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	03/10/2025

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

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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	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49428 Based on record review and interview, the facility failed to ensure staff notified the Physician of medication recommendations for one Resident (#15), out of a sample of 15 residents. Specifically, the facility failed to notify the Physician and/or Nurse Practitioner, in a timely manner, of the Psychiatric Nurse Practitioner (PNP)'s recommendations to increase Remeron (an antidepressant medication) dosage and implement a Gradual Dose Reduction (GDR) for Lexapro (an anti-anxiety medication), resulting in a 43-day delay in implementing the recommendations. Findings include: Resident #15 was admitted to the facility in June 2019 with diagnoses that included Alzheimer's disease, dementia, anxiety disorder, and major depressive disorder. Review of Resident #15's Psychiatric Nurse Practitioner (PNP) progress note/consult, dated 11/25/24, indicated but was not limited to the following: -Recommend GDR Lexapro (escitalopram). -Increase Remeron (mirtazapine) to decrease depression/enhance appetite. Review of Nurse Practitioner (NP) Encounter Notes, dated 12/11/24, 12/20/24, and 12/31/24, indicated but was not limited to: -Reviewed medications; escitalopram 10 mg (filled 6/29/22), escitalopram 5 mg (filled 9/1/24), mirtazapine 15 mg (filled 9/1/24). The NP's Encounter notes failed to address the PNP's recommendations to increase Remeron and implement a GDR of Lexapro made on 11/25/24. Review of a Physician's Encounter note, dated 12/18/24, indicated but was not limited to: -Reviewed medications; escitalopram 10mg (filled 6/29/22), escitalopram 5mg (filled 9/1/24), mirtazapine 15mg (filled 9/1/24). (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Encounter note failed to address the PNP's recommendations to increase Remeron and implement a GDR of Lexapro made on 11/25/24. Review of the NP's Encounter note, dated 1/10/25, indicated but was not limited to: -Reviewed medications; escitalopram 10mg (filled 6/29/22), escitalopram 5mg (filled 9/1/24), mirtazapine 15mg (filled 9/1/24). -Assessment/Plan: Major depressive disorder, 1/7/25- Seen by Psych services and recommending GDR of Lexapro to 10mg and increase in Mirtazapine to 22.5mg. Order written and patient to be monitored for behavioral changes. Further review of the medical record failed to indicate that there were additional PNP notes after 11/25/24. Review of Resident #15's November 2024 through January 2025 Medication Administration Records (MARs) indicated he/she was administered the following medications as ordered: -Escitalopram oxalate, 5mg, 3 tabs once a day, (dated 9/6/23-1/7/25); -Escitalopram oxalate, 5mg, 2 tabs (=10mg) once a day, (dated 1/7/25 - open ended); -Mirtazapine, 15mg, at bedtime, dated (dated 6/15/23 - 1/7/25). -Mirtazapine, 15mg, administer three half tabs (22.5mg) at bedtime, dated (dated 1/8/25-1/10/25). -Mirtazapine, 45mg, administer 1 half tab (22.5mg) at bedtime, dated (dated 1/10/25-open ended). Review of Resident #15's current Physician's Orders indicated but were not limited to the following: -Escitalopram oxalate, 5mg, 2 tabs to equal 10mg, once a day, 1/7/25; -Mirtazapine, 45mg, 1 half tab (22.5mg), at bedtime, 1/10/25. During an interview on 3/10/25 at 9:33 A.M., Nurse #3 said the PNP sends recommendations electronically to the Director of Nursing (DON) or Unit Manager who then places recommendations into the Physician's and/or NP's folder for review. Nurse #3 reviewed Resident #15's 11/25/24 PNP's recommendations and medication orders and said there was a big gap in time between the recommendation and implementation of the orders for Remeron and Lexapro. Nurse #3 said the change in Unit Managers for that unit might have contributed to the lapse in communication. During an interview on 3/10/25 at 9:45 A.M., the DON said the PNP emails reports and recommendations to the DON, Administrator, and MDS nurse. The DON reviewed the PNP's 11/25/24 recommendations for Resident #15. The DON was unsure why there was a 43-day delay in implementing the PNP's recommendations for Remeron and Lexapro. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephonic interview on 3/10/25 at 11:55 A.M., the Physician said he expected the facility to notify him or the NP in a timely fashion of any consultant recommendations. During a telephonic interview on 3/10/25 at 12:13 P.M., the PNP said recommendations are emailed to the DON, Administrator, and supervisors, and the Assistant Administrator and Social Services also received the emails since there were no unit supervisors in place currently. The PNP said there are rarely any issues with sending these emails or the facility receiving them. The PNP said she could not recall specifically why her Remeron or Lexapro recommendations were implemented 43 days after the recommendations were made. During an interview on 3/10/25 at 3:00 P.M., the DON said she was able to locate the PNP's 11/25/24 recommendations in her email. The DON said the Unit Manager, who was no longer at the facility, was responsible for printing the recommendations from the email and placing them into the Physician's and NP's folders for review. The DON said she was unsure why there was such a delay in getting the recommendations to the Physician/NP. During a telephonic interview on 3/11/25 at 2:25 P.M., the NP said she receives consultant recommendations in her folder located on the units. The NP said she aims to address consultant recommendations in a timely manner and was unsure why she became aware of the PNP's 11/25/24 recommendations to increase Resident #15's Remeron and implement a GDR for his/her Lexapro in January. The NP said there was a new Unit Manager in place when the PNP made the recommendations which could have affected when the NP received the recommendations. The NP said she and the PNP have increased direct communication with each other to lessen notification delays.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was complete and accurate to reflect the status of one Resident (#27), out of a sample of 15 residents. Specifically, the facility failed: a. To ensure an MDS was accurately coded for a fall with major injury, and b. To ensure the use of a bed alarm was accurately coded on all MDS assessments. Findings include: The facility's policy titled Policy and Procedures within the Nursing Documentation Department for MDS, revised 12/2024, indicated but was not limited to the following: -The RAI (Resident Assessment Instrument) manual is our policy and procedure manual for MDS. Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, indicated but was not limited to the following: 1) J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA (Omnibus Budget Reconciliation Act) or Scheduled PPS (Prospective Payment System)), whichever is more recent -If this is not the first assessment/entry or reentry, the review period is from the day after the ARD (Assessment Reference Date) of the last MDS assessment to the ARD of the current assessment. -Code 0, no: if the resident has not had any fall since the last assessment. -Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent. 2) P0200: Alarms -An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices. -Code 0, not used: if the device was not used during the 7-day look-back period. -Code 1, used less than daily: if the device was used less than daily. -Code 2, used daily: if the device was used on a daily basis during the look-back period. (continued on next page)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	a. Resident #27 was admitted to the facility in July 2024 with diagnoses including dementia and traumatic subdural hemorrhage (bleeding in the space around the brain after a head injury. Review of Resident #27's medical record indicated that the Resident sustained a fall on 12/21/24. The Resident required transfer to the hospital for further evaluation. Imaging completed at the hospital indicated the Resident had age-indeterminate right fifth and seventh rib fractures and likely acute compression fractures of the thoracic spine (T1 through T3). The facility reported the fall with injury to the Massachusetts Department of Public Health via the Health Care Facility Reporting System (HCFRS). Review of the most recent MDS assessment, dated 1/22/25, indicated but was not limited to the following: -Section J - Health Conditions J1800. Has the resident had any falls since admission or the prior assessment (OBRA or PPS), whichever is more recent? No During an interview on 3/10/25 at 12:46 P.M., the MDS Nurse said that Resident #27's medical record did indicate the Resident sustained a fall on 12/21/24. The MDS Nurse said that the fall with major injury should have been coded on the Resident's 1/22/25 MDS assessment but was not. b. Review of Resident #27's current Physician's Orders indicated but was not limited to the following: -Alarms: *Bed Alarm* Ensure alarm is on and functioning every shift (order date 7/30/24) Review of Resident #27's Care Plan indicated but was not limited to the following: Problem: Resident is at risk for falls due to: decreased mobility I fell on [DATE] trying to put my slippers on and did not call for assistance Approach: Evaluate need for bed alarm was applied after my fall 7/29/24. Please ensure it is in place and working correctly (approach start date 7/29/24) Review of Section P (Restraints) of the Resident #27's MDS assessments, dated 8/4/24, 11/1/24, and 1/22/25, indicated that a bed alarm was not used. During an interview on 3/10/25 at 11:38 A.M., Nurse #3 said that Resident #27 utilizes bed and chair alarms as part of his/her fall prevention care plan. During an interview on 3/10/25 at 12:34 P.M., the Director of Nurses said that Resident #27 utilizes bed and chair alarms. During an interview on 3/10/25 at 12:46 P.M., the MDS Nurse said that Resident #27 had an order in place for a bed alarm since July 2024 and the alarm should have been coded on the Resident's 8/4/24, 11/1/24, and 1/22/25 MDS assessments.