| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225284 | A. Building<br>B. Wing | 02/13/2026 |

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, records reviewed, and interviews, the facility failed to ensure that adequate supervision and interventions were implemented to prevent accidents and failed to maintain an environment free of accident hazards for four Residents (#80, #15, #82, #84) of a total of 20 residents sampled. Specifically, the facility failed to:1. Ensure adequate supervision for Resident #80, a known elopement risk, and enabled access to a designated smoking area with unlocked doors that had access to outside of the facility, thus placing Resident #80 at Immediate Jeopardy risk for serious harm or death.In addition to the Immediate Jeopardy, non-compliance of this requirement also existed because the facility failed to:2. Provide adequate supervision to prevent accidents and to accurately assess Resident #15, who was found to reuse cigarette butts and wore clothing with burn holes; and3. Educate Resident #82 regarding having an oxygen concentrator in a smoking area; and4. Ensure Resident #84, with multiple falls, was utilizing a care planned wheelchair wedge cushion. Findings include:1. Resident #80 was admitted to the facility in September 2022 with diagnoses including alcohol dependence (in remission), cerebral infarction (stroke), aphasia (a disorder that results from damage to areas of the brain that are responsible for language that impairs expression and understanding of language, as well as reading and writing), and bipolar disorder.<br><br>Review of the Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #80 had moderate cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15 and was independent with ambulation.<br><br>a. On 2/10/26 at 4:14 P.M., the surveyor observed the following:-Resident #80 exit the facility through the patio doors into the unsupervised and unsecured designated smoking area.-A wander guard (an electronic wander management system that includes wearable bracelets and door sensors to ensure residents do not wander or elope) on Resident #80's right wrist.-The surveyor did not hear anything alarm to notify the staff Resident #80 had exited the facility.<br><br>-Secure smoking area gate opened with open access to the parking lot.<br><br>Review of weather data obtained from the National Oceanic and Atmospheric Administration indicated the temperatures on 2/11/26 in [Town name], Massachusetts was a maximum of 34 degrees Fahrenheit and a minimum of 3 degrees Fahrenheit.<br><br>Review of Resident #80's current Physician's Orders indicated but was not limited to:- Check function of wander guard on right wrist weekly on Mondays, dated 12/26/25- Health Care Proxy invoked, dated 9/20/22<br><br>Review of Resident #80's medical record indicated but was not limited to:<br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -10/11/25 Nurse's Note:Nurse received call from a Certified Nursing Assistant (CNA) who was leaving for the day to let her know Resident was walking back into the driveway with a paper bag, at the same time a different CNA came up to nursing station to report they had seen the Resident walking on the street coming from direction of liquor store. The bag had bottles of vodka.<br><br>-10/13/25 Care plan updated to make Resident #80 a supervised smoker in response to the elopement on 10/11/25.<br><br>-10/13/25 Elopement Risk Evaluation:Resident was oriented to person and place. Resident was wanting to go home or leave; Resident had a history of substance abuse and was independent for mobility with aid (walker). Elopement attempted in the last 30 days. Resident was at risk for elopement. SCORE: 10 Category: High Risk.<br><br>-Resident #80 was on a leave of absence from the facility from 12/24/25 until 12/26/25.<br><br>-12/24/25 Alert Note:Phone conversation with Resident's Health Care Proxy regarding continued safety concerns with Resident attempting to leave the facility without proper authorization. The Clinical IDT (interdisciplinary team) including Nursing, Social Services, Administration and DON (Director of Nursing) all agree that this [refers to wander guard] is the least restrictive yet safest way for staff to be alerted to his/her whereabouts. The Resident's Health Care Proxy agrees with our decision and will share that information with the Resident prior to their return from his/her leave.<br><br>-12/24/25 Nursing Note:New order from the Nurse Practitioner for wander guard to apply when Resident returns from leave of absence.<br><br>-12/26/25 Elopement Risk Evaluation indicated but was not limited to:Resident was oriented to person, place, and time. Resident was oblivious to needs or safety, wanting to go home or leave, and watching others go out of doors. Resident was at risk for elopement. SCORE: 9 Category: High Risk.<br><br>Review of Resident #80's Elopement Care Plan indicated but was not limited to:Focus: Elopement: is at risk for elopement, revision on 12/26/25Goal: Resident will remain within the facility unless supervised, remain free of harm, target date 3/5/26Interventions: 12/24/25 When Resident returns from pass (leave of absence), he/she is to have a wander guard placed. Nursing to check placement every shift and check function weekly, revision date 12/24/25; wander guard applied to: right wrist revision date 12/26/25<br><br>Review of the Elopement Risk book indicated Resident #80 was an elopement risk and had a wander guard.<br><br>During an interview with observation on 2/10/26 at 4:22 P.M., Nurse #1 said residents used to go outside out the front door now they would go to the designated smoking area through the first-floor unit patio doors. Nurse #1 said there were two residents on the first who needed to be supervised when outside. Nurse #1 and the surveyor walked down to the first-floor unit patio doors which led to the unsecured designated smoking area and observed Resident #80 outside unsupervised. Nurse #1 said Resident #80 had a wander guard on and needed to be supervised when outside and should not have been outside unsupervised. She said no alarm sounded to notify staff that Resident #80 had exited the facility. She said she was not aware if the patio doors had a wander guard alert system. Nurse #1 said the gate leading from the designated smoking area in the parking lot was usually kept open, but she was not sure it should have been.