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	04/21/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and document review, the facility failed to ensure medications with a shortened expiration date were properly labeled once opened, in two of three medication carts observed. Findings include: Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, dated as revised 6/30/25, indicated but was not limited to:-Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened.-When an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. 1. On 4/15/26 at 3:41 P.M., the surveyor observed the #6 Medication Cart with Nurse #2 on Two South. The surveyor observed one bottle of Latanoprost eye drops (used to treat increased pressure in the eye) opened and stored in the box, neither the bottle nor the box was labeled with an open or use by date. Further review of the Latanoprost box indicated it had been filled by the pharmacy on 12/11/25. Review of the Latanoprost packaging indicated but was not limited to:-Once a bottle is opened for use, it may be stored at room temperature for 6 weeks. During an interview on 4/15/26 at 3:45 P.M., Nurse #2 said she could not say when the bottle of Latanoprost was opened or when it should be thrown away because it was not labeled. Nurse #2 said eye drop bottles should be labeled with the open date when they are opened. 2. On 4/15/26 at 4:01 P.M., the surveyor observed the #4 Medication Cart with Nurse #3 on Two North. The surveyor observed one Breyna inhaler (used to decrease inflammation in the lungs) out of the foil pouch and stored inside the box, neither the inhaler nor the box was labeled with an open or used by date. Further review of the Breyna inhaler box indicated it had been filled by the pharmacy on 10/2/25. Review of the Breyna packaging indicated but was not limited to:-Discard the inhaler when the labeled number of inhalations have been used or within three months of opening the foil pouch During an interview on 4/15/26 at 4:04 P.M., Nurse #3 said she could not say when the inhaler was opened because it was not labeled. Nurse #3 said inhalers should be labeled with the open or use by date when they are first opened. During an interview on 4/16/26 at 12:33 P.M, the Director of Nursing (DON) said medications with a shortened expiration date should be labeled with the open and discard date upon opening.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential for foodborne illness to residents who are at high risk. Specifically, the facility failed to maintain safe and clean equipment in two of three nourishment kitchenettes. Findings include:Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to:3-302 Preventing food and ingredient contamination; (A) FOOD shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under 4-602.11(A) and sanitizing as specified under S 4-703.11;3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (E) In a clean, protected location if the UTENSILS, such as ice scoops, are used only with a FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD;Review of the facility's policy titled Housekeeping, undated, indicated but was not limited to the following:-Standards for routing cleaning of all interior spaces will be followed, including, but not limited to, diet kitchens.-The housekeeping/Laundry Supervisor will: -ensure cleanliness of all interior areas -be familiar with regulations relating to cross contamination and the spread of infectious diseases and shall train staff and monitor compliance.On 4/14/26 at 9:56 A.M., the surveyor made the following observations of the Two North Unit nourishment kitchenette:- Brown/orange food splatter/residue was noted to the top, sides, and bottom of the inner portion of the microwave. The glass plate had brown food splatter/residue all along the edges of glass.-Large amounts of dried food residue were observed on the inner portion, on the top, on the side and underneath the toaster oven. On 4/15/26 at 10:07 A.M., the surveyor made the following observations of the Two North Unit nourishment kitchenette:- Brown/orange food splatter/residue was noted to the top and sides of the inner portion of the microwave.On 4/21/26 at 9:51 A.M., the surveyor made the following observations of the Two North Unit nourishment kitchenette:- Brown/orange food splatter/residue was noted to the top, sides, and bottom of the inner portion of the microwave. The glass plate had brown food splatter/residue all along the edges of glass. In the center of the bottom of the microwave, under the glass plate and plastic carousal wheel was noted to have a brown liquid pooled. -Large amounts of dried food residue were observed on the inner portion, on the top, on the side, and underneath the toaster oven. -The ice scoop was observed sitting in a holder noted to have brown residue on the inside walls of the holder. The inside bottom of the holder had a large amount of stagnant water with a milky white film floating on the water with particles floating in the water. On 4/21/26 at 10:00 A.M., the surveyor made the following observations on Unit One nourishment kitchenette:- Brown/orange food splatter/residue was noted to the top and sides of the inner portion of the microwave.