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	03/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48362 Based on observations, interviews, and record review, the facility failed to ensure medications were not self-administered without a physician's order and an assessment for self-administration for one Resident (#52), out of a total sample of 22 residents. Specifically, the facility failed to assess Resident #53's ability to self-administer and manage supplemental oxygen independently. Findings include: Review of the facility's policy titled Self-Administration of Medications, dated February 2021, indicated but was not limited to the following: - Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. - If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Review of the National Library of Medicine Chapter 11 Oxygen Therapy Nursing Skill Book, dated 2021 (https://www.ncbi.nlm.nih.gov/books/NBK593208/), indicated but was not limited to the following: - Several medical conditions, such as asthma, chronic obstructive pulmonary disease (COPD), pneumonia, heart disease, and anemia can impair a person's ability to sufficiently complete this oxygenation process, thus requiring the administration of supplemental oxygen. - Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. Resident #53 was admitted to the facility in December 2024 with diagnoses including pneumonia, chronic respiratory failure, asthma, and COPD. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's Minimum Data Set (MDS) assessment, dated 1/27/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Resident #53 was independent with ambulation and transfer tasks and required set up assistance for activities of daily living. Furthermore, the MDS assessment indicated he/she utilized oxygen therapy continuously. Review of Resident #53's Physician's Orders included but were not limited to: - 12/30/24: Oxygen at 2-liters continuous via nasal cannula to maintain saturation above 88% every shift. - 12/30/24: portable Oxygen via nasal cannula; confirm hours of use while out of room on portable Oxygen every shift. During an observation with interview on 3/24/25 at 12:33 P.M., the surveyor observed Resident #53 sitting at the edge of his/her bed with the nasal cannula oxygen tubing on, connected to an oxygen concentrator in the corner of his/her room. The oxygen concentrator was not turned on. Resident #53 said he/she has been using Oxygen for several years and uses the portable concentrator when he/she goes out of their room. Resident #53 said nursing staff do not really help him/her manage the nasal cannula tubing when he/she leaves the room. Resident #53 said he/she is able to disconnect the nasal cannula tubing and place it on the oxygen concentrator or portable oxygen tank. Resident #53 said he/she typically shuts the oxygen concentrator off when he/she leaves the room and turns it back on when he/she returns. On 3/24/25 at 4:01 P.M., the surveyor observed Resident #53 sitting at the edge of his/her bed with the nasal cannula oxygen tubing on, connected to an oxygen concentrator in the corner of his/her room. The oxygen concentrator was not turned on. During an interview with observation on 3/24/25 at 4:08 P.M., Charge Nurse #3 said Resident #53 uses Oxygen continuously. Charge Nurse #3 said Resident #53 removes the nasal cannula oxygen tubing and puts it on a portable tank when needed throughout the day. The surveyor reviewed the observations made regarding Resident #53's nasal cannula oxygen tubing and oxygen concentrator with Charge Nurse #3. Charge Nurse #3 entered Resident #53's room and turned on the oxygen concentrator. Charge Nurse #3 assessed Resident #53's oxygen saturation via a pulse oximeter and overall respiratory status. Resident #53's oxygen saturation was 91%. Charge Nurse #3 educated Resident #53 on importance of turning oxygen concentrator back on when returning to room. Resident #53 said he/she must have forgotten but was not having any respiratory distress. Review of Resident #53's comprehensive care plan failed to indicate he/she was independent with managing nasal cannula oxygen tubing between oxygen concentrator and portable oxygen tank until after the observation and interview was completed with Charge Nurse #3 and the surveyor. Review of Resident #53's medical record failed to indicate any Self-Administration of Medication assessments were completed until after the observation and interview with Charge Nurse #3 and the surveyor. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/25 at 9:47 A.M., Nurse #1 said Resident #53 utilizes continuous Oxygen via nasal cannula tubing everyday secondary to his/her diagnosis of COPD. Nurse #1 said Resident #53 has no issues with changing nasal cannula oxygen tubing between the oxygen concentrator and portable oxygen tank and is able to do it independently. Nurse #1 said there is no formal assessment completed to determine Resident #53's independent management of oxygen. During an interview on 3/26/25 at 9:49 A.M., Charge Nurse #3 said supplemental Oxygen was not considered a medication. Charge Nurse #3 said no assessments were completed on admission to indicate Resident #53 was safe to independently manage his/her oxygen use. Charge Nurse #3 said she was not sure if the Self-Administration of Medication assessment needed to be completed after the observations made on 3/24/25, but she did it in case. Charge Nurse #3 said she also updated the comprehensive care plan for Resident #53 after the observation on 3/24/25 but did not think his/her independent management of oxygen previously needed to be documented in the care plan. During an interview on 3/26/25 at 11:36 A.M., the Director of Nursing (DON) said her expectation was for a Self-Administration of Medication assessment to be completed prior to allowing a resident to independently manage his/her oxygen. The DON said without the assessment there was no way to ensure a resident would safely be able to manage his/her oxygen independently. The DON said the comprehensive care plan should also reflect the resident's independence with oxygen management.