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 2/10/26 at 4:34 P.M., the Administrator said the first-floor unit patio doors were newly installed for the residents to have easier access to the designated smoking area. She said the doors did not have a wander guard alarm alert system. She said the doors to the smoking area were unlocked from 7:00 A.M. to 7:00 P.M. daily and the gate leading from the smoking area to the parking lot was initially latched and secured but the facility had decided to leave the gate open in case a resident was outside after 7:00 P.M. without access to get back into the facility. She said Resident #80 had a wander guard and should not have been unsupervised.<br><br>During an interview on 2/10/26 at 5:06 P.M., CNA #3 said the doors to the designated smoking area were unlocked and unalarmed from 7:00 A.M. to 7:00 P.M. daily. She said if a resident with a wander guard went through the doors, the doors would not alarm to notify the staff someone had exited through the patio doors. She said if someone attempted to exit through the patio doors after 7:00 P.M. and before 7:00 A.M. the doors would alarm if pushed on. She said there was a camera pointed at the smoking area, but it would not alarm if a resident attempted to exit through the patio doors and they are not monitored continuously.<br><br>During an interview on 2/10/26 at 5:10 P.M., CNA #2 said if Resident #80 attempted to exit the facility through the front doors, the wander guard alarm alert system would sound loudly, the door will lock until a code is put in, and the Resident could not be missed. She said the first-floor unit patio doors did not have a wander guard alarm alert system, so if Resident #80 went outside unsupervised, staff would not have been aware he/she exited the facility unless someone notified them.<br><br>During an interview on 2/10/26 at 5:18 P.M, the Administrator and Director of Nurses (DON) said Resident #80 required supervision when outside. They said Resident #80 wore a wander guard. They said the first-floor patio doors were still under construction but because of the cold weather and snow the facility had made the decision to open the doors before being fully completed to make it a shorter walking distance to the patio. The Administrator said there needed to be safety measures in place before the newly renovated patio doors were opened and in use.<br><br>During an interview on 2/11/26 at 7:49 A.M., CNA #5 said there was a binder at the nurse's station which lists the residents who were at risk for elopement. She said Resident #80 was in the book because he/she was an elopement risk because he/she had left the facility before without supervision. She said Resident #80 wore a wander guard. She said the side patio doors which lead to the smoking area were not alarmed, so if no one saw him/her go outside then no one would know.<br><br>During an interview on 2/11/26 at 7:57 A.M., Nurse #1 said Resident #80 had followed another resident out to the smoking area on 2/10/26 and because the doors which led to the smoking area did not have a wander guard alarm alert system staff were unaware he/she had left the unit unsupervised. Nurse #1 said the Administrator had unlocked the doors leaving them unalarmed.<br><br>During an interview on 2/11/26 at 8:06 A.M., CNA #6 said Resident #80 would need supervision when he/she would go outside because he/she was an elopement risk. CNA #6 said Resident #80 would sit and wait for someone to go outside so he/she could follow them out.<br><br>During an interview on 2/11/26 at 9:45 A.M., the Administrator said the doors to the designated smoking area from the first-floor unit were left unlocked on 2/2/26 until 2/10/26. She said she had not provided official education to staff members, just told them to start using the doors for smoking. She said the doors were not ready for use, as still being renovated, but the facility tried to use them because of the weather. She said the facility had not implemented a wander guard alert system on the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | patio doors. She said she felt confident Resident #80 would continue to sit and wait to go outside like he/she had done with the front door because he/she knew the wander guard system alarm would sound if/she tried to go outside without a staff member. She said she had not realized exiting through the patio doors there was not an alarm sounding to notify staff if a resident had left the facility without the appropriate supervision. She said she had not realized using the patio exit door created confusion for Resident #80.<br><br>During an interview on 2/11/26 at 3:51 P.M., Activity Assistant #1 said Resident #80 had a wander guard on and needed supervision when he/she was outside. She said Resident #80 had wandered from the facility previously. She said if Resident #80 attempted to leave the facility through the front doors without supervision, the doors would lock and the wander guard alert system would sound notifying staff he/she was attempting to leave and would not turn off until a staff member would go and check the area and reset the alarm. She said the doors leading to the designated smoking area were not alarmed at this time.<br><br>During an interview on 2/11/26 at 3:54 P.M., CNA #8 said Resident #80 required supervision to go outside because he/she was an elopement risk and was in the elopement book. CNA #8 said when Resident #80 would attempt to go through the from doors the doors would lock and alarm but the new patio doors leading to designated smoking would not alarm if he/she tried to go outside between 7:00 A.M. and 7:00 P.M.<br><br>During an interview on 2/12/26 at 7:49 A.M., CNA #9 said Resident #80 had a wander guard because he/she would leave the facility unsupervised and would not notify anyone he/she was leaving. She said because the patio door did not have a wander guard alert system no one would be aware if Resident #80 had gone outside.<br><br>During an interview on 2/12/26 at 12:33 P.M., Resident #80 said he/she had a wander guard alarm bracelet on their right wrist. Resident #80 said he/she would leave the facility once in a while and walk down to the store.