-White residue was noted on the sides of the ice scoop holder. The ice scoop holder was observed to have water with white floating residue on the inside bottom of the holder with the ice scoop resting in the water.-Large amounts of dried food residue were observed on the inner portion, on the top, on the side, and underneath the toaster oven. During an interview on 4/21/26 at 10:12 A.M., the Food Service Director (FSD) said dietary staff are responsible for daily stocking and cleaning the refrigerators of the nourishment kitchenettes. The FSD said the dietary staff are also responsible for the ice process for the kitchenettes which includes maintaining and cleaning the ice coolers and the ice scoop/reservoir holders. The FSD said the dietary staff provide ice to the units three times a day and provide a new ice scoop at about 11:00 A.M. each day. The FSD said housekeeping is responsible for cleaning all other areas of the nourishment kitchenettes to include the microwaves, toasters and counters. The FSD said the reservoir that holds the ice scoop should have been cleaned daily and the ice scoop should not have been sitting in old water.During an interview on 4/21/26 at 10:24 A.M., the Housekeeping Manager (HM) said the housekeeping department is responsible for the cleanliness of all unit kitchenettes. The HM said the housekeeping team members clean the kitchenettes a few (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times a day. The HM said the housekeepers should have cleaned the microwaves, toaster ovens, and wiped down counters each time cleaning was completed and that was not done.During an interview on 4/21/26 at 1:14 P.M., the Administrator and the surveyor reviewed the observations of the nourishment kitchenettes. The Administrator said all equipment should have been cleaned. The Administrator said housekeeping is responsible for the overall cleaning to include the microwaves and toaster ovens and dietary is responsible for the cleaning of refrigerators, ice delivery, and ice equipment. The Administrator said he does not have a policy for ice delivery and storage of ice equipment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the physician or clinician in a timely manner when one Resident (#5) had a change in their compliance with their treatment of wearing an ordered neck collar at all times to treat a new cervical fracture, out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Resident Change in Condition, undated, indicated but was not limited to the following: The purpose is to facilitate nursing response for residents exhibiting a change in condition and to define requirements for notification of change- whenever there is a change in the resident's condition the nurse will follow protocols- prior to contacting the physician, the nurse will conduct a clinical assessment and collect pertinent information to report to the physician- a change in condition will be documented in the nurses' notes and other areas of the medical record Resident #5 was admitted to the facility in January 2026 and had diagnoses including wedge compression fracture of the third lumbar vertebrae, cognitive communication deficit, and compression fracture of the seventh cervical vertebrae. Review of the Minimum Data Set (MDS) assessment, dated 3/26/26, indicated Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status score of 3 out of 15, had behaviors of rejecting care, and a history of falls. On 4/14/26 at 9:30 A.M., the surveyor observed the Resident sitting on the edge of their bed leaning to one side with a hard collar neck brace in place. Nurse #4 was alerted to the situation and assisted the Resident. She said the Resident is confused and had been declining a little bit and to the best of her knowledge had to wear the neck brace related to a fall which resulted in a neck fracture. Review of the current Physician's Orders for Resident #5 indicated but were not limited to the following: -Keep cervical collar in place at all times, every shift. Check every shift for placement and check skin integrity (3/31/26)Review of the April 2026 Treatment Administration Record (TAR) (4/1/26-4/21/26) indicated the cervical collar was either held or otherwise not in place as ordered for 15 of 61 opportunities starting on 4/3/26. During an interview on 4/16/26 at 7:59 A.M., Unit Manager #2 said Resident #5 had an overall cognitive decline since admission and had fluctuating behaviors including yelling and being uncooperative related to his/her confusion. Throughout the survey the surveyor made the following observations of Resident #5 without his/her cervical collar in place: -4/16/26 at 8:05 A.M.