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, the facility failed to ensure residents were aware of and had access to grievance forms, and were aware they could formulate grievances anonymously, should they choose not to alert a staff member of their concern(s). Findings include: Review of the facility's policy titled Grievance/Complaints, Filing, last revised April 2017, indicated but was not limited to: -Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g. the State Ombudsman). -A copy of our grievance/complaint procedure is posted on the resident bulletin board. -Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. On 3/25/25 at 10:30 A.M., the surveyor held a resident group meeting with 12 residents, representing two of the facility's three units, in attendance. Nine of 12 residents who actively participated in the group said they have not seen any postings about the grievance process and do not know how to file a grievance except for telling a staff member about a problem. The residents said they were not aware of the availability of grievance forms or that they could file a grievance anonymously. One resident said they don't want to be known as a complainer or be identified, so he/she does not tell any staff if he/she has a grievance or concern. On 3/26/25 at 10:28 A.M., the surveyor toured all three units in the facility and was unable to locate any postings about the grievance process or grievance forms as follows: -Mayfair Unit. A copy of the grievance/complaint procedure was not posted on the resident bulletin board. A wall mounted plastic document holder was noted on the wall outside the unit dining/day room labeled Grievance Forms. The holder had a clipboard with a resident census list attached to it. No grievance forms were found on the unit. -Windsor Unit. A copy of the grievance/complaint procedure was not posted on the resident bulletin board and no grievance/complaint forms were found on the unit. -[NAME] Unit. A copy of the grievance/complaint procedure was not posted on the resident bulletin board. A wall mounted plastic document holder had a clipboard with several dining menus in it, but no grievance forms were found on the unit. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/25 at 10:50 A.M., the Social Worker said she was not aware that that residents could file a grievance anonymously and they have no process in place for residents to remain anonymous. She said information about the grievance process and grievance/complaint forms should be available on all the units. The Social Worker and surveyor toured the facility's three units. The Social Worker said there was neither information about the grievance process posted on the units, nor any grievances/complaint forms available on any of the units for residents or their representatives to file a grievance. During an interview on 3/26/25 at 11:30 A.M., the Administrator said there is no information about the grievance process and grievance forms on any of the units. He said there also needs to be a process in place for residents to file grievances anonymously.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on observation, interview, and record review, the facility failed to ensure a person-centered individualized comprehensive care plan was developed and implemented for one Resident (#4), in a total sample of 22 residents. Specifically, the facility failed for Resident #4, to: A. individualize their pain care plan with a Resident stated goal and individualized interventions that were in use, offered or attempted and failed in attempts to manage the Resident's actual pain; and B. develop and implement a person-centered care plan with non-pharmacological individualized interventions and targeted behaviors to help manage the Resident's ongoing psychiatric issues including anxiety, delusions, and weepiness. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated but was not limited to the following: - a comprehensive, person-centered care plan that includes measurable objectives to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident - care plan interventions are derived through analysis of the information gathered as part of a comprehensive assessment and are only chosen after gathering data, careful consideration of the relationship between the resident's problems and their causes and relevant clinical decision making - the person-centered care plan includes measurable objectives, describes services to be furnished and services the resident chooses to refuse or decline, resident stated goals, will build on the resident's strengths, and reflect recognized standards of practice for problems - when possible interventions address underlying problems not just symptoms or triggers Resident #4 was admitted to the facility in September 2022 and had diagnoses including: Pain in the right shoulder, complete rotator cuff tear or rupture of the right shoulder, lower back pain, Alzheimer's disease, psychotic disturbance, major depressive disorder, delusional disorder, and anxiety disorder. Review of the Minimum Data Set, dated dated [DATE], indicated the Resident was moderately cognitively impaired with a Brief Interview for Mental Status score of 10 out of 15, and suffers from mild pain. Behaviors include: inattention, wandering, rejection of care, verbal outbursts directed at others, other behaviors not directed towards others and the Resident has a PHQ-9 (test to determine severity of depression symptoms) score of 2 out of 27, indicating no depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. During an interview on 3/25/25 at 9:24 A.M., Resident #4 said he/she has pain all the time in his/her right shoulder and cannot recall a time when he/she was not at least uncomfortable. The Resident said their pain goal is to have no pain and remain consistently at a zero on a 0-10 verbal numeric pain scale. The Resident said the staff do provide medicine which does help manage the pain. During an interview on 3/25/25 at 9:31 A.M., Nurse #2 said he provided the Resident with a dose of Ibuprofen (an over-the-counter medication used to manage minor aches and pains) at approximately 9:11 A. M. for a complaint of right shoulder discomfort that the Resident did not provide a pain scale score for. He said the Resident has pain in the right shoulder related to an old torn rotator cuff and repair that occurred prior to their admission to the facility. He said the Resident does not always provide the staff a rating prior to receiving their medications and has had many different interventions in place to assist with the pain management including: numerous bouts of rehab, Activeice (a cold therapy gel pack pain management system), pain clinic referrals, and pain shots with the pain specialist and orthopedic follow up, but the Resident may not currently have all of those interventions in place because of ineffectiveness or family request. Review of the medical record for Resident #4 indicated, but was not limited to the following: - Orthopedic referral sheet: appointment on 1/22/25 was not completed and the Resident did not receive treatment as planned on this day for their pain - Pain Specialist referral notes: 12/4/24: Chronic severe right shoulder pain, lower back pain stable with intrathecal pump, schedule right shoulder suprascapular nerve ablation (a procedure to inject an anesthetic to temporarily block pain signals in the nerves) with sedation and 12/12/24: Resident is s/p Suprascapular nerve block - Nursing progress notes: 1/22/25: family cannot attend appointments and requests facility discontinue all future scheduled orthopedic appointments; and 2/20/25 family request to discontinue all orthopedic follow up for right shoulder injections, pain clinic only as needed, next pain pump refill 3/31/25 During an interview on 3/26/25 at 11:40 A.M., the Resident and their spouse said the Resident has chronic pain. The Resident said their pain goal is zero on the 0-10 pain scale and does not know how the facility is helping him/her reach that goal. The spouse said they are not aware of the current plans for pain management and is not sure