<br><br>During an interview on 2/12/26 at 1:10 P.M., Family Representative #1 said they had received a call from the facility asking for permission to apply a wander guard to Resident #80 and he/she gave permission. Family Representative #1 said Resident #80 needed a wander guard so he/she would not wander off by themselves while outside as he/she had poor safety awareness.<br><br>During an interview on 2/12/26 at 12:14 P.M. and 1:53 P.M., the DON said Resident #80 needed supervision when outside because he was an elopement risk. She said Resident #80 should not have been outside unsupervised with their history and risk of elopement. She said the gate leading to the parking lot in the designated smoking area should not have been opened. She said the goal was to have a wander guard alert system in place prior to opening the newly installed doors to the designated smoking area, however, there was not a system in place to notify staff if a resident with a wander guard left the facility through the patio door. She said the patio doors should not have been unlocked without them being secure.<br><br>During an interview on 2/12/26 at 2:22 P.M., the Maintenance Director said the facility unlocked the doors from the first-floor unit to the designated smoking area on 2/2/26. He said the doors did not have a wander guard alert system but should have.<br><br>During an interview on 2/12/26 at 2:33 P.M., the Administrator said the doors from the first-floor unit<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | patio were opened on 2/2/26 to allow for easier access to the designated smoking area because of the cold weather but the facility had forgotten about the wander guard alert system. She said the wander guard alert system should have been installed prior to unlocking the doors leaving them unsecured and unalarmed.<br><br>b. On 2/10/26 at 4:14 P.M., the surveyor observed the following:<br><br>-Resident #52 sitting in the smoking area smoking a cigarette.<br><br>-Resident #80 walked out into the designated smoking area unsupervised.<br><br>-Resident #80 take Resident #52's cigarette and use it to light his/her cigarette.<br><br>-No staff were present.<br><br>Review of a Smoking Evaluation, dated 12/4/25, indicated Resident #80 was safe to smoke with supervision and was safe to light their own cigarette with staff assistance.<br><br>Review of Resident #80's Smoking Care Plan indicated but was not limited to:<br><br>-Focus: Smoking: Resident wishes to smoke and requires supervision due to incident when he/she left the facility grounds during a smoking break 10/11/25, revision on 10/13/25<br><br>-Intervention: Resident will be supervised by staff when going outside to smoke, initiated 10/11/25.<br><br>Review of the Supervised Smoking Times provided to the survey team on 2/9/26 indicated Resident #80 required supervision with smoking.<br><br>During an interview with observation on 2/10/26 at 4:22 P.M., Nurse #1 said the first-floor unit had two supervised smokers. Nurse #1 and the surveyor walked down to the first-floor unit patio doors and Nurse #1 said Resident #80 should not have been outside unsupervised and he/she had a wander guard on and needed to be supervised when smoking.<br><br>During an interview on 2/12/26 at 1:53 P.M., the DON said Resident #80 should not have used Resident #52's cigarette to ignite their cigarette instead Resident #80 should have used the electric lighter to light it.<br><br>2. Review of the facility's policy titled Smoking Policy-Residents, dated as revised in September 2025, indicated:<br><br>-the facility shall establish and maintain safe resident smoking practices<br><br>-ashtrays/cigarettes are emptied only into designated receptacles<br><br>Resident #15 was admitted to the facility in January 2023 with a diagnosis of nicotine dependence.<br><br>Review of the MDS assessment, dated 12/5/25, indicated Resident #15 scored 10 out of 15 on the BIMS, indicating he/she had a moderate cognitive impairment and used tobacco products.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 2/9/26 at 10:25 A.M., the surveyor observed Resident #15 seated near the nurses' station wearing navy blue sweatpants with numerous burn holes.<br><br>Review of the Smoking Evaluation, dated 1/15/26, indicated Resident #15 had no evidence of burn holes on their clothing and was independent with smoking without the need for protective smoking equipment. The Evaluation was completed by the DON.<br><br>On 2/9/26 at 10:43 A.M., the surveyor observed the smoking gazebo area with multiple already smoked and extinguished cigarette butts on the ground. There was a large amount of cigarette butts scattered on the ground inside the gazebo and in a snowbank. The walkway leading to the gazebo had numerous cigarette butts on the ground and in the snow. There were cigarette butts scattered along the side of the building.<br><br>During an observation with interview on 2/10/26 at 12:41 P.M., the surveyor observed burn holes in Resident #15's navy blue sweatpants and on his/her t-shirt. Resident #15 said, Maybe ashes fell on them.<br><br>On 2/10/26 at 12:46 P.M., the surveyor observed Resident #15 pick up a cigarette butt from the ground, bring it to the stationary electronic lighter, light the cigarette, take a puff and then throw it to the ground.<br><br>On 2/11/26 at 9:20 A.M., the surveyor observed Resident #15 wearing navy blue sweatpants with multiple burn holes, mostly on the left thigh area.<br><br>On 2/11/26 at 12:40 P.M., the surveyor observed Resident #15 outside in the smoking area picking a cigarette butt up off the ground and lighting it on the stationary electronic lighter.<br><br>During an interview on 2/11/26 at 12:41 P.M., Resident #15 said he/she did not have their own cigarettes but had picked up the cigarette butt which was not lighting on the electronic lighter. The surveyor inquired about the multiple burn marks on the Resident's clothes, and he/she said the burns were from cigarettes. The surveyor observed multiple cigarettes butts on the ground in the smoking area.<br><br>During an interview on 2/11/26 at 3:02 P.M., CNA #1 said Resident #15 has had burn holes in his/her clothing since coming to the facility. She said Resident #15 did not like to change clothes and was usually wearing the clothing with burn holes. While the clothes had burn holes when the Resident was admitted , she could not say if all of the burn holes were old.