STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225284	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Harborside Healthcare	19 Obery Street Plymouth, MA 02360

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 - 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 - Actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents, (Resident #1) whose Plan of Care related to Activities of Daily living (ADLs) indicated that he/she required continual supervision (staff member to be with him/her during entire task) with meals, the facility failed to ensure that staff consistently implemented and followed his/her care plan interventions, when on 05/13/25, Resident #1 was served his/her breakfast tray, then left unsupervised in his/her room with his/her meal, he/she spilled a hot beverage on his/her upper legs, and sustained second-degree burns (partial thickness, involves both the outer (epidermis) and underlying layer (dermis) of skin, they cause pain, redness, swelling, and blistering) to the front side of his/her left thigh, which required treatment.Findings Include: Review of the Facility's Policy titled, Care Plans, Comprehensive Person-Centered, dated as revised 01/2024, indicated the following:-A comprehensive, person-centered care plan will be developed for each resident; the care plan will include objectives that meet the resident's physical, psychosocial and functional needs is developed for each resident.-The resident comprehensive care plan will identify problem areas, and their causes as warranted and developing interventions that are targeted and meaningful to the resident.-Evaluation of residents is ongoing and care plans are revised as information about the resident and the resident's condition changes. -The Interdisciplinary Team (IDT) reviews and updates the care plan when there has been a significant change in the resident's conditions, when there is a change and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment. Resident #1 was admitted to the Facility in August 2019, diagnoses included dementia, legal blindness, severe stage glaucoma right eye, muscle weakness, atrial fibrillation (irregular heartbeat) and hypertension. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, dated 05/02/25, indicated that he/she had severe cognitive impairment, and required supervision with touch assistance when eating.Review of Resident #1's ADL Deficit Care Plan, renewed and reviewed with his/her May 2025 MDS, indicated that he/she required continual supervision with meals. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/20/25, indicated that on 05/13/25, a Certified Nurse Aide (CNA) observed Resident #1 had spilled coffee on him/herself, he/she was washed, assisted back to bed, he/she did not complain of pain and there were no discolorations on his/her left thigh. The Report indicated that on 05/14/25 at approximately 8:00 A.M. while giving care to Resident #1 a CNA observed blisters on his/her left thigh and told the Nurse who was taking care of him/her. Review of Resident #1's Nurse Progress Note, dated 05/14/25, (written by the Unit Manager), indicated that at approximately 8:00 A.M. a CNA called this writer to Resident #1's room, where she observed three blisters on his/her thigh (left or right side not indicated). The Note indicated that while speaking to staff, they stated a CNA told them yesterday (05/13/25) that Resident #1 spilled coffee on him/herself. The Note further indicated that first aid was performed, the Nurse Practitioner (NP) was notified, and a new order was placed for Bactroban (topical antibiotic) ointment.During an interview on 08/05/25 at 1:10 P.M., (which included review of her written statement) CNA #1 said she worked the 7:00 A.M. to 3:00 P. M. shift on 05/13/25 and was assigned to provide care to Resident #1. CNA #1 said she has worked at the Facility for more than a year and said Resident #1 is on her assignment the days she works. CNA #1 said residents' care Kardex's are in Point Click Care (PCC, electronic medical record (EMR) system) under Point of Care (POC) and said she knew how to look at a resident's care Kardex.CNA #1 said Resident #1 was blind and required set-up with continual supervision for meals. CNA #1 said when she provided care for Resident #1 she would set-up Resident #1's meal tray, then leave to continue passing meal trays to other residents and then go back to Resident #1's room. CNA #1 said she could not remember if she gave Resident #1 his/her breakfast meal tray on 05/13/25, but said she might have. CNA #1 said she heard someone yell Ow, from Resident #1's room, ran to his/her room, saw Resident #1's coffee mug on the floor and that there was coffee on his/her upper pants area that was dripping onto the floor. CNA #1 said she asked Resident #1 what happened and he/she told her that his/her hand was shaking, and the cup slipped out of his/her hand. CNA #1 said Resident #1's meal tray was still in his/her room, and he/she was by him/herself that morning (05/13/25), with his/her meal tray.CNA #1 said she brought Resident #1 into the bathroom to wash and dress him/her and when she removed his/her pants she saw a dime size red spot on his/her left thigh. CNA #1 said that Resident #1 said, my legs feel very, very hot. CNA #1 said she put Resident #1 back into bed, then informed a nurse (thinks it was Nurse #2) that he/she had spilled hot coffee on him/herself and had a small red area on his/her left thigh During interviews throughout the day of the