what can be done but does state the Resident has seen numerous specialists and believes they have had rehab help as well but couldn't say what interventions other than medications are effective or in place or what has been tried and ineffective in the past. The Resident said it would be good to know what's been done to determine what can be done to get to their goal or consider adjusting their goal, the Resident said the pain is always there but not always horrible. Review of the current care plans for Resident #4 that included pain information and were reviewed and revised on 2/3/25, indicated but were not limited to the following: PROBLEM: Activities of daily living (ADLs) Functional Status: Potential for pain related to (r/t) status post (s/p) right shoulder arthroscopy, s/p rotator cuff repair, arthritis (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GOAL: Resident will be free from signs and symptoms of discomfort as evidence by a decrease of complaints of discomfort for 90 days INTERVENTIONS: Assess need for pain medication(s) (meds); reposition as needed, identify precipitating factors; consult with MD or Nurse practitioner (NP) as needed (PRN); monitor for verbal and non-verbal signs and symptoms of pain (facial grimacing, guarding, moaning); complete pain assessments per policy; meds as ordered (a/o): ibuprofen, gabapentin, diclofenac, acetaminophen, percocet, dilaudid pain pump PROBLEM: Resident has a dilaudid (narcotic pain medication) pump for pain r/t osteoarthritis, low back pain and spinal stenosis. GOAL: Resident will have pain relief INTERVENTION: Serial # of pump: NGV736297H; Resident is followed at the pain clinic for pump refills and management The care plans failed to indicate the Resident has actual chronic and ongoing pain or any non-medicinal interventions that are in use or have been attempted and failed in the past. During an interview on 3/27/25 at 8:04 A.M., Nurse #4 said the Resident sees or has seen numerous specialists for his/her pain and has attempted many interventions that have been ineffective. She said those interventions should be documented on the care plan to demonstrate all the attempted ways the facility has attempted to manage the Resident's ongoing chronic pain. She reviewed the pain care plans and said the care plans indicate the Resident has potential for pain, but the Resident has actual chronic and ongoing pain and the care plans do not have a measurable goal or include the Resident's personal pain goal. She said none of the numerous interventions that have been tried and failed in the past are indicated on the plan and the care plan should be more individualized to tell the whole story of the Resident's pain and best ways to assist in managing the Resident's pain and they currently appeared canned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/25 at 8:16 A.M., Unit Manager (UM) #3 said the Resident had actual chronic and ongoing pain that is difficult to manage and the care plan is not specific to this and alludes to just a potential to pain. She said the facility had consulted numerous specialists, attempted skilled rehab services numerous times and have attempted numerous other interventions for the Resident including pain injections, nerve blocks, and Activeice in addition to others and they have not all been effective. In addition, she said there are some interventions that the family has decided to discontinue at this time as well and those interventions, in addition to all the failed interventions should be on the Resident's care plan to demonstrate all the effort to help effectively manage the Resident's pain. She said the goal is for relief of pain but does not include the Resident's measurable individual pain goal or any barriers to reaching those goals that may exist. She said the care plan does not tell the whole story and does not indicate what doesn't work or has been declined so the team knows what else may be attempted and the care plan requires updating to be more person-centered. During an interview on 3/27/25 at 11:08 A.M., the Director of Nurses (DON) said the Resident has a long history of actual pain that is chronic and has been challenging to manage. She said the care plans should tell the full story of the Resident and include that the pain is actual and not potential and any interventions that have been offered and declined, ineffective, or currently in place to assist the Resident in reaching his/her individual goals and at this time the care plan is more generic and would require some updating. B. Review of the behavior monitoring on Resident #4's Medication & Treatment Administration Records (MAR/TAR) indicated but was not limited to the following: Findings of any and all behaviors on every shift: January 2025: -12 documented episodes of behaviors out of a possible 93 opportunities -Behaviors included: anxiousness, weepiness, demanding behavior, accusatory, wandering, screaming at staff, and other unspecified behaviors not directed toward others -Standard templated interventions are available on the TAR and were documented on all occasions in addition to seven instances of an as needed (PRN) Ativan (anti-anxiety medication) February 2025: -5 documented episodes of behaviors out of a possible 84 opportunities -Behaviors included: anxiousness, weepiness, physical agitation, verbal behavior towards others, and other unspecified behaviors not directed toward others -Standard templated interventions are available on the TAR and were documented on all occasions in addition to six instances of an as needed (PRN) Ativan (anti-anxiety medication) March 2025: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9 documented episodes of behaviors out of a possible 75 opportunities -Behaviors included: wandering, verbal behavior towards others, and other unspecified behaviors not directed toward others -Standard templated interventions are available on the TAR and were documented on all occasions in addition to two instances of an as needed (PRN) Ativan (anti-anxiety medication) Review of the Psychiatric consult notes for Resident #4 indicated but were not limited to the following: 1/23/25: Behaviors addressed included: anxiety, weepy, loud, difficult to redirect, restlessness, pacing back and forth, delusional at times with paranoia, crying spells, excessive worry, motor restlessness is associated with the anxiety. Plan is to utilize behavior interventions prior to PRN. 2/17/25: Behaviors addressed included: wandering back and forth, screaming to get dressed, progressively worsening anxiety, motor restlessness with anxiety, some delusional thinking, verbally aggressive behaviors. Plan is to utilize behavior interventions prior to PRN. 3/12/25: Behaviors addressed included: restless anxiety and sleep disturbance. Plan is for medication changes. 