<br><br>During an interview on 2/11/26 at 3:03 P.M, CNA #7 said Resident #15 has had burn holes in his/her clothes for a while and does not change their clothes.<br><br>During an interview on 2/11/26 at 3:04 P.M, CNA #10 said Resident #15 did not change his/her clothes and would wear clothes with burn holes. He said he was not sure how they would know which holes were new and which were old.<br><br>Review of the active care plans failed to include any information regarding Resident #15 wearing clothing with burn holes.<br><br>During an interview on 2/11/26 at 3:11 P.M., Resident #15 said he/she did not like to change their<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | clothes but probably should. He/she said there was no way for him/her to know if there were any new burn holes in the pants. Resident #15 denied ever having any burns on his/her skin.<br><br>During an interview on 2/13/26 at 10:55 A.M., the DON said she had not noticed the burn holes in the pants of Resident #15 but should have. She said there was no way to know if the burn holes were new or old. She said there should not be cigarette butts on the ground in the smoking area, and this area was supposed to be maintained. She said she was unaware Resident #15 was picking cigarette butts up from the ground and smoking them. She said she was not sure who was responsible for obtaining cigarettes for Resident #15.<br><br>During an interview on 2/13/26 at 11:00 A.M., the Staff Development Coordinator said he was going to re-assess Resident #15 for the Smoking Evaluation on 2/12/26 but the Resident had said he/she did not have cigarettes, and he hadn't inquired further about where the Resident was getting cigarettes. He said the Resident's family previously brought in cigarettes, but he had not seen the family member in a while. He said Resident #15 should not be picking cigarette butts up from the ground to smoke them.<br><br>3. Review of the facility's policy titled Smoking Policy-Residents, dated as revised in September 2025 indicated oxygen use was prohibited in smoking areas.<br><br>Resident #82 was admitted to the facility in January 2025 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).<br><br>Review of the MDS assessment, dated 1/30/26, indicated Resident #82 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact, used tobacco products, and used oxygen treatments.<br><br>Review of the care plans indicated Resident #82 was a smoker and would be educated on safe smoking practices.<br><br>On 2/10/26 at 12:49 P.M., the surveyor observed Resident #82 exit the facility through the patio door with an oxygen concentrator (a portable device used to take air and convert it into concentrated oxygen) attached to their ambulatory device and a nasal cannula (flexible tubing inserted into the nostrils to deliver supplemental oxygen) in his/her nose. The Resident walked to the gazebo and lit a cigarette.<br><br>During an interview at this time, Resident #82 said he/she had turned the power off to their oxygen concentrator.<br><br>Review of the medical record indicated Resident #82 had a physician's order to administer oxygen at 2 liters continuously.<br><br>Review of the Smoking Evaluation for Resident #82, dated 2/1/26, indicated Resident #82 smoked cigarettes and was educated on the dangers of smoking while on oxygen therapy. The Smoking Evaluation was completed by Unit Manager #1.<br><br>During an interview on 2/11/26 at 8:17 A.M., Resident #82 said the Staff Development Coordinator (SDC) had watched him/her smoke a long time ago and the SDC had removed their oxygen to watch smoking. The Resident said no staff members had provided education about smoking recently because he/she knew what to do. Resident #82 said they take their oxygen concentrator outside with (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | them because it was difficult to walk without it. He/she said staff had never talked about not having the oxygen concentrator in the smoking area. The Resident said they had bought this particular concentrator because it was not at risk for exploding like an oxygen tank. The Resident was observed to have an Inogen portable oxygen concentrator.<br><br>Review of the Inogen manufacturer's Safety of Portable Oxygen Concentrators information indicated the following:<br><br>-oxygen is a key catalyst in many chemical reactions and oxygen users need to be cautious and keep a safe distance from fire, sparks and other flammable materials<br><br>-keep sources of heat and flame at least five feet away from where oxygen unit is being used or stored<br><br>-smoking increases the risk of fire when oxygen is in use and puts the user in danger of severe burns or other serious injuries<br><br>-lighters, matches, cigarettes, cigars and even smoldering ashes are all a fire hazard near supplemental oxygen<br><br>During an interview on 2/11/26 at 8:28 A.M., Unit Manager #1 said she had completed the Smoking Evaluation for Resident #82. She said she did not go outside with Resident #82 to observe the smoking process but had observed the Resident while walking by the smoking area or front door to come into the facility. She said she was not sure where the Resident put the oxygen concentrator when smoking and had not provided any education regarding this as indicated on the Evaluation on 2/1/26.<br><br>On 2/11/26 at 9:24 A.M., the surveyor observed Resident #82 smoking in the gazebo with other residents. Resident #82 was actively smoking with their oxygen concentrator hanging from the back of their ambulation device. The Resident did not have their nasal cannula in their nose.<br><br>During an interview on 2/11/26 at 11:15 A.M., the SDC said Resident #82 was the only Resident who smoked and utilized portable oxygen. He said he had educated Resident #82 about a year ago on stepping away from the oxygen concentrator after turning it off and prior to lighting a cigarette. He said there was no plan for where the Resident would put the oxygen concentrator while smoking. He said the Resident having the oxygen concentrator and/or wearing the nasal cannula which had recently been in use puts the Resident at risk. He said when completing Smoking Evaluations, the staff should be with the residents from the beginning until the end to ensure safety including oxygen safety.