- Resident in bed with the cervical collar lying next to the Resident on the bed, not securing his/her neck.-4/18/26 at 10:45 A.M. and 12:17 P.M., Resident in bed with cervical collar on the bedside table, not securing his/her neck as ordered. During an interview on 4/21/26 at 8:50 A.M., Nurse #9 said the Resident can be resistive to wearing the cervical collar and will pull on the collar or self-remove it at times. She said when that happens, they just attempt to re-educate the Resident and put the collar back in place. During an interview on 4/21/26 at 8:55 A.M., Unit Manager #2 said Resident #5 is known to self-remove their cervical collar at times and this has been an ongoing behavior. She said she was not sure about the physician being notified when the behavior occurs, but they should be and she would have to look at the record and get back to the surveyor. Review of the treatment and nursing progress notes for Resident #5 from 4/1/26 through 4/21/26 indicated the Resident refused to wear the cervical neck collar and was non-compliant with its use on the following dates and times:4/3/26: 9:02 P.M.4/4/26: 1:31 A.M. and 7:07 P.M.4/7/26: 10:12 A.M.4/8/26: 3:52 A.M. 4/9/26: 1:53 A.M.4/10/26: 4:34 A.M. and 11:41 A.M.4/11/26: 5:10 A.M.4/12/26: 9:55 A.M.4/15/26: 3:20 A.M.4/16/26: 6:26 A.M.4/17/26: 7:26 A.M.4/18/26: 4:58 A.M.4/19/26: 8:27 A.M., 4:34 P.M., and 10:15 P.M4/20/26: 11:57 A.M. Further review of the treatment and progress notes failed to indicate the Attending Physician or the Nurse Practitioner (NP) were made aware of this change in the Resident's compliance with their ordered brace and behavior. The note on 4/20/26 indicated a call was placed to the orthopedic specialist but no call back had occurred. During an interview on 4/21/26 at 10:03 A.M., the Director of Nurses said the Resident returned from the emergency room on 3/31/26 with orders for the cervical neck collar to be in place at all times. She (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said Resident #5 had been resistant to wearing the collar consistently and began self-removing the device. She said when this first started occurring the staff should have notified the Physician or NP to prevent any possible complications and receive possible orders for further intervention. She reviewed the medical record with the surveyor and said the behavior of non-compliance with the cervical collar started on 4/3/26 and the physician should have been made aware at that time, but there is no documentation that indicated the attending physician, NP or orthopedic spine specialist was contacted at all until 4/20/26 and at that time only a message was left. She said the expectation was the staff would have notified the physician when this change in the Resident's compliance occurred and the behavior developed and she does not see that that happened. Review of the clinician progress notes for April 2026 failed to indicate any of the Physicians, NPs or Physician assistants had been notified of Resident #5's non-compliance with their cervical collar. During an interview on 4/21/26 at 10:32 A.M., NP #1 said she was not aware of the Resident's refusal to wear the cervical collar until recently (on or around 4/15/26) and she instructed the staff at that time to reach out to the orthopedic spine specialist and notify them for possible interventions and to ensure there would be no negative impact on the Resident. She said at this point she would expect that they had spoken with someone from the specialist's office and received further instruction or documented the follow up. She said since the order is currently in place for the cervical collar to be on at all times her expectation was that the order is being followed as written and if it cannot be for any reason then the facility staff would have notified herself or one of her colleagues immediately for intervention or guidance. She said on review of the progress notes from her colleagues and herself she could not locate any evidence that anyone of the Attending clinicians had been made aware of this change in the Resident's behavior or compliance with the cervical collar. A telephone call was placed to the Attending physician on 4/16/26 at 3:35 P.M., and the Orthopedic Spine specialist on 4/21/26 at 10:25 A.M., for this Resident