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	12/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225284	A. Building B. Wing	12/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews for one of three sampled residents (Resident #1), who was moderately cognitively impaired, had a Legal Guardianship in effect, and was known to leave the Facility without notifying staff, the Facility failed to ensure he/she was provided with an adequate level of staff supervision, to prevent him/her from eloping, when on several occasions Resident #1 exited the Facility unbeknownst to staff and they were unaware of his/her whereabouts for extended periods of time. Findings include: Review of the Facility's Policy titled Elopements, dated as revised June 2025, indicated the following:- If an employee discovers that a resident is missing from the facility, he/she shall: a. determine if the resident is out on an authorized leave or pass, and b. if the resident was not authorized to leave, notify the Director of Nursing and/Administrator. Resident #1 was admitted to the Facility in September 2025, diagnoses included paranoid schizophrenia and chronic obstructive pulmonary disease. Review of a Guardianship document (Decree and Order of Appointment of Guardian for an Incapacitated Person), dated 06/02/15, indicated Resident #1 did not retain the right to make and communicate decisions about healthcare. Review of Resident #1's admission Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 required supervision for ambulation, and had moderate cognitive impairment, evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15 (13-15 indicates intact cognition, 8-12 moderate cognitive impairment, and 0-7 severe cognitive impairment). Review of Resident #1's Elopement Assessment, dated 09/19/25, indicated he/she was at risk for elopement.Review of Resident #1's Nurse's Notes indicated the following: 10/16/25; Resident #1 left the Facility without signing out,10/18/25; Resident #1 was seen in the community, he/she had left without signing out and continues to be noncompliant despite education from staff,10/21/25; Resident #1 was outside walking along the sidewalk, staff met him/her and walked him/her back to the Facility,11/27/25; indicated Resident #1 had been seen along the roadway, and two staff members went to look for him/her but could not locate Resident #1. The Note indicated that staff called the Administrator immediately and the Administrator said Resident #1 typically returns, and if he/she did not, then notify Police. The Note indicated that Resident #1 returned.12/03/25, indicated Resident #1 left the Facility without signing out. Review of a Physician's Note, dated 11/18/25, indicated that nursing had concerns that Resident #1 was frequently noncompliant with supervision, was frequently ambulating outside with his/her walker on his/her own, staying outside in the cold temperatures, and that this was concerning. The Note indicated concerns that Resident #1 was not fully understanding the situation and that cognitive testing was ordered. During a telephone interview on 12/12/25 at 1:21 P.M., Nurse #1 said Resident #1 had left the Facility while he had been working on two separate occasions, that he told Administration that they needed to do something about this because he needed to take care of Resident #1 and he couldn't if he did not know where Resident #1 was.Review of Resident #1's Medical Record, indicated there was a Physician's order, dated 11/18/25, to complete the St. Louis University Mental Status (SLUMS) screening (cognitive exam). During a telephone interview on 12/04/25 at 2:22 P.M., the Nurse Practitioner (NP) said Resident #1 had been going outside alone for extended periods of time. The NP said she ordered the SLUMS to be completed because she needed more detailed information about Resident #1's level of cognition. The NP said she had concerns about Resident #1's ability to make appropriate choices related to safety. During an interview on 12/04/25, Social Worker #1 said that because Resident #1 kept leaving the Facility without letting staff know, which he/she was not safe to do, she was trying to transfer Resident #1 to another facility that had a locked or secured unit in order to keep him/her safe. During an interview on 12/04/25 at 3:46 P.M., the Director of Nurses (DON) said Resident #1 was at a supervision to independent level for ambulation in the facility. The DON said that what the Guardian had in place, as far as what he allowed Resident #1 to do, was not conducive to his/her (Resident #1) safety due to his/her impaired cognitive status, and that the Guardian had been made aware of this. The DON said Resident #1 did not have the cognitive ability to safely leave the Facility alone but had been doing so. During an interview on 12/04/25 at 3:45 P.M., the Administrator said Resident #1 was not consistently redirectable, and that it was unsafe for Resident #1 to remain at the Facility, so she had been working with his/her [NAME] to transfer Resident #1 to a Facility that could keep him/her safe. The Administrator said effective immediately (day of survey), Resident #1 would be placed on 1:1 supervision until he/she was transferred to another Facility.