<br><br>During an interview on 2/13/26 at 10:50 A.M., the DON said the Unit Manager should have gone outside with Resident #82 to watch the smoking process from start to finish and should have gone with the Resident to see where the oxygen concentrator was being stored. She said the oxygen concentrator should not be in the smoking area.<br><br>4. Review of the facility's policy titled Fall Prevention and Management, dated as revised in November 2024 indicated the following:<br><br>-develop an individualized care plan based on risk factors<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -care plans should be updated or revised with any changes in the resident condition and any time a resident experiences a fall<br><br>Resident #84 was admitted to the facility in October 2025 following recurrent falls.<br><br>On 2/10/26 at 11:30 A.M., the surveyor observed Resident #84 seated in a wheelchair in the hallway with a regular wheelchair cushion.<br><br>During an interview on 2/10/26 at 11:30 A.M., Nurse #2 said there were no staff in the unit dining room and the Resident needed supervision related to standing up often.<br><br>Review of the medical record indicated Resident #84 had seven falls from admission through 11/8/25 and was placed in a wheelchair for use on 11/11/25.<br><br>Review of the medical record indicated on 11/21/25 Resident #84 slid out of the wheelchair, on 11/25/25 Resident #84 slid out of wheelchair with a note on the incident report indicating therapy would order a wedge cushion for the Resident and on 11/26/25 Resident #84 slid out of the wheelchair.<br><br>Review of the Care Plan indicated Resident #84 was at risk for falls with an intervention added on 11/25/25 for Therapy to provide the Resident with a wedge cushion.<br><br>Review of the Occupational Therapy Treatment Encounter notes indicated on 12/9/25 Resident #84 was provided with a new cushion.<br><br>Review of the medical record indicated Resident #84 did not have any falls in December 2025. Further review indicated Resident #84 fell out of the wheelchair on 1/1/26, 1/6/26, and 1/26/26. Review of the incident reports failed to indicate if the wedge cushion was in place at the time of the falls.<br><br>On 2/13/26 at 9:05 A.M., the surveyor observed Resident #84 in the unit day room in a wheelchair with a regular cushion, not a wedge cushion.<br><br>During an interview on 2/13/26 at 9:15 A.M., the Unit Manager and the surveyor reviewed the Resident's falls and interventions. The Unit Manager said Resident #84 was losing his/her balance when ambulating with a rolling walker and a wheelchair was implemented to assist the Resident with further distances. The Unit Manager said the Therapy Department had implemented a wedge cushion for Resident #84 which was still in place. The surveyor and the Unit Manager observed Resident #84 at this time and the Unit Manager confirmed the Resident had a regular cushion and did not have a wedge cushion as indicated on the care plan.<br><br>During an interview on 2/13/26 at 10:15 A.M., the Director of Rehabilitation said she had ordered a wedge cushion for Resident #84 which had arrived while Resident #84 was in the hospital in early December. She said she placed the wedge cushion on the wheelchair for Resident #84, and the Resident was discharged from services shortly after with a plan to continue the wedge cushion. She said she was not sure where the wedge cushion was at this time.<br><br>During an interview on 2/13/26 at 11:03 A.M., the DON said when a resident falls the process was to review the Resident and the environment to ensure all interventions were in place. She said following the falls in January 2026, the facility staff should have identified if the wedge cushion was still in place. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interview, policy review, and document review, the facility failed to set priorities for an effective Quality Assurance Performance Improvement (QAPI). Specifically, the facility failed to develop a performance improvement project (PIP) to track, investigate, analyze and use data and information related to:1. The identification of adverse events of residents who required supervision leaving the facility unattended; and2. Resident Council and individual resident identified concerns with call light wait times. Findings include:Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI): Operations Department, dated as revised in June 2019, indicated the following:-the purpose of the Steering Committee was to review and analyze facility related data and direct appropriate actions for the facility response-data is reviewed initially to identify problems and challenges to be addressed through PIPs and then are used to prioritize the challenges to address first-data will be used to set goals for the PIP, monitor progress, and evaluate the effectiveness of intervention(s) implemented during the PIP, then determine how to expand the lessons learned systemically Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI): Clinical Department, dated as revised in June 2019, indicated the following:-the QAPI plan will address Quality of Life through resident/family concerns brought up at Resident or Family Committee meetings-Center leadership, including, but not limited to Administrator, Director of Nurses, Social Services, and Activity Director meet monthly to address life concerns.