but at the time of posting no return call had been received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop and implement an individualized care plan for one Resident (#5), who had documented non-compliance with an ordered cervical neck collar to treat a fracture of the 7th cervical vertebrae, out of a total of 21 residents. Findings include: Review of the facility's policy titled Care Planning - Comprehensive, dated as revised 5/2025, indicated but was not limited to the following: - purpose: 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- each comprehensive care plan is designed to: incorporate identified problem areas and associated risk factors, reflect expressed wishes and treatment goals, aid in preventing or reducing declines in the resident's functional status or levels, enhance optimal functioning, and reflect currently recognized standards of practice - identify problem areas and their causes and develop targeted and meaningful interventions- care plan interventions address the underlying source of the problem areas, rather than addressing only the symptom or trigger- assessment is ongoing and care plans are revised as information about the resident's condition change Resident #5 was admitted to the facility in January 2026 and had diagnoses including: wedge compression fracture of the third lumbar vertebrae, cognitive communication deficit, and compression fracture of the seventh vertebrae (C7). Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15, had behaviors of rejecting care, and a history of falls. Review of the current Physician's Orders for Resident #5 indicated but were not limited to the following:- Keep cervical collar in place at all times, every shift. Check every shift for placement and check skin integrity (3/31/26)Review of the progress and treatment notes for Resident #5 from April 1st through April 21st 2026 indicated a total of 18 times the Resident demonstrated non-compliance or removal of his/her cervical neck brace. Throughout the survey, the surveyor made the following observations of Resident #5 without his/her cervical collar in place: -4/16/26 at 8:05 A.M. Resident in bed with the cervical collar lying next to the Resident on the bed, not securing his/her neck.-4/18/26 at 10:45 A.M. and 12:17 P.M., Resident in bed with cervical collar on the bedside table, not securing his/her neck.During an interview on 4/21/26 at 8:25 A.M., Certified Nursing Assistant (CNA) #4 said Resident #5 is resistive to the cervical neck collar mostly when he/she is in bed and will attempt to self-remove the device and if successful push staff away if they attempt to replace it. She said the neck collar is for a neck fracture and when she finds the Resident without the collar in place she notifies the Nurse. During an interview on 4/21/26 at 8:50 A.M., Nurse #9 said the Resident can be resistive to wearing the cervical collar and will pull on the collar or self-remove it at times. She said when that happens, they just attempt to re-educate the Resident and put the collar back in place. During an interview on 4/21/26 at 8:55 A.M., Unit Manager #2 said Resident #5 is known to self-remove their cervical collar at times and this has been on ongoing behavior. She said she in not sure about a care plan for this refusal or behavior, but she would have to look into that.During an interview on 4/21/26 at 9:06 A.M., Rehab staff #1 said she knows Resident #5 well and the Resident pulls on the cervical collar or attempts to remove it frequently. She said they attempt to train the Resident on the importance of leaving the collar in place, but because the Resident's cognition fluctuates this is a challenge. During an interview on 4/21/26 at 9:10 A.M., Rehab staff #2 said the Resident started wearing the cervical collar following a fall in March of 2026 which resulted in a cervical fracture. She said Resident #5 does attempt to remove the collar or tug on it during rehab treatments and had to be redirected to leave the collar in place. She said although the Resident seemed reluctant to leave the collar in place during rehab treatments it does not get removed. She said there had been times that she had gone to collect the Resident for therapy and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found the cervical collar not in place and had to alert the Nurses to the situation at that time so they can follow up as needed. Review of the current care plans in place for Resident #5 indicated but were not limited to the following: PROBLEM: At Risk for falls related to (r/t) recent decline r/t recent hospitalization (3/10/26)INTERVENTIONS: PT/OT screens as needed, labs, assess for risk, encourage rest periods (3/10/26); perimeter mattress (3/13/26); mats on floor next to the bed (3/31/26); bed alarm/chair alarm (4/2/26) PROBLEM: Behavior, alteration in r/t socially inappropriate (3/19/26)INTERVENTIONS: medicate as ordered (a/o), psych services a/o, offer drink/snack, diversional activity, assess to determine unmet need, identify potential triggers to escalating behavior, offer alternative ways to cope, monitor behavior episodes every shift, monitor for changes in behavior and notify physician of changes (3/19/26) PROBLEM: Fracture, C7, risk for complications/strengths (4/2/26)INTERVENTIONS: PT/OT screens, assess for odors from immobilizer and notify physician as needed (PRN), observe for non-verbal indicators of discomfort and intervene accordingly (4/2/26) The care plans failed to identify the behavior of non-compliance and pulling at the cervical collar or how to intervene in the event the cervical collar is not used as ordered even though the staff were aware this was occurring. During an interview on 4/21/26 at 10:03 A.M., the Director of Nurses said the Resident returned from the emergency room on 3/31/26 with orders for the cervical neck collar to be in place at all times. She said Resident #5 had been resistant to wearing the collar consistently and began self-removing the device. She reviewed the medical record and care plans with the surveyor and said there should be individualized information in the care plan regarding the Resident's behavior and non-compliance and what to do if the Resident declines the collar and none of that information is there. She said the care plans were not individualized to the Residents' current situation. During an interview on 4/21/26 at 10:32 A.M., NP #1 said she was not aware of the Resident's refusal to wear the cervical collar until recently and she instructed them at that time to reach out to the orthopedic spine specialist and notify them for possible interventions and to ensure there would be no negative impact on the Resident. She said she believed Nurses should be documenting behaviors, changes and interventions for this specific situation but she was unsure how that information transferred to a care plan because she had nothing to do with that process. A telephone call was placed to the Attending physician for Resident #5 on 4/16/26 at 3:35 P.M., but at the time of posting no return call had been received.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and document review, the facility failed to ensure an ordered fluid intake restriction of 1500 milliliters (ml) a day was documented, monitored, and followed, for one Resident (#1) to maintain proper hydration and health, out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Encouraging and Restricting Fluids, dated as revised October 2010, indicated but was not limited to the following:- the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health- verify physician order and review care plan- record fluid intake on the intake and output record, record intake in milliliters (ml)- be accurate when recording fluid intake- if resident refuses, document the reasons why and the interventions taken Resident #1 was admitted to the facility in January 2026 and had diagnoses including End stage renal disease and dependence on renal dialysis. Review of the current orders for Resident #1 indicated, but were not limited to the following: Diet: House, No saltshaker renal - breakfast lunch and dinner, minced moist scrambled eggs for breakfast, thin 1500ml fluid restriction (2/22/26)Nepro with Carbsteady 240ml twice a day oral at 10:00 A.M. and 6:00 P.M. (2/6/26) Review of the current care plans for Resident #1 indicated but were not limited to the following: PROBLEM: Requires a mechanically altered diet (1/23/26)GOAL: Resident will exhibit good tolerance of mechanically altered diet as evidenced by (aeb) no episodes of choking, pocketing, significant weight changes, or alterations in fluid balance (1/23/26)INTERVENTIONS: Provide diet as ordered (a/o), observe for changes in ability to tolerate mechanically altered diet, allow time for meal consumption (1/23/26) PROBLEM: Resident is at potential nutritional risk related to (r/t) weight less than ideal body weight, possible weight shifts with hemodialysis treatment, need for therapeutic and texture modified diet (2/2/26)GOAL: By mouth (po) and supplement intake greater than or equal to 50% weight stability; gradual gain is desirable (2/2/26)INTERVENTIONS: Continue diet a/o, recommend 1500ml fluid restriction, monitor weights skin labs, Nepro supplement recommended twice a day (BID) to optimize/support intake (2/2/26) PROBLEM: Hemodialysis; Potential for complications (1/23/26)GOAL: Resident will have signs and symptoms of complications identified immediately