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	09/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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 four sampled residents (Resident #2), who was known to exhibit intrusive, combative and aggressive behaviors towards staff, residents, and visitors, the Facility failed to ensure that other residents residing on his/her unit were free from physical abuse, when between May 2025 and August 2025, Resident #2 was involved in several altercations, which included being witnessed by staff as he/she punched a resident in the stomach, climbed into another residents bed and became combative with attempts to be redirected, and it was alleged that he/she punched a resident on the arm and in the face during an unwitnessed altercation. Resident #2's combative and aggressive behaviors place other residents on his/her unit at increased risk for physical abuse.Findings Include:Review of the Facility Policy titled Abuse Investigation and Reporting, dated as last revised 02/2024, indicated that each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. Every resident in the Facility will be treated with respect and dignity. The Policy further indicated that physical abuse includes, but is not limited to, hitting, slapping, pinching, kicking, and so on. Resident #2 was admitted to the Facility in April 2025, diagnoses include Alzheimer's Disease, dementia with behavioral disturbances, and anxiety.Review of Resident #2's admission Minimum Data Set (MDS) dated [DATE], indicated that he/she exhibited both long- and short-term memory loss, severely impaired decision-making abilities, was sometimes understood and was rarely able to understand what was being said by others.The MDS indicated he/she exhibited physical behaviors, (hitting, kicking, pushing, scratching) one (1) to three (3) days per week, verbal behaviors (threatening, screaming, or cursing at others) one (1) to three (3) days a week, and other behaviors (hitting or scratching self, pacing, rummaging, disrobing) four (4) to six (6) days per week. The MDS further indicated that Resident #2 rejected care one (1) to three (3) times weekly and wandered four (4) to six (6) days per week. 1) Review of the report submitted by the facility via Health Care Facility Reporting System (HCFRS), dated 05/02/25, indicated that at 7:28 P.M., a Certified Nurse Aide (CNA) witnessed Resident #2 punched Non-Sampled Resident (NSR) A in the stomach/chest several times. The Report indicated that Resident #2 was standing in NSR A's doorway and when NSR A attempted to enter his/her room, Resident #2 hit NSR A in the stomach/chest with a closed fist several times.Further review of the Report indicated that the plan for Resident #2 was for staff to monitor him/her while ambulating on the unit and redirect him/her out of other residents' rooms. The Report indicated that staff had identified that Resident #2 had no interest in activities and was essentially non-verbal.2) Review of a Report filed with the Department of Public Health (DPH), dated 07/22/25, indicated that on 05/31/25 Resident #2 had been observed in Resident #3's bed (roommate of Resident #1) by Resident #1's Family Member.The Report indicated that Family Member #2 had gone into Resident #1's room and found Resident #2 sleeping in Resident #3's bed. The Report indicated that Family Member #2 had called out for help, and a CNA (later identified as CNA #1) went to get Resident #2 out of Resident #3's bed.The Report further indicated Family Member #2 said that when CNA #1 woke Resident #2 up from sleeping, he/she displayed aggression and was combative with CNA #1.During an interview on 09/16/25 at 1:43 P.M., CNA #1 said that she has found Resident #2 in other residents' beds multiple times. CNA #1 said that she has assisted with getting Resident #2 out of other resident's rooms, including Resident #1 and Resident #3's room. CNA #1 said Resident #2 has punched her and been combative towards her many times.During an interview on 09/16/25 at 11:03 A.M., Resident #3 said that there is an older resident (later identified as Resident #2) that comes into their room all the time. Resident #3 said that he/she will ask him/her to leave, but that staff usually have to escort him/her out of the room. Resident #3 said that Resident #2 has been found in his/her bed sleeping and said Resident #2 had hit him/her in the past.3) Review of the report submitted by the facility via the Health Care Facility Reporting System (HCFRS) Report, dated 08/25/25, indicated that at 5:15 P.M., yelling was heard coming from a resident's room (identified as Resident #4) and upon entering the room, Resident #4 was observed holding Resident #2's hands (trying to prevent Resident #2 from hitting him/her). The Report also indicated, that although unwitnessed, Resident #4 said that Resident #2 had grabbed his/her arm and punched him/her on his/her right arm and right cheek. Further review of the Report and Facility Investigative Findings indicated that Resident #4 told staff that Resident #2 had wandered into his/her room, picked up his/her lunch tray, removed some clothing from his/her bed and then Resident #2 laid down on his/her (Resident #4's) bed.Review of Resident #4's Behavior