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on observations, interviews, and records reviewed for two Residents (#19 and #48) of 15 sampled residents, the facility failed to ensure care was provided to residents in accordance with professional standards of practice. Specifically, the facility failed: 1. For Resident #19, to ensure a prescriber's order for Dycem (a thin, rubberlike material known for its non-slip material, used to reduce the likelihood of sliding or shifting) to wheelchair was implemented to prevent falls; and 2. For Resident #48, to follow the prescriber's orders for 1:1 (one to one) assistance and encouragement with meals. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #19 was admitted to the facility in April 2019 with diagnoses including chronic pain syndrome and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 1/22/25, indicated Resident #19 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS assessment indicated he/she had two or more falls without injury since the previous MDS assessment. Review of Resident #19's current Physician's Orders indicated but was not limited to: -Dycem to wheelchair at all times, check placement every shift, dated 11/19/24 Review of Resident #19's care plans indicated he/she was at high risk for falls due to impaired mobility and medication use. Further review of his/her care plans indicated interventions to prevent falls which included: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Please ensure I have dysem [sic] on my wheelchair (I remove the dysem [sic] from my chair when I want to), dated 11/21/24 Review of the Medication Administration Record (MAR) for 1/15/25 and 1/16/25 the order for Resident #19's Dycem was signed off every shift indicating the Dycem had been in place. Review of Resident #19's progress note, dated 1/16/25 and created by Nurse #1, indicated but was not limited to: -At approximately 7:45 P.M., Resident #19 was observed sitting in front of his/her wheelchair, stating that he/she slipped out of the chair because the Dycem had been stolen from his/her room. -Dycem was applied to the wheelchair after he/she was observed on the floor. During an interview on 3/6/25 at 12:29 P.M., Nurse #2 said Resident #19 had multiple falls and the interventions to prevent further falls were listed on his/her MAR to inform the nurses of his/her safety precautions. Nurse #2 said one of Resident #19's interventions included Dycem to his/her wheelchair. During a telephonic interview on 3/6/25 at 11:52 A.M., Nurse #1 said she was the Nurse assigned to Resident #19 on 1/16/25 when he/she sustained a fall. Nurse #1 said Resident #19 told her the Dycem was missing from his/her wheelchair and when she checked the wheelchair the Dycem was not in place. Nurse #1 said she tried to contact the rehabilitation department to get more Dycem for Resident #19, but nobody was there and she was unable to get more Dycem at that time. Nurse #1 said later in the shift, Resident #19 fell from his/her wheelchair. During an interview on 3/10/25 at 8:35 A.M., Resident #19 said the day he/she fell from their wheelchair, the facility staff was aware the Dycem was missing because he/she had told them it was missing from his/her wheelchair. Resident #19 said the Dycem had been missing for a day or so. During an interview on 3/6/25 at 4:08 P.M., Nurse #5 said when Resident #19 fell on [DATE] at approximately 7:45 P.M., she did not see the Dycem on the wheelchair. During an interview on 3/10/25 at 11:01 A.M., the Director of Nurses (DON) said Resident #19 had several falls and often would refuse interventions and would remove the Dycem from his/her wheelchair at times. The DON said that if the management team was made aware that the Dycem was not in place on 1/16/25, they would have ensured that it was reapplied to promote safety and prevent falls. 