with appropriate interventions daily (1/23/26)INTERVENTIONS: Monitor labs a/o, provide therapeutic diet a/o, encourage resident to maintain compliance with dietary restrictions, provide education on the reasons for restrictions and the potential effects of non-compliance, instruct resident to report headaches chest pain and change in mental status and observe and report non-verbal signs of the same, monitor vascular access device for redness drainage signs of infection, notify physician as needed (1/23/26) The current physician's orders and care plans for Resident #1 failed to indicate how the fluid restriction of 1500ml a day would be broken down and divided between dietary and nursing and how the restriction would be monitored and documented. During an interview with observation on 4/16/26 at 8:20 A.M., the surveyor observed Certified Nursing Assistant (CNA) #3 assisting Resident #1 with his/her breakfast. Review of the tray ticket on the tray failed to indicate that the Resident was on a 1500ml fluid restriction. CNA #3 said the Resident was an assist and she believed he/she was on a fluid restriction. She said the amount would have to be verified with the nurse. She said the CNAs are supposed to document fluid intake on the paper intake and output (I&O) sheets at the nurses' station or in the electronic system. The surveyor observed that the Resident's tray contained one 120ml cup of apple juice, a 120ml of coffee and 120ml of milk. CNA #3 said the Resident's intake does fluctuate, but he/she does not typically request more fluids and if he/she did, she would alert the nurse. Review of the I&O book on the unit failed to indicate Resident #1 had an I&O sheet for the staff to document his/her fluid intake each shift. Review of the point of care (POC) CNA documentation for fluid intake each shift in the electronic record for Resident #1 indicated fluid intake was documented 7 out of 46 opportunities for the month of April 2026. During an interview on 4/16/26 at 10:22 A.M., Unit Manager #2 reviewed Resident #1's medical record with the surveyor. She said the Resident does have an order for a 1500ml fluid restriction, but there is no breakdown indicating how (continued on next page)

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	04/21/2026

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.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the fluids would be split up between dietary and nursing and there is no I&O sheet for the Resident for the fluids to be monitored. She said the POC system does have some fluid intake documented but it is inconsistent and those documents are not monitored by the nurses to ensure the Resident does not exceed the prescribed fluid restriction. She said typically fluid restriction orders are broken down and placed in the system for the nurses to sign off an amount not to be exceeded each shift and the CNAs complete an I&O sheet so the total amount can be calculated for the 24-hour period to ensure the fluid restriction is maintained. She said it appears at this time that was not happening for Resident #1 and there was no documentation to show whether the fluid restriction had been maintained or monitored. Review of the Fluid Restrictions (general guidelines) sheet provided by the facility dietitian, indicated but was not limited to the following: 1500ml Fluid restrictionBreakfast 360ml, Lunch 360ml, Dinner 300ml for a total of 1020mlLeave 240ml for nourishments and 240ml for med pass During an interview on 4/16/26 at 11:52 A.M., Dietitian #1 reviewed the fluid restriction breakdown sheet with the surveyor and said the sheet is the standard breakdown she uses for all residents in the facility on a 1500ml fluid restriction. She said she knows Resident #1 well, he/she is on dialysis and is on a 1500ml fluid restriction since about February 5th of this year. She said she does not monitor the fluid restrictions or follow up on them for accuracy and had no way of doing that. She said she recommended a supplement drink of Nepro 240ml for the Resident around 2/6/26 and the Resident gets that twice a day. She said that fluid would count in the nursing portion of the fluid restriction for nourishments and med pass. She said she assumed the nurses would know not to provide other fluids than the Nepro supplement since all other fluids in the fluid restriction would come from the kitchen. She said she communicates with the dietitian at the dialysis center about weekly, but she does not know if that dietitian tracks or monitors the Resident's fluid restriction. During an interview on 4/16/26 at 12:06 P.M., the Food Service Director said that anyone on a fluid restriction would have that information indicated on their