3/19/25: Behaviors addressed included: agitation and difficulty falling asleep. Plan is continue medications and monitor. During an interview on 3/26/25 at 11:13 A.M., Certified Nurse Aide (CNA) #2 said Resident #4 does have some behaviors which typically don't start until after lunch. She said the Resident will become anxious and look for his/her spouse or attempt to get in touch with his/her son. She said she finds the Resident to be easily redirected with a snack and some distraction. She said the Resident's favorite thing is to sit by the hall window in the dayroom by themselves at their own table. During an interview on 3/26/25 at 11:35 A.M., CNA #3 said the Resident is anxious and restless and paces the halls usually looking for something like a pair of pants he/she likes or his/her spouse. She said the Resident mostly expresses some type of anxiety and will be fidgety until that is resolved or he/she is distracted from it in some way. She said she finds the Resident to have a good relationship with her and she can distract him/her with a snack and conversation about a different topic. Review of the current care plans for Resident #4 that included information on mood, behavior or psychosocial well-being and were reviewed and revised on 2/3/25, indicated but were not limited to the following: PROBLEM: Psychosocial well-being PROBLEM: Resident receives antipsychotic medications r/t psychotic disorder (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neither of these care plans provide any information on the Resident's targeted behavior for the medication use or non-medicinal interventions PROBLEM: Cognitive impairment r/t Alzheimer's/Dementia, episodes of behavior INTERVENTION: Use short direct phrases; attempt to capture Resident's attention when speaking with them and attempt eye contact; speak clearly with direct request; when making requests encourage Resident to respond with simple yes/no answers; observe and assess body language; approach in a gentle positive manner; assist to activities of choice; monitor for decline in cognition; provide calm therapeutic environment; psych and social service support PRN PROBLEM: Psychotropic medication use r/t anxiety, depression, psychotic disorder INTERVENTIONS: Allow time for Resident to express thoughts and feelings; educate on medications and possible interventions; encourage activity attendance PROBLEM: Mood State: Mood/Psychosocial/Disorders and Behaviors r/t anxiety, yelling out with confusion, depression, insomnia, sundown behaviors, paranoia, forgetful, delusional disorder, can hyper-focus on physiological status, weepy, agitated, anxious on evening shift and related to familial relationships INTERVENTIONS: Takes pride in their appearance and responds well to support; redirect to strengths and positive aspects; psych PRN; document signs and symptoms of depression/anxiety; encourage socialization; remind and escort to activities of choice; review positive impacts of long-term care placement as it relates to his/her clinical and functional needs The medication care plans fail to indicate targeted behaviors for the medication use and the mood care plan fails to indicate the Resident's preference of seating and distraction in the dayroom or any other additional individualized interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/25 at 8:04 A.M., Nurse #4 said the Resident has behaviors that include pacing, attention seeking, searching for family or items and these seem to be related to his/her anxiety. She said contacting the Resident's spouse or the spouse visiting are good interventions as well as bringing the Resident to their preferred seat in the dayroom by the window to people watch. She said she feels the Resident responds more positively to interventions by the CNAs and seems to just request medications from the Nurses. She reviewed the numerous care plans for the Resident and said they were canned and not specific to the Resident and they should be more individualized so unfamiliar staff could easily redirect and provide care to the Resident. During an interview on 3/27/25 at 8:16 A.M., UM #3 said Resident #4 has a complicated psychiatric history and takes both antipsychotic and antianxiety medications and exhibits behaviors. She said the Resident will obsessively speak about events occurring with his/her children and assisting them and will seek out relatives or a particular piece of clothing. In addition, the Resident exhibits worry or paranoia when he/she has pain which is what complicates their situation. She said the Resident does very well with sitting in a particular location in the dayroom when he/she is paranoid or anxious and likes to people watch. In addition, she said the Resident also responds better to certain people he/she feels most comfortable with as can be easily redirected by them. She reviewed the care plans and said they were the templated care plans in the system and the interventions are not anything they would not provide to every resident on the unit. She said the resident-specific information for interventions and targeted behaviors were not added as they should have been and they don't provide a good reflection of the Resident's needs to unknown staff. During an interview on 3/27/25 at 11:08 A.M., the DON said the Resident has a complex history related to their psychopharmacology and psychiatric and clinical needs. She said the facility has done a significant amount of coordinating with the family and psych services to attempt to ease the Resident's anxiety and anxious behaviors that go beyond their medication use and changes. She said the care plan is generic and does not identify the Resident specific interventions or reasons for those interventions as it should to tell the whole story.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34145 Based on record review and interviews, the facility failed to update and revise the dietary care plan for one Resident (#64), out of a sample of 22 residents. Specifically, the facility failed to revise the care plan after being informed by the Resident's family that he/she was no longer considered to have an inability to digest gluten (a protein naturally found in some grains including wheat, barley, and rye). Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised March 2022, indicated but was not limited to: -The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment. Resident #64 was admitted to the facility in May 2024 and had diagnoses including irritable bowel syndrome (IBS) with constipation, gastroesophageal reflux disease (GERD), and lactose intolerance. Review of the comprehensive Minimum Data Set assessment, dated 5/29/24, indicated Resident #64 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 2 out of 15, was dependent for all activities of daily living, received a therapeutic diet and had an activated Health Care Proxy (health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #64 had a diet order for a regular diet. Review of comprehensive care plans indicated, but was not limited to: -Problem: Impaired nutrient metabolism related to inability to digest gluten (5/22/24) -Approach: Diet as ordered-gluten free; honor preferences within diet; offer menu selection; monitor intake (5/22/24) -Goal: Minimize gastrointestinal distress (target date: 5/19/25) Review of Care Conference Reports indicated care plan reviews were conducted on 5/24/24, 6/10/24, 9/12/24, 12/12/24 and 3/13/25. Review of the 9/12/24 care conference report included, but was not limited to: -Attendees: Social Worker, Charge Nurse #2 and Activity Director). Per conversation with Health Care Proxy in July 2024, Resident remains on a house regular diet/unrestricted from gluten and lactose. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the Resident's care plans failed to indicate the care plan was revised to reflect notification from Resident #64's family that he/she was unrestricted from gluten as of July 2024. During an interview on 3/26/25 at 12:58 P.M., Charge Nurse #2 reviewed Resident #64's medical record and said she was not aware that Resident #64 had gluten intolerance. She reviewed the comprehensive care plans and said she now remembers the Resident's family saying the Resident was eating a gluten free diet prior to admission to the facility but could not remember when the gluten free diet was discontinued. She said the care plan for gluten intolerance and a gluten free diet should have been edited/removed from the care plan at the first care plan meeting. During an interview on 3/26/25 at 1:02 P.M., Resident Representative #1 said Resident #64 ate a gluten free diet while living in the community and never ate a gluten free diet at the facility. During a telephone interview on 3/26/25 at 2:05 P.M., the Dietitian said she spoke to the HCP in July 2024 and was told the Resident was not to have a gluten restricted diet. She said it was an oversight, and the care plan should have been updated at that time (eight months ago).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42742 Based on record review and interview, the facility failed for three Residents (#8, #32, and #97), out of a total sample of 22 residents, to ensure that each resident's drug regimen was free from unnecessary psychotropic medications. Specifically, the facility failed: 1. For Resident #8, to ensure a sufficient documented rationale was in place for the ongoing extended use of as needed (PRN) psychotropic medications including clonazepam (anti-anxiety medication) and triazolam (benzodiazepine - sedative, treats insomnia and anxiety); 2. For Resident #32, to ensure PRN use of Seroquel (antipsychotic) was limited to 14 days and the prescriber documented an evaluation of the Resident's current condition and the appropriateness to continue the use of PRN Seroquel and the rationale, benefit, duration and response to treatment; and 3. For Resident #97, to ensure the prescriber documented an evaluation of the Resident's current condition and the appropriateness to continue the use of PRN Seroquel and the rationale, benefit, duration and response to treatment. Findings include: Review of the facility's policy titled Use of Psychotropic Medications, dated 2025, indicated but was not limited to the following: Policy: Policy Explanation and Compliance Guidelines: -A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. -Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed , and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). -Psychotropic medications used on a PRN (as needed) basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. PRN orders for antipsychotic medications only shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. 1. Resident #8 was admitted to the facility in February 2025 with diagnoses including altered mental status, bipolar disorder, major depressive disorder, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident #8 received antianxiety medications and exhibited mood symptoms. The MDS indicated the Resident did not exhibit any behavioral symptoms. Review of current Physician's Orders indicated the following: -clonazepam (Klonopin) - Schedule IV (controlled substance with low potential for abuse and low risk of dependence) tablet; 0.5 milligrams (mg); amt: 1 tab = 0.5 mg; oral once a day- prn, special instructions: as needed for anxiety, re-eval on or before 6/11/25, order date 3/11/25 -triazolam - Schedule IV tablet; 0.125 mg; amt: 1 tab = 0.125 mg; oral at bedtime - PRN, special instructions: as needed at bedtime for sleep, re-eval on or before 6/11/25, order date 3/11/25 Review of the February 2025 through March 2025 Medication Administration Records (MARs) indicated the following uses of PRN clonazepam and triazolam: February 2025: -administered PRN clonazepam one time only on 2/26/25 -no behaviors, no side effects noted March 2025: -administered PRN clonazepam on 3/1/25, 3/5/25, and 3/15/25 -administered triazolam PRN on 3/13, 3/15, 3/16, 3/19, 3/21, 3/22, 3/23, 3/24, and 3/25 -no behaviors, no side effects noted During an interview on 3/26/25 at 10:00 A.M., Resident #8 denied any adverse events but said he/she has anxiety typically in the afternoon and takes medication for it as needed. Review of a Nursing Progress Note, dated 3/11/25, indicated but was not limited to the following: -May DC (discontinue) hydroxyzine d/t (due to) nonuse and continue PRN clonazepam (for anxiety) and PRN triazolam (for sleep) x 90 days per Nurse Practitioner (NP) Review of an NP Visit Note, dated 3/11/25, indicated but was not limited to the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	History of Present Illness: -Patient was seen today at the request of nursing staff for anxiety. Patient on Atarax, Klonopin, and Triazolam. Patient has no acute distress and is cooperative with today's assessment. I will review the MAR/Med regimen and current poc (plan of care) and discuss this with nursing staff. ROS otherwise negative other than noted above. Plan: -Medications were reviewed. D/C Atarax. Continue other meds and re-eval in 90 days. Further review of the medical record failed to indicate sufficient documentation that a rationale was in place for the ongoing extended 90-day use of the as needed psychotropic medications including a risk versus benefit rationale or any indication if the medications were still necessary for the Resident. During an interview on 3/27/25 at 8:44 A.M., the surveyor reviewed the medical record with Unit Manager (UM) #1 who said the Resident has a history of bipolar disorder, anxiety, and depression and takes clonazepam and triazolam for anxiety. She said the Resident is well managed without any adverse events. She said the Resident was admitted with PRN use of the medications and had a re-eval on 3/11/25 by the NP who extended the PRN use of the medications for another 90 days. She said during a re-eval they check things such as usage, any increase in anxiety, and will have a discussion with the Resident to see if they're agreeable to continued use. UM #1 said there should also be a conversation about symptoms to see if the medications should be continued. Upon review of the nurse's and NP progress notes, she said they did not indicate a clinical rationale for continued use and did not mention if the Resident had experienced any adverse events or side effects. She said there wasn't sufficient documentation of a rationale for extended use and said the information was not added. During an interview on 3/27/25 at 9:32 A.M., the NP said she re-evaluated the Resident for extended PRN psychotropic med use and said as part of a re-eval, she speaks to nursing staff and the patient to determine if the medications are helping them and if they took them at home. She said she assesses side effects or any adverse events and looks to see how often the medications are being used, whether it be only a couple of times or on occasion and will ask the Resident if they would like to keep them in place. She said if so then she will and will do another re-eval. The NP said her visit note is template based, and she did not elaborate on these things in the note but should have. The NP said when she evaluates a medication, she just asks questions such as if they're having side effects but did not include those things in her note. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 10:15 A.M., the surveyor reviewed the medical record with the Director of Nursing (DON) who said the process for psychotropic medication PRN extended use is to start with a 14-day dose, then re-eval on day 14 for extended use for all psychotropic medications. She said after that, it could be extended for 14 days, 30 days, or 90 days depending on the provider. The DON said on the re-eval the provider gets a report from nursing on what's happening with the resident and a decision is made to extend out where an order is then given. She said documentation of the evaluation should include the reasons why they are continuing the medications and the symptoms that go along with their reasoning. The DON said the continuation should list the name of each medication separately, but they do not always do it that way. She said they also document behaviors and adverse side effects. The DON said nursing is doing their piece to ensure doctors are evaluating the medications, but they could be more thorough. She said documentation of the re-eval is very important to support the PRN medication being extended. She said there was no sufficient documentation of a rationale for Resident #8's extended use of the PRN psychotropic medications and said, it's not there. 34145 2. Resident #32 was admitted to the facility in September 2022 with diagnoses including vascular dementia, psychotic disturbance, mood disturbance, and anxiety. Review of the MDS assessment, dated 2/13/25, indicated Resident #32 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, received antipsychotic and antidepressant medications daily and exhibited verbal behaviors toward others and behavioral symptoms not directed toward others. Review of current Physician's Orders indicated but was not limited to: -Seroquel 25 mg; once a day PRN; special instructions: severe agitation/anxiety (2/28/25 - 3/14/25) -Seroquel 25 mg at bedtime (3/8/24) -Seroquel 25 mg; give 12.5 mg once a day (4/3/24) -Seroquel 25 mg; give three half tabs=37.5 mg once a day (11/15/24) -Re-evaluate the use of psychotropic medication (Seroquel) and obtain MD/NP progress note with appropriateness, rationale, and duration. Confirm MD/NP progress note with continued appropriateness, rationale, and duration Further review of the medical record indicated the orders for Seroquel 25 mg once a day PRN for severe agitation/anxiety was initiated on 2/22/24 and renewed every 14 days by the prescriber through 4/8/24. On 4/8/24, the order was extended to 7/8/24, a 91-day duration and not limited to 14 days as required. On 7/8/24, the order was extended to 8/30/24, a 53-day duration for a total duration of 144 days and not limited to 14 days as required. On 8/30/24, the prescriber resumed the PRN order for Seroquel 25 mg once a day every 14 days through 3/28/25. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's and NP's progress notes failed to indicate the prescriber assessed and documented in the medical record an evaluation of the Resident's current condition and the appropriateness to continue the use of PRN Seroquel and the rationale, benefit, duration, and response to treatment. During an interview on 3/26/25 at 1:13 P.M., Charge Nurse #2 said Resident #32's order is a reminder for nursing to remind the MD/NP to document their review of the antipsychotic medication in their notes. She said nursing does not confirm it is done; they just remind them to do their evaluation. Charge Nurse #2 said the MD/NPs don't always do it and they need to make sure it's done. During telephone interviews on 3/27/25 at 9:32 A.M. and 3/28/25 at 11:38 A.M., NP #1 said when she reviews Resident #32's psychotropic medications, she speaks with staff and asks if the medications are effective. The surveyor reviewed the NP's progress notes and orders for PRN Seroquel with her and she said her documentation should include more information. She said the notes she uses on the computer are template-based and carry forward each time. She said her assessment and documentation needs to include a clinical rationale, specify which medication order is being reviewed, targeted symptoms and potential adverse effects for its use. The NP said she was not aware of the regulation that PRN antipsychotic medication orders had to be limited to 14 days and could only be extended for another 14 days after evaluating the resident to determine if it is appropriate to extend the order. 3. Resident #97 was admitted to the facility in June 2023 and had diagnoses including dementia with behavioral disturbance, depression, anxiety disorder, restlessness, and agitation and visual hallucinations. Review of the MDS assessment, dated 3/20/25, indicated Resident #97 was unable to complete the BIMS assessment, had severely impaired cognitive skills for daily decision making, received antipsychotic and antidepressant medications daily and exhibited verbal behaviors toward others and behavioral symptoms not directed toward others. Review of current Physician's Orders indicated but was not limited to: -Seroquel 25 mg; once a day PRN; special instructions: aggressive behaviors (2/14/24 - 2/28/25) -Seroquel 50 mg at bedtime (8/22/24) -Seroquel 25 mg twice a day (8/29/24) -Re-evaluate the use of psychotropic medication (Seroquel) and obtain MD/NP progress note with appropriateness, rationale and duration. Confirm MD/NP progress note with continued appropriateness, rationale, and duration Further review of the medical record indicated the orders for Seroquel 25 mg once a day PRN for severe agitation/anxiety was initiated on 8/22/24 and renewed every 14 days by the prescriber through 3/28/25 which would require MD/NP evaluation and documentation on 14 occasions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's and NP's progress notes failed to indicate the prescriber assessed and documented in the medical record an evaluation of the Resident's current condition and the appropriateness to continue the use of PRN Seroquel and the rationale, benefit, duration and response to treatment on 13 of 14 occasions in which the PRN Seroquel was renewed for 14 days. During an interview on 3/27/25 at 10:15 A.M., the DON reviewed Resident #32 and Resident #97's physician's orders for PRN Seroquel with the surveyor. She said when a resident is prescribed a PRN antipsychotic, it should be for no longer than a 14-day duration and then be reviewed by the Physician or NP to extend it if needed. She said nursing reminds the Physicians and NPs to review the PRN medications and document it, but said would probably find that there are no notes or notes that don't include adequate documentation of clinical rationale and other required information for continuation of psychotropic medications.