STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225477	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marian Manor of Taunton	33 Summer Street Taunton, MA 02780

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), the facility failed to ensure his/her environment was free of accident hazards as possible, when on 06/28/25, while activity staff were assisting residents onto the elevator after an activity, they did not lock the elevator, which would have kept the door in the open position, as Resident #1 entered the elevator the door began to close and hit him/her causing him/her to fall into the elevator. Resident #1 complained of severe left leg pain and was transported to the Hospital Emergency Department (ED) for evaluation. Resident #1 was diagnosed with a left intertrochanteric fracture (break in the upper part of the thigh bone (femur), was admitted and underwent surgical intervention to repair the fracture.Findings include:Review of the Facility Policy titled, Fall Prevention Program, dated October 2024, indicated the following:-each resident will be assessed for risk factors and predisposition for falling using the Facility Fall Risk Assessment Form;-residents who experience a fall will have a Fall Risk Assessment completed by the Nurse Manager/Supervisor or designee on duty at the time of the fall which includes a detailed nurse's note, an incident report and incident investigation follow-up;-the Nurse Manager/designee will review the fall prevention/incident interventions/staff educations with all staff;-physician and family members will be notified by the nurse on duty at the time a resident falls.Review of the Facility Policy tilted, Accidents and Incidents Investigation, undated, indicated the following:-begin an investigation: what happened to the resident, who was involved with the resident, how did this happen and how can we prevent this from happening again;-interview the resident, the caregivers, the recreation staff;-observe the environment where the resident was found;-assist the resident and staff with completion of statements;-review all statements and ensure all questions have been addressed;-director of nurses (DNS) reviews accidents and incidents;-DNS reviews if staff performed duties according to standard of practice;-DNS ensures there is a plan so that the problem will not continue to occur.Review of the Facility Policy titled, Formal Investigation Guidelines, dated March 2025, indicated the following:-incidents have many causes including unsafe conditions, unsafe acts such as not following procedures;Resident #1 was admitted to the Facility in October 2015, diagnoses included bipolar disorder, hypertension, major depressive disorder, anxiety, chronic kidney disease, hypothyroidism and cataracts.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 04/15/25, indicated that he/she was alert, oriented and independent with ambulation.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/28/25, indicated that at 11:00 A.M, Resident #1 was ambulating into the first-floor elevator after activities, lost his/her balance and fell onto his/her left side in the doorway of the elevator. The Report indicated that the fall was witnessed by an activities staff member. The Report indicated that Resident #1 complained of left hip and leg pain, the Nurse Practitioner and Health Care Agent were notified, and he/she was transferred to the Hospital Emergency Department (ED) for evaluation. The Report indicated that Resident #1 was admitted to the hospital, was diagnosed with a left intertrochanteric fracture and had an Open Reduction Internal Fixation (ORIF, surgical procedure to repair broken bones with hardware) of his/her left hip.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that Resident #1 presented to the ED after a fall at the nursing home. The Summary indicated that Resident #1 had a left intertrochanteric femur fracture resulting from the fall and underwent an ORIF surgical procedure. The Summary indicated that Resident #1 also had mild anemia secondary to the hip fracture and subsequent surgery.During a telephone interview on 08/19/24 at 11:25 A.M., Family Member #1 said that Resident #1 told him/her on 6/28/25 that while he/she was walking into the elevator, the elevator door closed and hit him/her, causing him/her to fall into the elevator. Family Member #1 said that no one from Facility Administration told him/her that the elevator door closing and hitting Resident #1 was the reason why Resident #1 fell. Review of Activity Assistant #1's Written Witness Statement, dated 06/28/25, indicated that at approximately 11:10 A.M., Resident #1 was walking into the elevator when he/she lost his/her balance and fell to the floor.During an interview on 08/19/25 at 12:00 P.M., Activity Assistant #1 said that on 6/28/25, as Resident #1 walked into the elevator, the elevator door started to close, hit Resident #1 on his/her right arm, he/she lost his/her balance and fell to the floor of the elevator onto his/her left side. Activity Assistant #1 said she was behind Resident #1 transporting another Resident into the elevator when Resident #1 walked into the elevator. Activity Assistant #1 said that she should have locked the elevator (door stays in the open position) while she was transporting residents into the elevator so the elevator door would not close. Activity