meal ticket. She provided the surveyor with a meal ticket print out for Resident #1, and said the Resident is not on a fluid restriction to her knowledge. She reviewed all dietary notation forms provided to the dietary department from the nursing department for Resident #1 and said there was only one form available from 2/17/26, and it did not indicate the Resident was on a fluid restriction. On review of the dietary notation form the communication indicated the Resident had a diet change to minced moist texture but failed to indicate the 1500ml fluid restriction. She reviewed the orders for the Resident in the medical record and said the Resident was supposed to be on a fluid restriction since February 2026, but she was unaware of that since she never received communication of that and that is why the Resident did not have his/her fluid restriction noted on their dietary tray ticket. During an interview on 4/16/26 at 12:22 P.M., Nurse #4 said Resident #1 takes their meds in applesauce or pudding with either water or juice. She said the Resident gets a Nepro supplement twice a day, but that is not typically given with his/her medications. She said she was unsure of where in the fluid restriction breakdown the Nepro supplement would be counted and would have to look into that information. During an interview on 4/16/26 at 1:31 P.M., Dietitian #2 said she is the dietitian at Resident #1's dialysis center and knows the Resident well. She said she communicates with the facility dietitian about weekly, but if she was recommending a change to a diet order, fluid restriction, or supplements she would send that information directly to the nursing staff. She said she was not involved with how a fluid restriction was provided by the facility, and she does not monitor the fluid intake or restriction documentation. She said she monitors the Resident by interdialytic weights. She said her expectation was that when a fluid restriction was recommended for a resident that the facility was ensuring it was followed as ordered for optimal resident outcomes. During an interview on 4/16/26 at 4:15 P.M., CNA #5 said she was not aware that Resident #1 was on a fluid restriction. She said she does assist the Resident with their dinner meal, and he/she tends to consume all the provided fluids, but she wasn't sure if the Resident receives any additional snacks or fluids throughout the evening shift. During an interview on 4/16/26 at 4:19 P.M., CNA #6 said she knows Resident #1 but was not aware he/she was on a fluid restriction. During an interview on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/16/26 at 4:26 P.M., Nurse #1 said Resident #1 is assisted with his/her meals. She said the Resident takes their medications crushed in pudding with either juice or ginger ale to wash them down. She said the Resident does have a supplement order that is twice a day and that is consumed in varying amounts. She said she was not aware of all the details of the fluid restriction, but the Resident does not typically request any additional fluids. During an interview on 4/17/26 at 8:30 A.M., the Director of Nurses said when a recommendation is received for a resident to be placed on a fluid restriction it is approved by the physician or Nurse practitioner and then the order is placed on the medication administration record with a maximum amount that can be received by each shift. Then, it is to be signed off by the nurse to ensure that amount has not been exceeded each shift and a care plan is created. She said the CNAs complete an I&O sheet documenting the amounts per shift and that is how the fluid restriction is monitored to ensure compliance is maintained. She said the documentation for monitoring Resident #1's fluid intake was not occurring and there was no way to demonstrate whether the Resident was following his/her fluid restriction of 1500ml daily. She said she would expect that the dietitian would have noticed the documentation was missing and be monitoring this side by side with nursing. She said she was not aware that any supplements would be counted in the total amount for nursing and this Resident's supplement was not timed to be provided only when medications were received. She said I &O sheets should have been implemented and completed for Resident #1. She said there was some work to be done in this area to ensure all the pieces were in place. During an interview on 4/21/26 at 10:34 A.M., Nurse Practitioner #1 said Resident #1 was on a 1500ml fluid restriction and her expectation would be that the facility was documenting the fluid intake each shift or day to ensure the fluid restriction was followed and the Resident was not exceeding the prescribed amount of fluid daily.