2. Resident #48 was admitted to the facility in April 2022 with diagnoses including adult failure to thrive, malnutrition and legal blindness. Review of the MDS assessment, dated 12/18/24, indicated Resident #48 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of 15. Further review of the MDS assessment indicated he/she received setup or clean-up assistance when eating. Review of Resident #48's current Physician's Orders included but was not limited to: -Please provide 1:1 assist and encouragement with meals, dated 11/6/24 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's nursing progress note, dated 11/4/24, indicated nursing assisted the resident with dinner and he/she ate 100% of soup, drank 100% of his/her milkshake, ate pie that his/her son had provided and a chocolate candy bar. Further review of the progress note indicated that Resident #48 was typically just a set-up for meals but would benefit from 1:1 feeding. Review of Resident #48's Provider Encounter Note, dated 11/6/24, indicated but was not limited to: -Review of Systems: Patient would benefit from 1:1 assistance with meals -Assessment/Plan: Adult failure to thrive syndrome: Will request 1:1 assistance at meals as he/she eats better when he/she is assisted -Discussion Notes: Nursing reporting he/she does better with meals with assistance and encouragement. Will request that he/she be provided with 1:1 assist at meals Review of Resident #48's Provider Encounter Note, dated 12/6/24, indicated but was not limited to: -Review of Systems: Patient would benefit from 1:1 assistance at meals. Now receiving assistance for meals -Assessment/Plan: Discussed on-going need for assistance at meals with nursing. Son concerned that he/she had been eating well and is now not eating. On the following dates and times of survey, the surveyor observed Resident #48 alone in his/her room eating a meal: -3/4/25 at 8:45 A.M. -3/5/25 at 12:12 P.M. -3/6/25 at 8:28 A.M. -3/6/25 at 12:26 P.M., and -3/10/25 at 8:32 A.M. Review of the March 2025 Medication Administration Record (MAR) indicated but was not limited to: -On March 4th, 5th, and 6th, the nursing staff had signed the order acknowledging Resident #48 had required 1:1 assistance and encouragement with meals. During an interview on 3/6/25 at 2:12 P.M., Certified Nursing Assistant (CNA) #1 said Resident #48 required set-up assistance for meals and to be oriented to his/her tray because he/she was legally blind. CNA #1 said Resident #48 did not receive 1:1 assistance with meals. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:31 P.M., Nurse #2 said Resident #48 was a very picky eater and his/her intake depended on his/her mood. Nurse #2 said Resident #48 needed set-up assistance and to be told where everything on his/her plate was because he/she was legally blind, but he/she did not need 1:1 assistance with meals. During an interview on 3/6/25 at 1:49 P.M., Nurse #4 said the Nurse Practitioner wrote the order for 1:1 assistance and encouragement with meals because Resident #48's intake would be improved. During an interview on 3/6/25 at 2:04 P.M., Nurse Practitioner #1 said she wrote the order for Resident #48 to have 1:1 encouragement and assistance with meals because he/she was losing weight and does much better with encouragement. Nurse Practitioner #1 said she spoke with nursing at the time who said when said when Resident #48 was assisted with meals he/she would consume most of their meal. During an interview on 3/10/25 at 11:01 A.M., the Director of Nurses (DON) said the order for 1:1 assistance with meals for Resident #48 was not initiated because he/she was at risk for aspiration, but because he/she was legally blind. The DON said that staff would orient the resident to his/her tray and he/she was able to feed himself/herself.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46562 Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility Medical Director and Director of Nurses (DON) each failed to attend one of five Quarterly QAPI meetings reviewed. Findings include: Review of the facility's policy titled Quality Assurance on Performance Improvement (QAPI) Program, dated as revised 4/2024, indicated but was not limited to: -A facility must maintain a Quality Assessment and Assurance provision at 42 CFR, Part 483.75 (0) Quality Assessment and Assurance: 1. A facility must maintain a Quality Assessment and Assurance Committee consisting of: (i) the Director of Nursing Services; (ii) A physician designated by the facility; and (iii) At least 3 other members of facility's staff Review of the facility's QAPI Attendee sign-in sheets for January 2024 indicated the Medical Director was not in attendance. Review of the facility's QAPI Attendee sign-in sheets for July 2024 indicated the DON was not in attendance. During an interview on 3/10/25 at 1:59 P.M., the Administrator reviewed the January and July 2024 QAPI attendance sheets and said that the Medical Director was not present for the January 2024 QAPI meeting and must have been on vacation and the DON was not present for the July 2024 QAPI meeting and may have been on vacation at that time.