-the following data is monitored through QAPI: input from caregivers, residents, families and others including adverse events, performance indicators and survey findings-the information gathered is analyzed and compared to benchmarks and/or targets established by the facility 1. Review of the Facility Reported Incidents (FRIs) prior to the survey start indicated in December 2025 the facility had developed a plan of correction for deficient practice related to a resident eloping from the facility. On 2/10/26 at 4:15 P.M., Resident #80 was observed outside in the opened courtyard, adjacent to the parking lot, with a wander guard on his/her wrist. Resident #80 was not supervised or with any staff members. During an interview on 2/10/26 at 4:22 P.M., Nurse #1 said Resident #80 should be supervised and should not be outside alone. Review of the medical record indicated Resident #80 had an activated Health Care Proxy and had previously left the facility unattended in October 2025. During an interview on 2/13/26 at 1:35 P.M., the Administrator said the facility used multiple ways to identify projects for improvement including plans of correction. She said the facility had developed a plan of correction (POC) for residents at risk for elopement in December 2025 which included staff education and audits. She said she did not have a PIP for the surveyor to review because she brought the POC audits to the QAPI committee meeting in January 2026. She reviewed the facility form utilized for PIPs and said there was not one to address the residents at risk for elopement. She said there were no measurable goals for the POC and the goal was to supervise residents who were identified as needing wander guards. She could not say how she was measuring the success of the implemented interventions through the QAPI process. 2. Review of the Resident Council Minutes for November 2025 indicated that when asked, the residents responded that they could not get help or care without waiting a long time and call lights were not always answered in a timely manner. Review of the Resident Council Minutes for January 2026 indicated that when asked, the residents responded that sometimes they could get help or care without waiting a long time and call lights were sometimes answered in a timely manner. During a group meeting with 14 residents on 2/10/26 at 1:30 P.M., the residents said they did not feel call lights were being answered timely. Residents said the call light wait times could vary and the issue was usually during the 3:00 P.M. to 11:00 P.M. shift. Seven out of 14 residents said they had waited over a half hour for call lights to be answered. During an interview on 2/11/26 at 10:30 A.M., the Activities Director said sometimes during Resident Council meetings the residents would say they waited a long time for call lights to be answered, but it was not all the residents, so<br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | she verbally provided the information to the Administrator. During an interview on 2/13/26 at 1:30 P.M., the Administrator said the resident's input was used for the QAPI process through resident conversations, grievances, and Resident Council. She said residents had voiced concerns with long call light wait times and she felt this had improved. She said call light wait time was an active QAPI but that she did not have a PIP for the surveyor to review. She reviewed the facility form utilized for PIPs and said there was not one for call light wait times. She said she had done education with the staff and lunch and learns to tell staff to answer the call lights and the weekend Manager on Duty was completing audits. She said there was no documentation to analyze, measure, or track the data from audits and that audits were only being completed on the weekends. She said she felt the call light wait time was improving but did not have any data to indicate the improvements and had not attended Resident Council to receive feedback from the residents on the success of the implemented interventions. During an interview on 2/13/26 at 2:45 P.M., the [NAME] President of Operations and a member of the Governing Body, said these two examples of improvement were missed as part of the QAPI process. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview and record review, the facility failed to follow professional standards of practice for three Residents (#2, #8, and #39), out of a total sample of 20 residents. Specifically, the facility failed:1. For Resident #2, to inform Nurse Practitioner (NP) #1 timely of medication dosage recommendations following a neurology consult, resulting in a 22-day delay in ordering and implementing the recommendations; 2. For Resident #8, to obtain a urology consultant report per NP #1's order resulting in a 57-day delay in reviewing the recommendations; and3. For Resident #39, to monitor the continuous glucose sensor or hand held reader to ensure they were both working properly and providing accurate blood glucose results, and to ensure the manufacturer's recommendations of changing the sensor every 14 days and rotation of the sensor application site were followed, and to ensure infection control parameters were followed to minimize risk of infection since Resident #39 was admitted to the facility. Findings include: 1. Facility reported no policy for consultant visit recommendations. During an interview on 2/12/26 at 11:22 A.M., Nurse Practitioner (NP) #1 said it can be challenging to get consult reports. She said in a perfect world she refers the residents to see a consultant, they have the consult visit, return to the facility with a visit summary report, and that report is put in her folder. NP #1 said she doesn't always receive the visit summary report. When she does not, she writes an order for the nurses to obtain the report, or she can sometimes see them in the hospital based electronic medical record. NP #1 said it is important to get consultant reports for collaboration of care, medication recommendations or changes. She said there have been some communication issues with getting the consultant summary visits timely. Resident #2 was admitted to the facility in February 2025 with diagnoses which included Parkinson's disease and dementia. During an interview on 2/10/26 at 12:10 P.M., Resident #2's Family Member #3 said the Resident was seen by the neurologist and was never started on the recommended medication until he/she brought in the neurologist report and gave it to a nurse because it was not in his/her medical record. Review of Physician's Orders indicated the Carbidopda-Levodopa ER oral tablet 25-100 milligrams (mg), give by mouth two times a day for Parkinson's disease was initiated on 2/4/26. Review of Resident #2's Neurology Consultant Progress note, dated 1/13/26, indicated but was not limited to the following:-Patient is here for a follow up, at a nursing home but has deteriorated since last visit with us.-His/her Mini-Mental State Examination (screening tool to monitor progression of Parkinson's disease) is much worse and he/she has more Parkinsonian with symmetry which may be related to anti-psychotic medication, but also possibly Parkinson's disease.