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	01/08/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was recovering from a recent right hip fracture and whose Plan of Care indicated that he/she required the use of chair and bed alarms for safety, the Facility failed to ensure nursing staff consistently implemented and followed interventions identified in his/her Plan of Care while meeting his/her care needs. On 12/25/24, Certified Nurse Aide (CNA) #1 transferred Resident #1 into bed but did not attach the alarm box to the bed alarm sensor pad. Resident #1 was found lying on the floor complaining of right hip pain. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and was diagnosed with a new right non-displaced greater trochanter fracture (upper part of the femur) which was inoperable. Findings include: Review of the Facility's Policy, titled Interdisciplinary Care Planning, dated as revised April 2024, indicated the following: -the facility will assess and analyze each resident's individual needs and provide effective person-centered care that meets professional standards of quality; -the Interdisciplinary process is performed by qualified medical professionals drawing from nursing, rehabilitation, social service, activities, dietetics, medical, and other consultative staff as deemed appropriate to promote continuity of care and communication among staff; -the care plan process is not limited to developing a written plan but also addresses the ongoing execution of care, treatment, and services that includes resident goals that are reasonable and measurable. Review of the Facility's Policy, titled Guidelines for the Use of Position Change Alarms, dated September 2018, indicated the following: (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 0689 Level of Harm - Actual harm Residents Affected - Few	-it is the policy of the facility to promote each resident's quality of life, ensure the highest practicable level of functioning and well-being and implement interventions to reduce and decrease risk of falls; -a position change alarm is an alerting device intended to monitor a resident's movement and emits an audible signal when the resident moves a certain way; -position change alarms included bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, infrared beam motion detectors, chair and bed sensor pads; -the position change alarm will be utilized when it is determined that the benefit of the alarm is greater than the risk and potential negative effect of using the alarm; -the individualized, resident-centered care plan and CNA Care Card will be updated to reflect this approach and the specific type of alarm to be utilized. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS) Report, dated 12/31/24, indicated that on 12/25/24 at approximately 6:45 P.M., a staff member notified the nurse that Resident #1 was on the floor in his/her room. The Report indicated that the nurse observed Resident #1 [on the floor] with his/her feet facing the foot of the bed, the bed alarm was not sounding, and he/she complained of right hip pain. The Report indicated that although the CNA (later identified as CNA #1) had a printed assignment sheet detailing Resident #1's safety interventions, which included a bed and chair alarm, the alarm was not attached. The Report indicated that the physician was notified and Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and treatment. The Report further indicated that an x-ray of Resident #1's right hip revealed he/she had a nondisplaced right great trochanteric hip fracture that was non-operative. Resident #1 was admitted to the Facility in September 2024 diagnoses included: displaced fracture of base of neck of right femur, cerebral infarction, hemiplegia (complete paralysis on one side) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting the right dominant side, type 2 diabetes mellitus, dementia, psychotic disturbance, mood disturbance and anxiety, unspecified macular degeneration, osteoporosis, osteoarthritis, atrial fibrillation and intervertebral disc degeneration. Review of Resident #1's Care Plan related to Fall Risk, dated 12/04/24, indicated that he/she required the use of a bed alarm while in bed and a chair alarm while in chair. Review of Resident #1's CNA Care Card, (reviewed and updated in conjunction with his/her plan of care), indicated that he/she required the use of a bed and chair alarm. Review of Resident #1's Significant Change Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 required maximal assistance of staff with transfers. Review of the Assignment Sheet provided to CNA #1 for Resident #1, dated 12/25/24, indicated that Resident #1 required the use of bed and chair alarms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 01/09/25 at 1:51 P.M., (which included review of his written witness statement), CNA #2 said that on 12/25//24, Resident #1's roommate yelled out for help and said that Resident #1 had fallen. CNA #2 said that he ran into Resident #1's room and saw him/her lying on the floor. CNA #2 said that he immediately called the nurse to notify her that Resident #1 was lying on the floor. CNA #2 said that Resident #1 required bed and chair alarms for safety and said that he was surprised that the bed alarm had not sounded. CNA #2 said that he noticed that the alarm box was still attached to Resident #1's wheelchair and that the alarm box needed to be moved to Resident #1's bed when he/she was transferred into bed. CNA #2 said that Resident #1's CNA Care Card also indicated that he/she required the use of bed and chair alarms. Review of a Nurse Progress Note, dated 12/25/24, (written by Nurse #1) indicated that Resident #1 was found lying on the floor beside the bed with his/her feet facing the foot of the bed, with facial grimacing noted. The Note indicated that the bed alarm was not sounding and that the alarm box was attached to alarm sensor pad on the wheelchair. The Note indicated that Resident #1 was transferred to the Hospital ED for evaluation. Review of the Hospital Discharge Summary, dated 12/26/24, indicated that Resident #1 had previously underwent a right hip hemiarthroplasty (surgical procedure that replaces the femoral head of the hip joint) on 11/28/24 for a displaced right femoral neck fracture. The Summary indicated that on 12/25/24 Resident #1 was brought to the Hospital ED after an unwitnessed fall, complaining of right hip pain. The Summary indicated that x-rays were obtained of the right hip and revealed a new right nondisplaced right greater trochanter fracture that is non-operative. During an interview on 01/08/25 at 3:10 P.M., (which included review of her written witness statement), Nurse #1 said that on 12/25/24, CNA #2 called her into Resident #1's room and she found Resident #1 lying on the floor complaining of right hip