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 48695 Based on interviews and review of the Health Care Facility Reporting System (HCFRS- State agency reporting system), the facility failed to provide written notice to the State agency when a change in the facility's Director of Nurses (DON) occurred. Findings include: During an interview on 3/24/25 at 8:05 A.M., the DON said that she started working at the facility as the DON in July 2023. Review of HCFRS indicated the last time the State was notified of a DON change for the facility was 6/23/21. Further review of HCFRS failed to indicate the State Agency was notified when the change took place for the current DON. During an interview on 3/26/25 at 2:27 P.M., the Administrator reviewed HCFRS and said the last time the DON information was updated for the facility was on 6/23/21. The Administrator said the DON had started at the facility in July of 2023 as an interim DON. The Administrator said he thought the information had been updated, but it had not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43935 Based on document review and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Specifically, the facility failed to: 1. Maintain an accurate surveillance system that reflected potential illnesses and infections in the facility and calculate an accurate facility infection attack rate in accordance with their pre-defined McGeer criteria; 2A. Ensure personal protective equipment (PPE) was used properly by staff while cleaning an isolation room with Contact precautions in place for Resident #360; and B. Ensure staff wore the appropriate PPE while providing care for Resident #34, who was on droplet precautions, to prevent the potential spread of infection. Findings include: 1. Review of the facility's policy titled Infection Prevention and Control Programs, dated as reviewed 2/5/25, indicated but was not limited to the following: SURVEILLANCE: - a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services a contractual arrangement based upon facility assessment and accepted national standards - the Infection Preventionist (IP) serves as the leader in surveillance activities and maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility Quality assessment and assurance committee - RNs and LPNs participate in surveillance through assessment of the residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes an in-house reporting of communicable diseases and infections Review of the facility's policy titled Infection Surveillance, dated as revised 5/29/24, indicated but was not limited to the following: A system of infection surveillance serves as a core activity in the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. - McGeer criteria or other nationally recognized surveillance criteria will be used to define infections (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- surveillance activities will be monitored facility-wide, and may be broken down by department or unit, depending on measures observed. A combination of process and outcome measures will be utilized - the facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying by identifying: data to be collected, infection site, pathogen (if possible), signs and symptoms, resident location, including a summary and analysis of number of residents who develop infections, observations of staff, and identification of unusual or unexpected outcomes infection trends or patterns - monthly time periods will be used for capturing and reporting data; line charts will be used to show data comparisons over time and will be monitored for trends - formulas used to calculate infection rates will remain constant for a minimum of one calendar year During an interview on 3/25/25 at 4:24 P.M., the Director of Nurses (DON) said the facility IP is on vacation and unavailable and she will speak to the facility infection control practices, in addition she said the facility uses McGeer criteria to define an infection. Review of the key in use by the facility indicated but was not limited to the following: Categories: UTI (Urinary tract infection); NTM/URI (nose, throat, mouth/upper respiratory infection); PNU (pneumonia); LRI (lower respiratory infection); GI (gastrointestinal infection) Review of the McGeer criteria in use by the facility indicated, but was not limited to the following: Syndrome: Urinary tract infection (UTI) Must fulfill both 1 and 2 criteria 1. At least one of the following sign or symptoms: -Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate -Fever or leukocytosis (a high level of white blood cells), and one or more of the following: -Acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency or frequency. -If no fever or leukocytosis, then two or more of the following: -Suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency and frequency. 2. At least one of the following microbiologic criteria - greater than or equal to 50,000 count of no more than two species of organisms in a voided urine sample, OR (continued on next page)

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	225518	A. Building B. Wing	03/27/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- greater than or equal to 20,000 count of any organism(s) in a specimen collected by an in-and-out catheterization Syndrome: Common cold or pharyngitis Must fulfill at least 2 criteria -Runny nose or sneezing - Stuffy nose or congestion - Sore throat, hoarseness, or difficulty swallowing - Dry cough - Swollen or tender glands in the neck Syndrome: Gastroenteritis Must fulfill at least 1 criteria: - diarrhea: greater than or equal to 3 liquid stools above what is normal for the resident in 24 hours (hrs.) - vomiting: greater than or equal to 2 episodes in 24 hrs. - BOTH of the following signs and symptoms: positive specimen stool specimen and at least one criteria of diarrhea, vomiting, abdominal pain/tenderness, nausea Review of the facility Surveillance sheets indicated but were not limited to the following: December 2024: Resident #3, Category: resp; date of onset: 12/19; symptoms: increase congestion; results: sinusitis; final status: HAI (healthcare acquired illness); count: Yes Resident #92, Category: GU; date of onset: 12/4; symptoms: mental status change; culture: 12/6 results: Proteus; final status: HAI; count: Yes The December 2024 facility surveillance failed to identify an approved category for the syndrome/illness being monitored or to indicate an appropriate amount of symptom information to count the illness as an infection in their surveillance numbers in accordance with their pre-determined McGeer criteria, making the information inaccurate and potentially incomplete. January 2025: Resident #30, Category: GU; date of onset: 1/1; symptoms: