around 10:00 P. M. CNA #1 said that both of them stood Resident #1 to pivot him/her into bed. CNA #1said Resident #1's left leg caught the bed frame and that a piece of exposed metal from the bed frame caused him/her to get a laceration to his/her left leg. CNA #1 said that Resident #1 was sitting at the edge of the bed with his/her legs hanging down and said that there was a lot of blood coming from the laceration. CNA #1 said they physically lifted Resident #1 into bed and notified the nurse. During a telephone interview on 11/17/25 at 9:35 A.M., (which also included review of her written witness statement, dated 9/22/25) CNA #2 said that on 9/22/25 around 10:00 P.M., she asked CNA #1 to help her transfer Resident #1 into bed. CNA #2 said that they both stood Resident #1 up to pivot him/her into bed. CNA #2 said Resident #1 began letting go, his/her knees began to buckle so they grabbed onto the waist band of his/her pants and lifted him/her into bed. CNA #2 said that during the transfer, Resident #1's left leg bumped into the bed frame and a piece of exposed metal caused him/her to get a laceration. CNA #2 said that there was a lot of blood from the laceration and the piece of metal on the bed frame had blood on it as well. CNA #2 said that she notified the nurse of the</p>		