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	12/16/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 was at high risk for falls, was on an anti-coagulant medication and was severely cognitively impaired, the Facility failed to ensure staff provided care consistent with professional standards of practice, when on 11/07/25 at 6:09 A.M., Resident #1 was found after unwitnessed fall on the floor sitting upright in front of his/her roommates bed, he/she was unable to communicate the circumstances surrounding the fall or whether or not he/she sustained a head strike, however neurological assessments were not initiated or conducted, per facility protocol, by nursing after his/her unwitnessed fall. Findings include:Resident #1 was admitted to the Facility in June 2024, diagnoses included late onset Alzheimer's disease, adjustment disorder with anxiety, major depressive disorder, dementia with behavioral disturbance, restlessness and agitation, abnormalities of gait and mobility, transient ischemic attack and cerebral infarction and chronic obstructive pulmonary disease.Review of a Physician's Order, dated 09/09/2025, indicated that Resident #1 had an order for Aspirin tablet 81 milligrams (mg) by mouth once daily for anticoagulation.Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 09/18/25, indicated Resident #1 was severely cognitively impaired and required substantial/maximal assistance from staff for ambulation and transfers.Review of Fall Risk Evaluation, dated 10/20/25, indicated that Resident #1 was assessed as being at high risk for falls. Review of the Facility's Internal Investigation Report, dated 11/07/25, indicated that at 6:09 A.M., Resident #1 was found sitting upright on the floor in front of his/her roommate's bed unable to verbalize what happened.During an interview on 12/16/25 at 2:10 P.M., (which also included review of her written witness statement, dated 11/07/25), the Unit Manager said that Resident #1 had many falls while at the facility and was assessed at high risk for falls. The Unit Manager said that on 11/07/25 she was working on the unit, and a staff member informed her that Resident #1 was on the floor in his/her room.The Unit Manager said that when she entered Resident #1's room, Resident #1 was on the floor, near his/her roommate's bed, sitting on his/her buttocks with his/her legs straight out in front of him/herself. The Unit Manager said that Resident #1 was sitting on the floor approximately six feet away from his/her own bed and was on the other side of the room. The Unit Manager said that this was considered an unwitnessed fall, and that neurological assessments were to be completed by nursing immediately after an unwitnessed fall and for the next 72 hours after the fall. The Unit Manager said that Resident #1 received Aspirin (anticoagulant, blood thinner, increases the time it takes for blood to clot) daily and said that neurological assessments should be completed after an unwitnessed fall to monitor for any signs of bleeding.The Unit Manager said that she asked Resident #1's roommate if Resident #1 hit his/her head and that the roommate said Resident #1 had not hit his/her head during the fall, so she did not think Resident #1 needed neurological assessments. The Unit Manager said that on 11/07/25 she did not initiate neurological assessments on Resident #1 after his/her unwitnessed fall, but said she was informed by the Director of Staff Development and Director of Nurses that it is the facility's protocol that nursing must complete neurological assessments on Resident's who have sustained an unwitnessed fall even if the roommate/witness states they did not see the resident hit their head. Review of Resident #1's Medical Record indicated there was no documentation to support that neurological assessments were initiated or completed on Resident #1 after his/her 11/07/25 unwitnessed fall. During an interview on 12/16/25 at 3:00 P.M., the Director of Staff Development said that it is the facility's protocol that neurological assessments must be completed on residents who have sustained an unwitnessed fall even if the roommate/witness states that there was no head strike. During an interview on 12/16/25 at 4:05 P.M., the Director of Nurses (DON) said Resident #1 had sustained many falls at the facility and was assessed as being at high risk for falls. The DON said that Resident #1 sustained an unwitnessed fall on 11/07/25 and the roommate stated that he/she did not have a head strike. The DON said that even if the roommate states that a resident who fell did not sustain a head strike, staff are not to take the word of the roommate.The DON said that it was her expectation that neurological assessments be initiated after any unwitnessed fall and conducted for 72 hours after an unwitnessed fall to monitor for any signs of bleeding or head injury. The DON stated that the facility does not have a specific policy on when to perform neurological assessments but said that it was facility's' protocol for nursing to perform neurological assessments after any unwitnessed fall. The DON said that she could not find any documentation to support that any neurological assessments were completed on Resident #1 after his/her 11/07/25 unwitnessed fall.Although the facility did not have a specific policy as to when to initiate neurological assessments, interviews with the Unit Manager