STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225518	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sippican Rehabilitation and Healthcare Center	15 Mill Street Marion, MA 02738

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 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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who upon admission, was assessed as being at high risk for elopement, and on 06/29/25 walked away from the activity patio area unbeknownst to staff, and was found walking outside, unattended, in the front of the building by a visitor, the Facility failed to ensure nursing developed and implemented a comprehensive person-centered care plan with interventions, treatment goals and outcomes that addressed his/her risk of elopement. Findings include:Review of the Facility's Policy titled, Comprehensive Person-Centered Care Plans, dated March 2022, indicated that: - a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;- the care plan will build on the residents' strengths and reflects currently recognized standards of practice for problem areas and conditions;- care plan interventions are chosen only after gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making;-assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change;-care plans are reviewed and updated when there is a significant change in the resident's condition.Review of the Facility's Policy titled, Wandering and Elopements, dated March 2109, indicated that:-the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents;-if identified at risk for wandering, elopement, or other safety issues, the resident's care plan will include interventions to maintain the resident's safety.-when the resident returns to the facility from an elopement, the director of nurses or charge nurse shall complete and file an incident report and document relevant information in the resident's medical record.Resident #1 was admitted in January 2025, diagnoses included nondisplaced fracture of second cervical vertebra, cognitive communication deficit, depression, displaced fracture of right humerus (bone of upper arm), difficulty in walking, unsteadiness on feet, type 2 diabetes mellitus, dementia, osteoarthritis, heart failure and hypertension.Review of an Elopement Risk Evaluation, dated 04/24/25, indicated that Resident #1 scored at high risk for elopement and had no exit seeking behaviors.Review of an Incident Report, dated 06/29/25, indicated that on 06/29/25 Resident #1 was observed by a family member (of another resident) leaving the back patio area through side gate and ambulated to the flower bed, (located in the front of the building). The Report indicated that the family member notified facility staff and Resident #1 was redirected back into the facility by a staff member.During a telephone interview on 10/02/25 at 3:13 P.M., Family Member #1 said that on 06/30/25, the Unit Manager told her that Resident #1 was found outside by a visitor walking towards the front entrance of the facility. Family Member #1 said that Resident #1 had been on the outside activity patio, which is on the side of the building, went through the patio gate and walked toward the front of the building without any staff member seeing or being aware that he/she had walked away.Review of a Written Witness Statement, written by the Unit Manager, dated 06/30/25, indicated that on 06/29/25, Resident #1 was observed by a family member (of another resident) leaving the back patio through a side gait and the family member notified facility staff. The Statement indicated that Resident #1 was redirected by a staff member back into the facility. During an in-person interview on 09/30/25 at 2:05 P.M. and subsequent telephone interviews on 10/02/25 at 2:15 P.M. and 3:34 P.M., the Unit Manager said that on 6/30/25, Activity Assistant #1 told her that Resident #1 had been in the outside activity patio area and went out the patio gate to look at flowers near the front entrance. The Unit Manager said that Resident #1 had been outside on the activity patio, opened the gate and walked over to the flowers which are near the front entrance of the facility and a visitor saw him/her and notified the activity staff. The Unit Manager said that she did not implement an elopement care plan after the incident because she did not consider the incident an elopement.During an in-person interview on 09/30/25 at 3:30 P.M. and a subsequent telephone interview on 10/06/25 at 8:43 A.M. , the Director of Nurses (DON) said that she was notified that Resident #1 had unlatched the gate of the outside activity patio and walked over to see the flowers in the front of the building. The DON said that an elopement risk care plan was not implemented for Resident #1 after the incident because she did not consider the incident an elopement. Review of Resident #1's Comprehensive Care Plan indicated there was no documentation to support the Facility developed and implemented a care plan after the 6/29/25 incident to address Resident #1's wandering behavior and elopement risk.