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of four sampled residents (Resident #2) the Facility failed to ensure they reported and/or investigated incidents/allegations of abuse when 1) a family member reported that he attempted to redirect Resident #2 out of his family members room by pushing on Resident #2 and 2) Resident #2 punched a staff member in the face, neither of which were reported or investigated by the Facility.Findings include:Review of the Facility Policy titled Abuse Investigation and Reporting, dated as last revised 02/2024, indicated that each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. Every resident in the Facility will be treated with respect and dignity. The Policy indicated the definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical hurt or pain or mental anguish to a resident.The Policy further indicated that physical abuse includes, but is not limited to, hitting, slapping, pinching, kicking, and so on. Resident #2 was admitted to the Facility in April 2025, diagnoses include Alzheimer's Disease, dementia with behavioral disturbances, and anxiety.Review of Resident #2's admission Minimum Data Set (MDS) dated [DATE], indicated that he/she exhibited both long- and short-term memory loss, severely impaired decision-making abilities, was sometimes understood, and was rarely able to understand what is being said.The MDS indicated he/she exhibited physical behaviors, (hitting, kicking, pushing, scratching) one (1) to three (3) days per week, verbal behaviors (threating, screaming, or cursing at others) 1 to 3 days a week, and other behaviors (hitting or scratching self, pacing, rummaging, disrobing) four (4) to six (6) days per week and Resident #2 rejected care 1 to 3 times weekly and wandered 4 to 6 days per week. 1) Review of Resident #2's Nurse Progress Note (written by Unit Manager #1), dated 06/18/25, indicated that Resident #1's son (Family Member #2), informed Unit Manager #1 that Resident #2 wandered into Resident #1's room and Family Member #2 asked Resident #2 to leave. The Note indicated that Family Member #2 said that he pushed Resident #2 with his fingers to direct him/her out of the room and Resident #2 tried to grab him.Review of Resident #2's medical record indicated that there was no documentation to support that the facility initiated an investigation or reported the incident involving a visitor to resident altercation.During an interview on 09/16/25 at 2:04 P.M., Unit Manager #1 said that there was no incident report completed, or report filed to the Department of Public Health (DPH) after the documented incident.Unit Manager #1 said she thought the incident should have been a reportable event, however, said that after the management team discussed the incident with the Corporate Team, it was decided not to investigate the incident or report it.During an interview on 09/16/25 at 3:53 P.M., the Executive Director (ED) said that on 06/18/25 (day of the Incident), Family Member #2 stormed into her office telling her that Resident #2 wandered into Resident #1's room and Family Member #2 said that he pushed Resident #2 out of the room.2) During an interview on 09/16/25 at 11:16 A.M., Certified Nurse Aide (CNA) #4 said that on 08/28/25, during the evening shift (3:00 P.M. to 11:00 P.M.), she was assisting Resident #2 with evening care, that she was standing in front of Resident #2, went to lower his/her pants to get him/her changed into sleep wear and Resident #2 took both of his/her hands, made a fist with each hand and punched her on each side of her face very hard.CNA#4 said that she reported the incident to the nurse on the unit but said she was never asked to write a statement. During a telephone interview on 09/24/25 at 10:52 A.M., Nurse #2 said that she was aware of the incident that had occurred between CNA #4 and Resident #2 on 08/28/25, Nurse #4 said that she had reported it to Unit Manager #2.Nurse #2 said that Unit Manager #2 told her that if CNA #4 did not want to write a statement, then she did not have to.Nurse #2 said she did not know why an incident report wasn't completed and said she just followed what Unit Manager #2 told her and said she never asked CNA #4 for a statement.During a telephone interview on 09/24/25 at 11:20 A.M., Unit Manager #2 said that he does not recall anyone reporting a resident to staff member altercation on 08/28/25.Unit Manager #2 said that if a staff member had reported a resident to staff altercation, he was not certain that he would have initiated an incident report. The Executive Director said that she was not made aware of the 08/28/25 incident involving Resident #2 and CNA #4. The Executive Director said that she does not know why they did not do an incident report for either of these two incidents. The ED said that it was the Facility's expectation that all altercations that occur in the Facility be followed by an incident report and properly reported.