frequency; culture: 1/2 results: E-coli; final status: HAI; count: Yes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90, Category: GU; date of onset: 1/4; symptoms: frequency; culture: 1/4 results: E-coli; final status: HAI; count: Yes The January 2025 facility surveillance failed to identify an approved category for the syndrome/illness being monitored or to indicate an appropriate amount of symptom information to count the illness as an infection in their surveillance numbers in accordance with their pre-determined McGeer criteria, making the information inaccurate and potentially incomplete. February 2025: The surveillance for February 2025 included a separate Acute Gastroenteritis Surveillance line listing that included 41 affected residents. Review of the document indicated 19 of the 41 monitored residents suffered from vomiting and diarrhea for over 48 hrs., and remained in the facility, no residents had stool specimens performed and no residents were counted as having an active infection in the facility attack rate and placed on the surveillance sheet that includes active infection attack counts (count: yes), even though they meet McGeer criteria for a gastroenteritis infection. During an interview on 3/27/25 at 10:48 A.M., the DON reviewed the surveillance and said the categories are not in line with the facility approved key or McGeer criteria and the documented symptoms on the surveillance sheets for Residents #3, #92, #30 and #90 did not reflect that the illness met McGeer criteria and the count should have been no and the sheets were inaccurate. Review of the February gastroenteritis and surveillance sheets indicated there were 19 residents who met criteria for gastroenteritis and should have been included in the facility infection rate and added to the surveillance for counted infections and were not. She said the February facility infection rate would be inaccurate based on this information and those infections should have been counted in the facility infection attack rate and were not. 48362 2. Review of the facility's policy titled Isolation- Categories of Transmission-Based Precautions, last revised September 2022, indicated but was not limited to: - Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet, and airborne. - When a person is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for the type of precautions. - The signage informs the staff of the type of the CDC (Centers for Disease Control and Prevention) precaution(s) PPE, instructions for use of PPE. -Contact Precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 10:20 A.M., the surveyor observed a contact precaution sign posted on the doorway entrance of Resident #360's room. Resident #360 was seated in a wheelchair with a bedside table in front of him/her, watching television. The surveyor observed Housekeeper #1 enter the room, begin cleaning including wiping down the bedside table in front of the Resident. Housekeeper #1 did not have a gown or gloves on prior to entering the room. At approximately 10:28 A.M., Charge Nurse #1 was observed knocking on the door and told Housekeeper #1 she needed to put on a gown and gloves prior to entering the room. Housekeeper #1 was then observed to exit the room and put on a gown and gloves before reentering. During an interview on 3/26/25 at 10:30 A.M., Housekeeper #1 said she looks for signage posted on the doorway entrance to determine if a room has a precaution. Housekeeper #1 said Resident #360's room did have signage posted on the doorway indicating precautions were required prior to entering the room. Housekeeper #1 said she should have put a gown and gloves on prior to entering and starting to clean. During an interview on 3/26/25 at 10:32 A.M., Charge Nurse #1 said Resident #360 was on contact precautions and required a gown and gloves to be put on before entering the room. Charge Nurse #1 said Housekeeper #1 should have put on a gown and gloves prior to entering the Resident's room. 48695 B. Resident #34 was admitted to the facility in February 2025. Review of Resident #34's current Physician's Orders indicated but was not limited to: - Maintain airborne isolation precautions every shift due to Influenza A infection (dated 3/22/25 to 3/24/25) - Maintain Droplet/Contact precautions every shift due to Influenza A infection, (dated 3/24/25) On 3/24/25 at 10:33 A.M., the surveyor observed that Resident #34 had an Isolation sign, undated, from the CDC posted outside his/her room, which indicated but was not limited to the following: - STOP ISOLATION DROPLET/CONTACT PRECAUTIONS - Staff and Providers MUST: - Clean hands: when entering and exiting - Gown - Mask - Eye protection - Gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/25 at 10:34 A.M., the surveyor observed the Unit Secretary in Resident #34's room. The Unit Secretary failed to don (put on) a gown, gloves, mask, and eye protection. On 3/24/25 at 12:25 P.M., the surveyor observed a Certified Nursing Assistant (CNA) don a gown, gloves, and mask and enter Resident #34's room. The CNA failed to don eye protection. On 3/24/25 at 12:37 P.M., the surveyor observed a CNA don a gown, gloves, and mask and enter Resident #34's room. The CNA failed to don eye protection. On 3/25/25 at 8:10 A.M., the surveyor observed a Nurse #7 don a gown, gloves, and mask and enter Resident #34's room. The Nurse failed to don eye protection. On 3/25/25 at 8:36 A.M., the surveyor observed CNA #1 don gloves, a gown, and mask and enter Resident #34's room. CNA #1 failed to don eye protection. On 3/25/25 at 11:49 A.M., the surveyor observed the Speech Language Pathologist (SLP) in Resident #34's room, wearing gloves, a gown, and mask. The SLP failed to don eye protection. On 3/25/25 at 2:39 P.M., the surveyor observed CNA #1 don a gown, gloves, and mask and enter Resident #34's room. CNA #1 failed to don eye protection. During an interview on 3/25/25 at 2:46 P.M., CNA #1 said Resident #34 was on precautions for Influenza A. CNA #1 and the surveyor reviewed the sign outside of Resident #34's room. CNA #1 said she should have donned eye protection but did not. During an interview on 3/25/25 at 3:00 P.M., the SLP said Resident was on precautions for Influenza A. The SLP said when she was in Resident #34's room she had not been wearing eye protection as indicated per the sign outside Resident #34's room. The SLP said she should have donned eye protection. During an interview on 3/25/25 at 3:08 P.M., the Unit Secretary said she had not donned a gown, gloves, mask, and eye protection when she entered Resident #34's room on 3/25/25. The Unit Secretary said she should have worn PPE but she did not. During an interview on 3/25/25 at 3:10 P.M., Charge Nurse #1 said Resident #34 was on isolation droplet precautions for Influenza A which required staff to wear eye protection, gloves, a mask, and a gown. Charge Nurse #1 said the expectation was for all staff to wear appropriate PPE every time they enter Resident #34's room. During an interview on 3/26/25 at 3:53 P.M., the DON said the expectation was for all staff to follow precautions and wear the appropriate PPE.