-We discussed a trial of Carbidopa/ Levodopa (Sinemet- Used to treat Parkinson's disease by reducing symptoms, like muscle stiffness, tremors, spasms, and poor muscle control by increasing dopamine levels in the brain) at 25/100 mg initially twice a day (BID), then increased to three times a day (TID). -Follow up in three months, sooner if needed.-Copy in the chart indicated NP #1 signed reviewing the consultant report on 2/4/26. Review of a Nursing note, dated 1/13/26 at 11:16 P.M., indicated Resident #2 returned from neurology appointment with Consultant Neurologist. Consult notes indicated deterioration in function and memory with recommendations for trial of Carbidopa/Levodopa at 25/100 mg, initially twice a day and then increased to three times a day. Review of Nursing note, dated 1/13/26 at 11:20 P.M., indicated. NP #1 notified of neurology recommendations at 10:21 P.M. During an interview on 2/12/26 at 1:15 P.M., Family Member #3 said the transport driver brought Resident #2 back to the facility and had the paperwork from the neurologist. Family Member #3 said about week and half after the appointment he/she followed up with Nurse #1 to see if the medication was started and Family Member #3 was told by Nurse #1 the neurologist consult report was not in the medical record. Family Member #3 provided Nurse #1 with a copy of the neurology consult report and was told Nurse #1 was going to put it in the medical record. Family Member #3 said he/she followed up with NP #1 on 2/4/26 to inquire how the medication change was and NP #1 told him/her she had not seen the neurology consult. Family Member #3 said NP #1 found the consultation report in the medical record and that's<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | when Resident #2 was started on the medication the neurologist recommended. During an interview on 2/12/26 at 11:22 A.M., NP #1 said she was not aware of the neurologist summary report until FM #3 brought it to her attention on 2/4/26. NP #1 said when she read the report, she started Resident #8 on the medication the neurologist recommended. NP #1 said there was a delay in starting the medication because she was delayed in receiving the report. 2. Resident #8 was admitted to the facility September 2025 with diagnoses which included prostatic hyperplasia (enlargement of prostate gland) with lower urinary symptoms, urinary tract infection(s), and urinary retention. Review of Physician's Orders indicated but were not limited to:-NP #1 on 12/15/25 wrote order to please obtain urology visit summary from 12/12/25 and leave in provider book for review. Every shift for visit summary request needed for coordination of care. Review of Resident #8's Treatment Administration Record (TAR) for December 2025, January 2026, and February 2026 indicated this order was signed off 171 times and signed off as completed and coded 8 (other) 23 times over three shifts. Review of a Nursing note, dated 12/17/25 at 9:59 A.M., indicated Urology Consultant's office was called and a message left to fax over visit summary from last week's visit at NP's request. On 2/11/26, a review of Resident #8's medical record indicated there was no urology consult report for date of service 12/12/25 in the paper or electronic medical record. During an interview on 2/11/26 at 3:42 P.M., Nurse #1 said the Assistant Director of Nurses said Resident #8's Urology report was never received in the facility. Review of a fax received in the facility on 2/12/26 at 2:06 P.M. from the consultant urology office included an office visit note with date of service 12/12/25 which indicated but was not limited to the following: -Resident's Health Care Proxy (HCP) stated Resident #8 had about four urinary tract infections over the last four to five months.-Resident has been on several courses of antibiotics.-I did recommend maybe starting him/her on some cranberry supplements and we will have to consider maybe about suppressive antibiotics in the future as well as maybe Methenamine Hippurate (Antiseptic medication used to prevent recurrent urinary tract infections) moving forward. During an interview on 2/12/26 at 11:22 A.M., NP #1 said she never received Resident #8's urologist's consult report from the visit on 12/12/25, so she wrote orders on 12/17/25 to obtain urology note and leave it in the providers folder. NP #1 said she referred Resident #8 to see the urologist as a follow up to Resident #8's recurrent UTIs and follow-up to his/her hospitalization recommendations. NP #1 said she wrote a second request today for the nurses to obtain the urology note. NP #1 said there are some communication issues on the first floor. Resident #8's consultant urology report, dated 12/12/25, was received in the building on 2/12/26, 57 days after the visit. 3. During an interview on 2/13/26 at 2:14 P.M., the Director of Clinical Services said they do not have a policy for using a continuous glucose monitor (CGM). Review of the manufacturer's guidelines for the use and care of the CGM system used by Resident #39, indicated but was not limited to the following:-Continuous Glucose Monitoring system has 2 main parts: A disposable sensor and either a handheld reader or a mobile app to wirelessly receive and display glucose readings from the sensor.-Failure to use the System according to the instructions for use may result in you missing a severe low blood sugar or high glucose event and or making a treatment decision that may result in injury.-14-day wear duration.-Take standard precautions for transmission of bloodborne pathogens to avoid contamination.-Wash application site on the back of your upper arm using plain soap. Dry, and then clean with an alcohol wipe (Not included in the kit). Allow site to air-dry before proceeding.-Clean hands prior to sensor handling/insertion to help prevent infection.-Change the application site for the next sensor application to prevent discomfort or skin irritation.-Only apply the sensor to the back of the upper arm. If placed in other areas, the sensor may not function properly.-Do not touch inside sensor application as it contains a needle.-Applying the sensor may cause bruising or bleeding.