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed, interviews and observation, for two of four sampled residents (Resident #1 and #4), the Facility failed to ensure they developed and/or consistently implemented and followed interventions identified in their plan of care related to the placement and use of a magnetic stop sign across their doorways to minimize the risk of other residents wandering into their rooms. Findings include: Review of the facility Policy titled Care Plans, Comprehensive Person Centered, dated as last revised 01/2024, indicted that a comprehensive, person-centered care plan will be developed for each resident and include objectives that meet the resident's physical, psychosocial and functional needs for each resident.1) Resident #1 was admitted to the Facility in February 2024, diagnoses include legal blindness, history of falls with vertebral fractures, and dementia.Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated he/she scored a six (6) out of 15 on his/her Brief Interview for Mental Status (BIMS, evaluates cognitive impairment and can help dementia diagnosis) (0-7 indicates severe cognitive impairment).Review of Resident #1's Physician's Orders, dated as of 09/16/25, indicated that his/her Health Care Proxy (HCP) was activated and his/her Health Care Agent (HCA) had been invoked since 02/16/24.During a telephone interview on 09/15/25 at 1:42 P.M., Family Member #1 said that she had been in contact with the Facility multiple times in regard to her concerns of maintaining Resident #1's safety from another resident (identified as Resident #2) who had been wandering in and out of his/her room. Family Member #1 said she was concerned because Resident #2 exhibited aggressive and combative behaviors at times. Review of Resident #1's Nurse Progress Note, dated 06/18/25, indicated that Resident #2 had wandered into his/her room and required staff redirection to escort him/her out of Resident #1's room.Review of Resident #1's Nurse Progress Note, also dated 06/18/25, indicated that Unit Manager #1 spoke with Family Member #1 and discussed interventions that the Facility had put into place to help prevent further episodes of intrusive wandering.The Note further indicated that the interventions that had already been in place were redirecting Resident #2 out of other resident's rooms and placing a magnetic stop sign across the doorway of Resident #1's room to inhibit Resident #2 from entering.Review of Resident #1's care plans indicated that although Nursing told Family Member #1 that they had implemented the use of a magnetic stop sign across his/her doorway as an intervention to maintain his/her safety, there was no documentation to support that the intervention was added to his/her care plan.During an interview on 09/16/25 at 10:51 A.M., with Resident #1, the surveyor noted that upon arrival to his/her room, there was no stop sign across the doorway. Resident #1 said that there was a resident here (identified as Resident #2) that walks into his/her room all of the time. Resident #1 said that he/she (Resident #2) will come to the window, look out and then will he/she would sit on his/her (Resident #1's) bed. During interview with Resident #1 (at 11:06 A.M.), the Surveyor observed as Resident #2 wander into Resident #1's room and walk towards his/her bed. The Surveyor stayed with Resident #1 and a CNA then entered Resident #1's room and redirected Resident #2 out of the room.During three observations on 09/16/25 at 9:36 A.M., 10:51 A.M. and 2:47 A.M., the Surveyor observed the magnetic stop sign that should have been secured in place across Resident #1's door, was left hanging off to one side of the doorway and therefore would not stop or inhibit any one from entering his/her room.During an interview on 09/16/25 at 1:43 P.M., Certified Nurse Aide (CNA) #1 said that she does not know why the stop sign was not across Resident #1's doorway and said Resident #1 has had a stop sign across his/her doorway for a while to help prevent Resident #2 from wandering into his/her room.During an interview on 09/16/25 at 1:32 P.M., CNA #2 said that Resident #1 has had a stop sign across his/her doorway for quite some time and that sometimes she finds it hanging on the side of the door and not properly attached.During an interview on 09/16/25 at 1:21 P.M., CNA #3 said that Resident #1 has had a stop sign at his/her door for about 6 months and said it is now broken and does not always stay in place properly,During an interview on 09/16/25 at 12 :10 P.M., Nurse #1 said that she does not know why Resident #1's stop sign was not across his/her doorway during surveyor observations.During an interview on 09/16/25 at 2:04 P.M., Unit Manager #1 said that it was her responsibility to ensure each resident's care plan includes all identified interventions and goals. Unit Manager #1 said she thought she added the intervention of the stop sign to Resident #1's care plan. Unit Manager #1 said she did not know that Resident #1's stop sign was not being consistently utilized. 2) Resident #4 was admitted to the Facility in March 2024, diagnoses include dementia with psychotic disturbances, major depression, and anxiety Review of Resident #4's Physician's Orders, dated 09/16/25