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	06/08/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record reviews and interviews for one of three sampled residents (Resident #1), who was receiving Hospice Services, and had physician's orders for the administration of morphine, the Facility failed to ensure he/she was free from a significant medication error, when after nursing obtained new orders to administer a higher dosage of morphine to Resident #1, the previous order for morphine was not discontinued as ordered, and he/she was administered both dosages at the same time in error.Findings include:Review of the Facility Policy titled, Preventing and Detecting Adverse Consequences and Medication Errors, dated 08/2020, indicated the following:-the facility employs a system to ensure that medication usage is evaluated on an ongoing basis;-when a resident has a change in condition, medication-related problems are considered;-significant medication-related problems are assessed, documented and reported as appropriate to the resident's attending physician;-when a resident receives a new medication, the medication order is evaluated for: the dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines and manufacturer's specifications for use, that the resident is not taking other medication that would be incompatible with the prescribed medication;-in the event of a significant medication-related error, immediate action is taken to protect the resident's safety and welfare;-a significant medication-related error is defined as: requiring medication discontinuation or dose modification;-the physician is notified promptly of any significant medication errorReview of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 5/07/26, indicated that the facility received a call from a Department of Public Health (DPH) representative to report that a complaint was received regarding an alleged medication error. The Report indicated that an internal investigation was initiated immediately and during the medical record review it was determined that medication transcription errors had occurred during the processing of Hospice recommendations and provider orders. The Report indicated the following:On 5/05/26, during the 3:00 P.M. to 11:00 P.M. shift, Hospice recommendations were made as follows:*Morphine 20 milligrams (mg) / 1 milliliter (ml) - administer 10 mg (0.5) ml sublingually (under the tongue) every two hours as a scheduled dose and*Morphine 20 mg / 1ml - administer 10 mg (0.5) ml sublingually every hour as needed (prn) for severe painThe Report indicated that on 5/06/26, the Hospice Nurse made additional recommendations for Resident #1 as follows:*Discontinue scheduled Morphine 10 mg (0.5) ml every two hours and initiate*Morphine 20 mg / 1 ml - administer 20 mg (1) ml sublingually every two hours scheduledThe Report further indicated that during the transcription of this order, the original scheduled dose of Morphine 10 mg (0.5) ml was not discontinued, resulting in two active scheduled orders totaling Morphine 30 mg (1.5) ml every two hours. The Report indicated that Resident #1 received multiple doses prior to the discrepancy being identified.Resident #1 was admitted to the Facility in September 2021, diagnoses included acute respiratory failure with hypoxia, major depressive disorder, severe protein malnutrition, dementia, sever sepsis with septic shock, anxiety disorder, chronic venous insufficiency and kidney failure.Review of Resident #1's Facility Medication Error Report, dated 5/07/26, indicated that Resident #1's Morphine medication orders were not transcribed correctly, and he/she had two active scheduled orders, one for Morphine 20 mg every two hours and one for Morphine 10 mg every two hours. The Report indicated that the Nurse Practitioner (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified of the medication discrepancy and the scheduled Morphine 10 mg every two hours was discontinued.Review of a Nurse Progress Note, dated 5/05/26, written by Nurse # 5 indicated that Resident #1 was restless and agitated throughout the shift, PRN (as needed) medications were administered with minimal effect. The Note indicated that Hospice was notified and a new order [was recommended] to increase Morphine 20 mg / 1 ml - give 10 mg (0.5) ml every two hours scheduled and give Morphine 10 mg (0.5) ml every hour PRN.During a telephone interview on 6/11/26 at 10:43 A.M. (which included review of her written witness statement, dated 5/05/26), Nurse #5 said that Resident #1 seemed like he/she was in a lot of pain and that she called the Hospice Nurse to report the change in Resident #1's condition and obtain recommendations for pain. Nurse #5 said that the Hospice Nurse recommended scheduling Morphine 10 mg (0.5) ml every two hours and Morphine 10 mg (0.5) ml every hour as needed. Nurse #5 said that she notified the NP of Resident #1's Hospice recommendations and the NP agreed and gave her a new order for the same. Nurse #5 said that she transcribed the orders into Resident #1's Electronic Medication Administration Record (EMAR).Review of Resident #1's Physician's Orders for May 2026 indicated his/her orders related to Morphine were as follows:- 5/05/26, Morphine Sulfate Oral Solution 100 mg / 5 ml, give 10 mg (0.5) ml sublingually every two hours for pain.