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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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who required continual supervision (staff member to stay with resident during entire task) during meals, the Facility failed to ensure that he/she was provided with the necessary level of staff supervision during meals in an effort to prevent an incident resulting in an injury. On 05/13/25, Resident #1 was served his/her breakfast tray, left unsupervised in his/her room with his/her meal, spilled a hot beverage on his/her upper legs, and sustained second-degree burns (partial thickness, involves both the outer (epidermis) and underlying layer (dermis) of skin, they cause pain, redness, swelling, and blistering) to the front side of his/her left thigh and required daily treatment to the areas for around four weeks.Findings Include: Review of the Facility's Policy tilted, Activities of Daily Living (ADLs), Supporting, dated as revised 11/2024 indicated the following:-residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. -appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including appropriate support and assistance with: dining (meals and snacks). Resident #1 was admitted to the Facility in August 2019, diagnoses included Dementia, legal blindness, severe stage glaucoma right eye, muscle weakness, atrial fibrillation (irregular heartbeat) and hypertension. Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], indicated that he/she had severe cognitive impairment, and required supervision with touching assistance with eating.Review of Resident #1's ADL Deficit Care Plan, renewed and reviewed with his/her May 2025 MDS, indicated that he/she required continual supervision with meals.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/20/25, indicated that on 05/13/25 a Certified Nurse Aide (CNA) observed Resident #1 had spilled coffee on him/herself, he/she was washed, assisted back to bed, did not complain of pain and there were no discolorations on his/her left thigh. The Report indicated that on 05/14/25 at approximately 8:00 A.M. while giving care to Resident #1 a CNA observed blisters on his/her left thigh and told the Nurse who was taking care of him/her. The Report further indicated that Resident #1's Primary Care Provider (PCP) was notified, treatment was ordered for mupirocin (Bactroban) 2% ointment (a topical antibiotic used to treat and/or prevent bacterial skin infections) to the area three times a day.Review of Resident #1's Nurse Progress Note, dated 05/14/25, (written by the Unit Manager), indicated that at approximately 8:00 A.M. a CNA called this writer to Resident #1's room, where she observed three blisters on his/her thigh (left or right side not indicated). The Note indicated that while speaking to staff, they stated a CNA told them yesterday (05/13/25) Resident #1 spilled coffee on him/herself. The Note further indicated that first aid was performed, the Nurse Practitioner (NP) was notified, and a new order was placed for Bactroban (topical antibiotic) ointment.Review of Resident #1's Weekly Skin Evaluation, dated 05/14/25, indicated that Resident #1 had three blisters on the front of his/her left thigh, measuring 7.0 centimeters (cm) by 3.0 cm, 4.0 cm by 2.5 cm and 1.5 cm by 2.5 cm.During an interview on 08/05/25 at 2:24 P.M., CNA #3 said she worked the 7:00 A.M. to 3:00 P.M. shift on 05/13/25 and said she did not give Resident #1 his/her breakfast tray that morning. CNA #3 said the CNA that is assigned to Resident #1 would give his/her breakfast tray to him/her after getting him/her out of bed into his/her wheelchair.During an interview on 08/05/25 at 1:10 P.M., (which included review of her written statement) CNA #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 05/13/25 and was assigned to provide care to Resident #1. CNA #1 said Resident #1 was blind and required set-up with continual supervision for meals. CNA #1 said she would set-up Resident #1's meal tray, then leave to continue passing meal trays to other residents then go back to Resident #1's room. CNA #1 said she could not remember if she gave Resident #1 his/her breakfast meal tray on 05/13/25, but said she might have. CNA #1 said she heard someone yell Ow, from Resident #1's room, ran to his/her room, saw Resident #1's coffee mug on the floor and that there was coffee on his/her upper pants area that was dripping onto the floor. CNA #1 said she asked Resident #1 what happened and he/she told her that his/her hand was shaking, and the cup slipped out of his/her hand. CNA #1 said Resident #1's meal tray was still in his/her room, and he/she was by him/herself that morning (05/13/25), with his/her meal.CNA #1 said she brought Resident #1 into the bathroom to wash and dress him/her and when she removed his/her pants she saw a dime size red spot on his/her left thigh. CNA #1 said that Resident #1 said, my legs feel very, very hot. CNA #1 said she put Resident #1 back into bed, then informed nursing (believed it was Nurse #2) that he/she had spilled hot coffee on him/herself and had a small red area on his/her left thigh.During an interview