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	03/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1) who had a diagnosis of Dysphagia (difficulty swallowing), and required an altered textured diet, the Facility failed to ensure that he/she remained as free from hazards as is possible, when on 03/04/26, Resident #1 was served his/her lunch time meal tray with a food item that was inconsistent with his/her diet orders, he/she consumed it, started to choke and required staff intervention to help expel the food. Findings Include: Review of the Facility's Policy titled Food and Nutrition Services, dated as revised October 2017, indicated the following:-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 Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/05/26, indicated that on 03/04/26, at approximately 12:15 P.M. Nurse #1 heard a resident in the dayroom on Resident #1's unit ask if he/she (Resident #1) was choking? The Report indicated Nurse #1 immediately ran to the day room, asked Resident #1 if he/she was choking, he/she nodded yes, and Nurse #1 successfully performed the Heimlich Maneuver (abdominal thrusts, life-saving first-aid technique for choking when a person cannot breathe, speak or cough, effectively dislodging items using upward pressure) on him/her. The Report indicated that Nurse #1 assessed Resident #1, he/she exhibited normal breathing, and his/her vital signs were stable. The Report further indicated that Resident #1's lunch meal was not prepared by dietary staff according to his/her diet order, and that nursing staff had not checked his/her meal tray for accuracy according to his/her meal ticket and he/she was served the incorrect meal texture. Resident #1 was admitted to the Facility in December 2025, diagnoses included dysphagia (difficulty swallowing), parkinsonism (neurological syndrome characterized by slow movement, rigidity and tremors), dysarthria (slurred, slow or mumbled speech), cerebral infarction (ischemic stroke caused by blocked blood flow to the brain), hyperlipidemia (high cholesterol), and anxiety. Review Resident #1's admission Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was moderately cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 12 out of 15 (0-7 indicates severe cognitive impairment, 8-12 indicates moderate cognitive impairment, 13-15 indicates cognitively intact). Review of Resident #1's Physician's Orders, dated February 2026, indicated he/she required a House diet, ground texture with nectar thick liquids. Review of Resident #1's Lunch meal ticket, dated 03/04/26, indicated that he/she required a House ground diet with nectar thick liquids.However, review of the facility lunch menu for 03/04/26, indicated the following meal was being prepared that day and therefore Resident #1 was served:-Chicken parmesan [not ground], spaghetti noodles, cauliflower and garlic bread knot.Review of Resident #1's Nurse Progress Note, dated 03/04/26, (written by Nurse #3), indicated that at approximately 12:15 P.M., Resident #1 was sitting in the secondary dining room (also known as the dayroom) eating lunch with another resident. The Note indicated Nurse #3 heard a resident in the room ask Resident #1 if he/she was choking, she (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ran into the room and asked Resident #1 are you choking? and he/she nodded yes. The Note indicated the Heimlich Maneuver was performed with success, Resident #1 began breathing and he/she was able to speak in full complete sentences. The Note further indicated that Resident #1's skin was warm, dry, and pink, his/her vitals were taken, and the Physician, Resident #1's Health Care Proxy (HCP) and the Administrator were notified of the incident.During an interview on 03/30/26 at 4:06 P.M., (which included review of her written statement), Nurse #3 said she worked the 6:00 A.M. to 2:30 P.M. shift on 03/04/26. Nurse #3 said around 12:15 P.M. she was sitting at the nurses' station across from the secondary dining room with Nurse #2 and Nurse #1 when she heard a resident (exact name unknown) say to Resident #1 are you choking? Nurse #3 said she looked at Resident #1, saw him/her doing the universal choking sign (person clutches one or both hands to their throat), so she immediately ran into the dining room and asked Resident #1 are you choking?' and he/she nodded yes.Nurse #3 said she got behind Resident #1, performed the Heimlich Maneuver on him/her and a piece of chicken was expelled from his/her mouth. Nurse #3 said Resident #1 took a deep breath in, was able to speak in full sentences and Resident #1 said he/she was okay. Nurse #1 said Resident #1's vital signs were taken and she notified the Administrator.Nurse #3 said she observed Resident #1's lunch tray which had chicken parmesan on it and the chicken had been cut up into pieces [not ground]. Nurse #3 said she did not know what Resident #1's diet order was, so she looked it up, and she saw that he/she had an order for a ground diet but had been given a regular texture diet.Nurse #3 said she did not know if Nurse #2 or Nurse #1 had checked Resident #1's meal tray prior to him/her being served his/her meal because she was not on the unit at the time the food truck had been delivered. Nurse #3 said nurses are responsible to check all residents' meal trays against