pain. Nurse #1 said that Resident #1 had recently undergone surgical repair of his/her right hip and required the use of bed and chair alarms for safety. Nurse #1 said that she noticed that the bed alarm was not sounding and that the alarm box was not attached to the bed alarm sensor pad but was still attached to the wheelchair sensor pad. Nurse #1 said that the CNA who was assigned to Resident #1 (later identified as CNA #1) told her that she was unaware that Resident #1 required the use of bed and chair alarms for safety. Nurse #1 said that Resident #1's assignment sheet [which was provided to CNA #1 at the start of the shift] and CNA Care Card clearly indicated that he/she required bed and chair alarms for safety. During a telephone interview on 01/08/25 at 1:15 P.M., (which included review of her written witness statement), CNA #1 (Agency CNA) said that on 12/25/24 she was assigned to provide care to Resident #1 and that he/she asked her to be transferred into bed. CNA #1 said that she transferred Resident #1 from the wheelchair into bed and said that no alarm sounded when he/she got up from the wheelchair. CNA #1 said that she did not transfer the alarm box from the wheelchair sensor pad to Resident #1's bed sensor pad and said she was not aware that Resident #1 required bed and chair alarms for safety. CNA #1 said she had two other residents on her assignment that day who required the use of bed and chair alarms, but could not recall where she obtained that information. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said that someone gave her a piece of paper at the beginning of the evening shift on 12/25/24, with a list of the residents on her assignment. CNA #1 said that she looked at the piece of paper but could not recall if the paper indicated if Resident #1 required bed and chair alarms for safety. CNA #1 said that she was unaware that Resident #1 had a CNA Care Card. CNA #1 said that no one told her that Resident #1 required the use of bed and chair alarms until after he/she fell out of bed. During a telephone interview on 01/09/25 at 2:44 P.M., CNA #3 (Senior CNA on Resident #1's unit) said that she worked the 7:00 A.M. to 3:00 P.M. shift on 12/25/24. CNA #3 said that it is the Facility's process for the Senior CNA to give a verbal report and do walking rounds with the next shift CNA's, CNA #3 said the process included reviewing the CNA Care Card and assignment sheet of each resident with the oncoming CNA, and identifying those residents who require the use of alarms, including bed and chair alarms. CNA #3 said that at the beginning of the shift, at approximately 3:00 P.M. on 12/25/24, she gave verbal report and did walking rounds with the 3:00 P.M. to 11:00 P.M. (evening) shift CNA's and reviewed the CNA Care Card, as well as the assignment sheets with each of them. CNA #3 said that she remembers specifically stating that Resident #1 required the use of bed and chair alarms when she gave report and again when she did walking rounds that day with the evening shift CNA's. During an interview on 01/08/25 at 3:26 P.M., the Director of Nurses (DON) said that Resident #1 required the use of bed and chair alarms. The DON said that Resident #1's CNA Care Card and Assignment Sheet clearly indicated that he/she required the use of both a bed and chair alarm. The DON said that CNA #1 was an experienced CNA, who had been educated and trained on the need to review the CNA Care Card and assignment sheet before caring for a resident. The DON said that CNA #1 should have moved the alarm box from the wheelchair sensor pad and attached it to the bed sensor pad when she transferred Resident #1 from the wheelchair into bed. The DON said that CNA #1 did not follow Resident #1's plan of care. On 01/08/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by: A. On 12/25/24, Resident #1 was assessed by the nurse and transferred to the hospital for evaluation. B. On 12/25/24, Nurse #1 re-educated CNA #1 on the need to review the CNA Care Card and CNA Assignment Sheet for care directives prior to caring for a resident. Nurse #1 also reviewed Resident #1's CNA Care Card with CNA #1 that clearly indicated that he/she required the use of bed and chair alarms. C. On 12/25/24, Nurse #1 re-educated the staff on alarm boxes and the proper placement of alarm boxes. D. On 12/26/24, a full house audit was conducted by the DON and Unit Managers of all residents who utilize any kind of alarm to ensure that all of the components, alarm box, bed sensor pad and chair sensor pads were in working condition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	E. On 12/26/24, the Charge Nurses re-educated Licensed Nursing Staff and CNA's on alarms to ensure that they are plugged into the box and functioning and to utilize the reset button instead of turning off the alarm when transferring residents. F. On 12/26/24, the DON initiated a Quality Assurance Performance Improvement Plan (QAPI) on ensuring that all alarms are functioning properly, to decrease the number of alarms and falls, increase evening activities and weekly alarm audits with the Unit Managers, Nursing Supervisors, Staff Development Coordinator and Charge Nurses. G. On 12/26/24, Resident #1's Care Plan and CNA Care Card were updated to include that he/she had separate alarm boxes for the bed and chair alarms and to keep frequently used items in close proximity to him/her. H. On 12/28/24, the Staff Development Coordinator re-educated Licensed Nursing Staff and CNA's on updating CNA Care Cards, that CNA's are required to review each residents Care Cards prior to providing care so they are aware of the resident's specific plan of care including safety interventions, adaptive equipment and Fall Prevention. I. On 01/03/25, the Senior CNA began weekly audits of all residents with alarms to ensure they have the correct alarms, the alarms are functioning and attached to the correct sensor pad, that all components are present and functioning. Audits will continue to be conducted weekly, as instructed by nursing. J. On 01/06/25, the Staff Development Coordinator re-educated Licensed Nursing Staff and CNA's on alarms and that they need to be checked at the start of each shift during walking rounds, check alarms for placement, function and to report any issues to the Nurse. K. Unit Managers and/or their Designee will conduct weekly audits x 90 days, on all residents with alarms to ensure that they are functioning properly, that all the components are present, the bed and chair sensors, and that the alarm box is not set to the OFF mode but set to the RESET mode. L. The results of the audits will be forwarded to the DON and Administrator, and will be brought to QAPI meeting quarterly x 3 or until the committee determines compliance. M. The Director of Nursing and/or Designee are responsible for overall compliance.