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	01/15/2026

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 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 records reviewed and interviews, for one of three sampled residents (Resident #1), who had an activated Health Care Proxy (HCP), the Facility failed to ensure nursing promptly notified his/her Health Care Agent (HCA), when nursing transcribed a physician's order to decrease the dosage of his/her antidepressant medication without notifying the HCA of the change, Resident #1 received the lower dosage of the medication for more than a month before the HCA was made aware.Findings include:Review of the Facility's Policy titled, Change in Resident Condition, dated as revised December 2025, indicated the following:-the resident's responsible party/next of kin are notified of a change in condition;-a licensed nurse in charge is responsible for timely notification of the responsible party/next of kin and notify with his or her consent the resident representative when there is: a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment;-all changes and notifications should be documented in the resident's medical record.Resident #1 was admitted to the Facility in March 2020, diagnoses included: non-displaced intertrochanteric fracture of left femur, Alzheimer's disease, osteoarthritis, occlusion and stenosis of carotid artery, anxiety disorder, Bullous disorder, cellulitis of right and left lower limb, chronic obstructive pulmonary disease and recurrent major depressive disorder.Review of Resident #1's Medical Record indicated Resident #1's Health Care Proxy was invoked on April 15, 2020.Review of Resident #1's Advanced Directives Care Plan, dated as initiated 03/18/2022, reviewed and revised with the Annual Minimum Data Set (MDS) Assessment, dated 11/12/25, indicated that Resident #1 had an invoked HCP and that his/her family will be contacted as necessary in order to be kept up to date with any changes in his/her condition.Review of a Consultant Pharmacist Recommendation to Prescriber Form, dated 09/30/25, indicated that Resident #1 currently receives Sertraline 100 mg by mouth daily, dose evaluation is recommended periodically in order to help determine the lowest effective dose and to attempt to taper Sertraline unless clinically contraindicated. The Form indicated that the NP agreed with the recommendation, wrote a new order for Sertraline and wrote that it was unlikely that the HCA would agree with the GDR.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 12/23/25, indicated that on 09/30/25 the facility's pharmacy consultant recommended that Resident #1's Sertraline (antidepressant medication) be decreased from 100 milligrams (mg) by mouth daily to 75 mg by mouth daily. The Report indicated that the Nurse Practitioner (NP) agreed with the gradual dose reduction (GDR) and on 10/03/25 wrote an order to decrease the Sertraline from 100 mg to 75 mg by mouth daily. The Report indicated that the NP wrote on the pharmacy recommendation form that Resident #1's HCA probably would not agree with the recommendation. The Report indicated that on 10/03/25 the Nursing Supervisor transcribed the NP's order to decrease Sertraline to 75 mg in Resident #1's Electronic Medical Record (EMR) and was under the impression that a conversation took place with Resident #1's HCA prior to the order being written.The Report (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that on 11/20/25 Resident #1's HCA attended a Quarterly Care Plan Meeting, and his/her plan of care was reviewed which included his/her current medications. The Report indicated that Resident #1's HCA stated that he/she was not notified of the decreased dosage of Sertraline prior to the meeting and requested that the Sertraline be increased back to 100 mg. The Report indicated that the NP was notified of Resident #1's HCA's request and on 11/21/25 Sertraline was increased to 100 mg by mouth daily. During a telephone interview on 01/15/26 at 2:10 P.M., Resident #1's HCA said that Resident #1 receives an antidepressant medication and that he/she had requested that the dosage of the medication not be changed. The HCA said that in November 2025 at a care plan meeting, she was informed that the dosage of Resident #1's antidepressant medication was decreased in October 2025. The HCA said that as Resident #1's HCA, that the facility was supposed to notify her of any medication changes and said that the facility just decreased the dose of Resident #1's antidepressant without notifying her prior to implementing the lower dose. Review of a Physician's Order, dated 10/03/25, indicated to discontinue Sertraline 100 mg by mouth daily and administer Sertraline 75 mg by mouth daily.Review of Resident #1's Medication Administration Record, dated 10/04/25 through 11/21/25 indicated that Resident #1 received Sertraline 75 mg by mouth daily.During an interview on 01/15/26 at 12:45 P.M., the Nurse Practitioner (NP) said that she reviewed Resident #1's Pharmacist GDR recommendation to decrease Sertraline, agreed with the recommendation and wrote an order to decrease Sertraline to 75 mg daily. The NP said that she agreed with the dose reduction pending Resident #1's HCA's approval. The NP said that it was her expectation that nursing would notify Resident #1's HCA of the recommendation to lower the dose of Sertraline and obtain approval before implementing the new order. During a telephone interview on 01/21/26 at 8:20 A.M., Nurse Supervisor #2 said that she transcribed the NP's order for Sertraline 75 mg into Resident #1's EMR. Nurse Supervisor #2 said that she thought that the NP had discussed the dose reduction with Resident #1's HCA prior to writing the order for Sertraline and assumed that the HCA approved the lower dosage of Sertraline. Nurse Supervisor #2 said she was not aware that Resident #1's HCA was not notified of the dose reduction of Sertraline.Review of Resident #1's Medical Record indicated that there was no documentation to support that Resident #1's HCA was notified of the dose reduction of Sertraline.During an interview on 01/15/26 at 4:00 P.M., the Director of Nurses (DON) said that the NP wrote an order to decrease Resident #1's Sertraline per the Pharmacist's GDR recommendation. The DON said that Resident #1 had an invoked HCP and the Nursing Supervisor transcribed the order without notifying Resident #1's HCA of the new dosage recommendation. The DON said that it was her expectation that nursing notified the HCA of any changes in medication dosage prior to implementation.