their meal tickets prior to them being passed to a resident to ensure they receive the correct diet order.During an interview on 03/24/26 at 2:25 P.M., (which included review of her written statement), Nurse #1 said she worked the 6:00 A.M. to 2:30 P.M. shift on 03/04/26. Nurse #1 said she was at the nurses' station with Nurse #2 and Nurse #3 when she heard a resident in the dayroom ask Resident #1 are you choking? Nurse #1 said she and Nurse #3 immediately ran into the dayroom, they asked Resident #1 are you choking?' and he/she nodded yes. Nurse #1 said Nurse #3 got behind Resident #1, performed the Heimlich Maneuver and he/she expelled chewed up food. Nurse #1 said Resident #1 was able to breathe and said he/she was okay. Nurse #1 said Resident #1 had an order for a ground diet and that she observed that the chicken on his/her lunch plate was cut up into pieces, not grounded up, as it should have been. Nurse #1 said she knew the nurses were supposed to check all residents' meal trays for accuracy against their meal tickets to ensure they receive the correct diet texture. Nurse #1 said she had not checked Resident #1's or any of the other resident's meal trays for accuracy that day.During an interview on 03/25/26 at 10:50 A.M., (which included review of her written statement), Nurse #2 said she worked the 6:00 A.M. to 2:30 P.M. shift on 03/04/26. Nurse #2 said when the food trucks are delivered to the units, nurses must check all residents' meal trays against their meal tickets so that they match what is on their tray before being passed to residents to ensure they are receiving the correct diet texture. Nurse #2 said she had not checked Resident #1's meal tray or any other residents' tray that day.During an interview on 03/24/26 at 1:51 P.M., (which included review of her written statement), Certified Nurse Aide (CNA) #1 said she worked the 6:00 A.M. to 2:30 P.M. shift on 03/04/26 and helped pass lunch trays that day. CNA #1 said she could not recall if the nurses on the unit had checked the resident's meal trays on the food trucks that day, prior to helping them pass them out. During an interview on 03/24/26 at 2:06 P.M., (which included review of her written statement), CNA #2 said on 03/04/26 she was behind doing morning care to her assigned residents when the food tucks for lunch were delivered to the unit. CNA #2 said she helped pass lunch trays that day. CNA #2 said she saw CNA #1 and CNA #3 passing out the meal trays and asked them if the nurses had checked the meal trays and that both CNA #1 and CNA #3 had said yes.During a telephone interview on 03/30/26 at 1:09 P.M., the Former Administrator said on 03/04/26 Nurse #3 informed him that Resident #1 had choked on his/her lunch meal, that she (Nurse #3) performed the Heimlich (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maneuver on him/her, he/she had expelled some food and said he started an investigation right away. The Former Administrator said he interviewed the nurses working (Nurse #1, Nurse #2, and Nurse #3) on the unit the day of the incident and determined that the nurses had not checked Resident #1's meal tray or any other residents' tray at lunch prior to them being passed to residents. The Former Administrator said he could not determine which staff member gave Resident #1 his/her lunch tray but said that nurses were responsible and supposed to check all meal trays for accuracy prior to meals being served to a resident, and that the meals are accurate according to the resident's meal ticket.During an interview on 03/25/26 at 2:56 P.M., the Director of Nursing (DON) said on 03/04/26 the Former Administrator notified her that Resident #1 had a choking incident at lunch time and one of the nurses (identified as Nurse #3) had to perform the Heimlich Maneuver.The DON said the Dietary Department had sent the wrong diet texture order for Resident #1 and that the nurses on the unit had not checked Resident #1's meal tray against his/her meal ticket before he/she was served the meal.The DON said nurses were responsible for checking all residents' meal trays according to the resident's meal ticket to ensure they receive the correct meal and that it is her expectation that all nurses check residents' meal trays before being passed to them.On 03/25/26, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction with an effective date of 03/06/26, which addressed the area(s) of concern as evidenced by:A. On 03/04/26, Resident #1 was assessed by the nurse, the physician was notified, and a new order was obtained for a chest X-ray. Resident #1 returned to his/her baseline following the incident and had no further complaints.B. On 03/04/36 Resident #1 was evaluated by the Speech Language Pathologist and seen six days during 03/04/36 through 03/13/26 with recommendations to continue ground diet and no waffles or pasta.C. On 03/05/26, the Unit Managers conducted a house wide audit on all units: to ensure all residents' meal trays were checked for accuracy according to their diet order on their meal tickets prior to meal service.D. On 03/04/26, the Staff Development Coordinator initiated and provided education to all Licensed Nursing Staff on checking residents' meal trays for accuracy according to their meal ticket prior to meal service: all Licensed nurses are to check all