- 5/06/26, Morphine Sulfate Oral Solution 100 mg / 5 ml, give 10 mg (0.5) ml sublingually every two hours for pain and,-5/06/26, Morphine Sulfate Oral Solution 100 mg / 5 ml, give 20 mg (1) ml sublingually every two hours for pain.There was no documentation to support that the Morphine 10 mg dose was discontinued when the Morphine 20 mg dose was ordered.Review of Resident #1's EMAR, dated 5/06/26, indicated that Resident #1 received both Morphine 10 mg sublingually and Morphine 20 mg sublingually at the same time at 2:00 P.M., 4:00 P.M., 6:00 P.M., 8:00 P.M., and 10:00 P.M., in error.Review of Nurse Progress Note, dated 5/06/26, written by the Unit Manager, indicated that a new order for Morphine 20 mg (1) ml every two hours scheduled was recommended by the Hospice Nurse, the NP was notified and was in agreement with the recommendation.During an interview on 6/08/26 at 1:10 P.M., (which included review of her written witness Statement, undated), the Unit Manager said that she was unaware that Resident #1 already had a scheduled dose of the Morphine 10 mg (0.5) ml every two hours and said she did not discontinue that dose when she transcribed the Morphine 20 mg (1) ml order every two hours scheduled into the EMAR on 5/06/26.The Unit Manager said she should have discontinued Resident #1's scheduled Morphine 10 mg every two hours when she obtained the new order for Morphine 20 mg every two hours. The Unit Manager said that the next day, 5/07/26, the 11:00 P.M. to 7:00 A.M. Nurse informed her that there were two scheduled doses for Resident #1's Morphine and that when she (Unit Manager) reviewed Resident #1's Physician Orders, she saw the error that she made. The Unit Manager said that Resident #1 received several doses of Morphine totaling 30 mg in error instead of Morphine 20 mg.Review of a Nurse Practitioner's Progress Note, dated 5/07/26, indicated that nursing requested that Resident #1 be assessed for pain control. The Note indicated that Resident is currently ordered Morphine every two hours and Hospice recommended to increase Morphine to 20 mg every two hours scheduled. The Note further indicated that nursing endorses, that Resident #1 received Morphine 30 mg every two hours scheduled the previous evening.During a telephone interview on 6/10/26 at 3:09 P.M., the Nurse Practitioner (NP) said that on 5/05/26, during the 3:00 P.M. to 11:00 P.M. shift, a Nurse informed her that Hospice made recommendations for Resident #1's pain management. The NP said that Hospice recommended scheduling Morphine 10 mg every two hours and that she agreed with their recommendation and gave them an order. The NP said that she was informed that Resident #1's pain was not relieved, and Hospice made new recommendations to increase the Morphine to 20 mg every two hours, that she agreed and gave them an order to increase the Morphine to 20 mg every two hours.The NP said that the Morphine 10 mg order should have been discontinued when the Morphine 20 mg order was implemented. The NP said that the facility informed her that the Morphine 10 mg dose was not discontinued when the Morphine 20 mg was implemented and Resident #1 received several doses of Morphine for a total of 30 mg in error, before the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication error was caught.During a telephone interview on 6/10/26 at 11:37 A.M., Nurse #1 said that she administered Resident #1's medications as they appeared on his/her EMAR. Nurse #1 said that she did not question the Morphine dosages and administered a total of 30 mg of Morphine sublingually to Resident #1 on 5/06/26 at 2:00 P.M., 4:00 P.M., 6:00 P.M., 8:00 P.M., and 10:00 P.M. During an interview on 6/08/26 at 3:15 P.M. the Assistant Director of Nurses (ADON) said that Resident #1 was receiving Hospice services and experiencing increased pain. The ADON said that on 5/05/26, Hospice made recommendations for Morphine 10 mg sublingually every two hours scheduled, the NP was notified and gave orders to implement the recommendations. The ADON said that Resident #1 continued to experience pain on the scheduled Morphine, Hospice made recommendations to increase the Morphine to 20 mg sublingually every two hours scheduled, the NP was notified and gave orders to implement the recommendations.The ADON said that during the transcription of the medication orders, the Morphine 10 mg order was not discontinued, and Resident #1 received several doses of Morphine for a total of 30 mg in error. The ADON said that the Morphine 10 mg order should have been discontinued when the Morphine 20 mg order was implemented but was not. The ADON said his expectation was that nurses discontinue the current medication order before implementation of a new medication order.