meal trays to ensure the correct diet on the meal ticket matches the meal.E. On 03/05/26, the Food Service Director provided education to all Dietary staff on checking meal trays for meal accuracy: all resident meal trays must be checked for accuracy during meal service to ensure that each meal plated is accurate according to each resident's diet orders/texture on their meal tickets.F. On 03/05/26, the Dietary Department Management started daily audits on all residents' meal trays for accuracy according to their meal tickets.G. The Nursing Department Staff will continue to conduct audits on resident's meal trays for accuracy according to their diet orders on the meal tickets daily for seven days, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.H. The Dietary Department Management will continue to conduct audits on residents' diet orders on the meal tickets are accurate to the meal tray being served daily for seven days, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.I. The results of the audits will be presented and reviewed at the quarterly QAPI meeting for a minimum of two quarters or until substantial compliance is achieved.J. The Director of Nursing, Food Service Director, and/or designees are responsible for overall compliance.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 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 (ground) texture diet, the Facility failed to ensure meals prepared and served to him/her met his/her individual needs and physicians order for diet, when on 03/04/26 dietary staff preparing his/her lunch time meal tray did not put the correct texture of food on his/her tray, he/she tried to consume it and experienced a choking episode.Findings Include: Review of the Facility's Policy titled Food and Nutrition Services, dated as revised October 2017, indicated the following:-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 Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/05/26, indicated that on 03/04/26, at approximately 12:15 P.M. Nurse #1 heard a resident in the dayroom on Resident #1's unit ask if he/she was choking? The Report indicated Nurse #1 immediately ran to the day room, asked Resident #1 if he/she was choking, he/she nodded yes, and Nurse #1 successfully performed the Heimlich Maneuver on him/her. The Report indicated that Nurse #1 assessed Resident #1, he/she exhibited normal breathing, and his/her vital signs were stable. The Report further indicated that Resident #1's lunch meal was not prepared by dietary staff according to his/her diet that nursing staff had not check his/her meal tray for accuracy according to his/her meal ticket and he/she was served the incorrect meal texture. Resident #1 was admitted to the Facility in December 2025, diagnoses included dysphagia (difficulty swallowing), parkinsonism (neurological syndrome characterized by slow movement, rigidity and tremors), dysarthria (slurred, slow or mumbled speech), cerebral infarction (ischemic stroke caused by blocked blood flow to the brain), hyperlipidemia (high cholesterol), and anxiety. Review of Resident #1's Physician's Orders, dated February 2026, indicated he/she required a House diet, ground texture with nectar liquids. Review of Resident #1's Lunch meal ticket, dated 03/04/26, indicated that he/she required a House diet, ground with nectar thick liquids.Review of the Facility's Dietary Menu, dated 03/04/26, indicated the following meal was on the menu to be prepared and served for lunch:-Chicken parmesan, spaghetti noodles, cauliflower and garlic bread knot.During an interview on 03/24/26 at 1:15 P.M., the [NAME] said the Dietary Aide assigned to the food truck calls out resident's diet orders from their meal tickets to the Cook. The [NAME] said he prepares the resident's meal plate according to the diet order called out by the Dietary Aide then hands the plate to the Dietary Aide. The [NAME] said the Dietary Aide is supposed to double-check the resident's meal plate against their meal ticket to ensure the diet order is correct before placing the meal plate on the tray.During an interview on 03/24/26 at 12:48 P.M., Dietary Aide #1 said he worked 6:00 A.M. to 2:30 P.M. on 03/04/26 and called out all residents' diet orders to the Cook. Dietary Aide #1 said the lunch meal was Chicken parmesan with spaghetti noodles. Dietary Aide #1 said when he calls out a resident's diet order, the cook prepares the meal plate, hands it back to him, and he is supposed to then check that the meal on the plate matches the resident's meal ticket before placing it on the tray and into the food truck.Dietary Aide #1 said Resident #1 was on a ground diet and he did not realize he had made a mistake with his/her meal plate. Dietary Aide #1 said he must have read the wrong resident's diet order to the cook for a regular diet and placed the plate with the regular diet on Resident #1's tray. Dietary Aide #1 said he did not check if Resident #1's meal ticket matched the meal on the plate before he covered the plate and placed it on his/her tray.During an interview on 03/24/26 at 4:18 P.M., the Food Service Director (FSD) said a Dietary Aide calls out all resident's diet orders, any restrictions, allergies, and preferences from their meal tickets to the Cook, the [NAME] prepares the meal plate according to what the Dietary Aide calls out and hands the (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plate to the Dietary Aide. The FSD said the Dietary Aide is supposed to check the meal on the plate to the resident's meal ticket to make sure that the meal is correct, then covers the plate, places it on the tray in the food truck. The FSD said Resident #1 had a house ground texture diet order and on 03/04/26 he/she was served a regular texture diet order which was a whole piece of chicken that was not grounded up. The FSD said Dietary Aide #1 told her that he could not remember if he had put the wrong meal on Resident #1's tray and that he was unaware the wrong diet texture had been sent to the unit for Resident #1.The FSD said it is her expectation that the Dietary Aides follow the process for preparing all residents' meal trays and they are double checking the meal on the plate against the resident's meal tickets to make sure they receive the correct diet order.During an interview on 03/30/26 at 4:06 P.M., (which included review of her written statement), Nurse #3 said she worked the 6:00 A.M. to 2:30 P.M. shift on 03/04/26. Nurse #3 said around 12:15 P.M. she was sitting at the nurses' station across from the secondary dining room with Nurse #2 and Nurse #3 when she heard a resident (exact name unknown) say to Resident #1 are you choking? Nurse #3 said she looked at Resident #1, saw him/her doing the universal choking sign (person clutches one or both hands to their throat), she immediately ran into the dining room and asked Resident #1 are you choking?' and he/she nodded yes. Nurse #3 said she got behind Resident #1, performed the Heimlich Maneuver on him/her and a piece of chicken expelled from his/her mouth. Nurse #3 said she observed Resident #1's lunch tray which had chicken parmesan on it and the chicken had been cut up into pieces. Nurse #3 said she did not know what Resident #1's diet order was, so she looked it up and saw that he/she had an order for a ground diet but had been given a regular texture diet.During an interview on 03/25/26 at 2:56 P.M., the Director of Nursing (DON) said nurses were responsible for checking all residents' meal trays according to the resident's meal ticket to ensure they receive the correct meal and that it is her expectation that all nurses check residents' meal trays before being passed to them.During a telephone interview on 03/30/26 at 1:09 P.M., the Former Administrator said on 03/04/26 Nurse #3 informed him that Resident #1 (whose diet order was for ground diet, had been served regular consistency diet) had choked on his/her lunch meal, that she (Nurse #3) performed the Heimlich Maneuver on him/her, he/she had expelled some food and he started an investigation right away. The Former Administrator said the FSD told him that on 03/04/26 the incorrect meal texture was prepared for Resident #1 and that he/she should have received his/her meal according to his/her diet order (ground diet).On 03/25/26, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction with an effective date of 03/06/26, which addressed the area(s) of concern as evidenced by:A. On 03/04/26, Resident #1 was assessed by the nurse, the physician was notified, and a new order was obtained for a chest X-ray. Resident #1 returned to his/her baseline after the incident and had no further complaints.B. On 03/04/36 Resident #1 was evaluated by the Speech Language Pathologist and seen six days during 03/04/36 through 03/13/26 with recommendations to continue ground diet and no waffles or pasta.C. On 03/05/26, the Unit Managers conducted a house wide audit on all units: to ensure all residents' meal trays were checked for accuracy according to their diet order on their meal tickets prior to meal service.D. On 03/04/26, the Staff Development Coordinator initiated and provided education to all Licensed Nursing Staff on checking residents' meal trays for accuracy according to their meal ticket prior to meal service: all Licensed nurses are to check all meal trays to ensure the correct diet on the meal ticket matches the meal.E. On 03/05/26, the Food Service Director provided education to all Dietary staff on checking meal trays for meal accuracy: all resident meal trays must be checked for accuracy during meal service to ensure that each meal plated is accurate according to each resident's diet orders/texture on their meal tickets.F. On 03/05/26, the Dietary Department Management started daily audits on all residents' meal trays for accuracy according to their meal tickets.G. The Nursing Department Staff will continue to conduct audits on resident's meal trays for accuracy according to their diet orders on the meal tickets daily for seven days, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.H. The Dietary Department Management will continue to conduct audits on residents' diet (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders on the meal tickets are accurate to the meal tray being served daily for seven days, then weekly for four weeks, then monthly for a minimum of two QAPI cycles.I. The results of the audits will be presented and reviewed at the quarterly QAPI meeting for a minimum of two quarters or until substantial compliance is achieved.J. The Director of Nursing, Food Service Director, and/or designees are responsible for overall compliance.