-During the first 12 hours of sensor wear the magnifying glass/drop of blood symbol will display, and you cannot use sensor values to make treatment decisions during this time period. Confirm sensor glucose readings with a blood glucose test before making treatment decisions during the first 12 hours of sensor. There when you see the magnifying glass/blood drop symbol.-If the reader is dropped (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | or subjected to impact, do a reader test to check that it is still working properly. Resident #39 was admitted to the facility in November 2025 with diagnoses which included Type II diabetes mellitus with proliferative diabetic retinopathy with macular edema right eye and traction retinal detachment involving macular left eye, legally blind, and on long-term use of insulin. Review of the Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident #39 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #39 was cognitively intact. Review of Resident #39's Physician's Orders indicated the following orders:- Resident has a continuous glucose monitor, before meals and at bedtime related to diabetes mellitus (DM) (sic), order date 11/24/25. During an interview on 2/13/26 at 12:45 P.M., Resident #39 said the nurses check his/her blood glucose levels using his/her CGM system since he/she was admitted . Resident #39 said they never prick his/her finger to get his/her sugar readings. During an interview on 2/13/26 at 2:13 P.M., the Director of Nurses (DON) said they don't use a CGM system in the building. She said her expectation is that the nurses do a finger stick to monitor a resident's blood glucose levels. The DON said she was not aware the nurses were monitoring Resident #39's blood glucose levels using only the CGM system. The DON reviewed Resident #39's orders and said there were no orders in place for the care of the CGM system or changing of the CGM sensors. During an interview on 2/13/26 at 2:18 P.M., Nurse #1 said she regularly works on the first floor and cares for Resident #39. She said she checks Resident #39's blood glucose level using the Resident #39's CGM monitoring system. Nurse #1 said she does not know who monitors the sensors, changes the sensor unit, how often it is changed, or where Resident #39 gets the supplies to change the sensor. During an interview on 2/13/26 at 2:20 P.M., Nurse #7 said she has worked with Resident #39, and she uses Resident #39's glucose monitor to check his/her blood sugar levels. Nurse #7 said she never does a finger stick to check blood glucose levels. Nurse #7 said she did not know anything about the care or maintenance of the CGM monitoring machine system. Nurse #7 said she just reads the meter for the results; that's the way the patient wants it. During an interview on 2/13/26 at 2:26 P.M., with Consultant Chief Clinical Officer (CCCO) present, Resident #39 said the nurses get his/her blood glucose reading from the meter reading all the time and showed the surveyor the small digital reader on his/her bedside table. Resident #39 said he/she changes the device every two weeks him/herself and proceeded to demonstrate for the surveyor with an actual sensor he/she removed from a box, raised their left arm and said, you just put it against your skin and press down; it is easy. Resident #39 did not demonstrate or state he/she cleans the area or rotates the location of the sensor. During an interview on 2/13/26 at 2:27 P.M., CCCO said Resident #39 said the nurses use his/her CGM system all the time to monitor blood glucose levels. She said she has the CGM package insert and will have to review the manufacturer's instructions. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care or services that was trauma informed and/or culturally competent.<br><br>Based on observation, interview, and record review, the facility failed to ensure a person-centered plan of care with individualized interventions for trauma-informed care was developed for one Resident (#84), out of 20 sampled residents. Specifically, the facility failed to assess and implement care plan interventions for Resident #84 who had a history of trauma. Findings include:Review of the facility's policy titled Trauma Informed Care, dated as revised in October 2019, indicated as part of the comprehensive assessment, identifying history of trauma or interpersonal violence when such information is provided to the facility. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Resident #84 was admitted to the facility in October 2025 with diagnoses of substance use disorder and cognitive impairment. On 2/10/26 at 11:30 A.M., the surveyor observed Resident #84 sitting across from the nurses' station. Resident #84 said he/she was scared and asked the surveyor for help. During an interview on 2/10/26 at 11:30 A.M., Nurse # 2 said Resident #84 always says they were scared and this was their behavior. Review of the care plans indicated Resident #84 had a focus for behaviors related to wandering, pacing, refusing care, yelling at staff, physically aggressive, verbally abusive, disruptive sounds and disrobing in public with the following interventions: administer and monitor the effectiveness and side effects of medications, anticipate care needs, invite and encourage activity programs, provide non-confrontational environment and to reduce the following stressors that may be contributing to the resident's inappropriate behaviors: calling sister. Review of the medical record indicated on 11/5/25 the Licensed Mental Health Counselor (LMHC) noted Resident #84 had a history of trauma, and all subsequent visits with the LMHC noted a history of trauma. Review of the Social Service Evaluation, dated 1/9/26, which included a Trauma Informed Care Assessment indicated Resident #84 had not ever had an experience so upsetting it changed him/her emotionally, spiritually, physically or behaviorally. No further information was indicated on the trauma assessment. The Behavior section indicated Resident #84 demonstrated agitation, anxiousness, restlessness and tearfulness. The Plan of Care comments indicated Resident was followed by psychiatric services including a most recent visit with the LMHC on 1/6/26. There was no further indication the Social Worker inquired to the Resident or the Resident's sister about the noted trauma on the LMHC visit. During an interview on 2/13/26 at 10:10 A.M., the Administrator said the Social Worker was unavailable for interview this week. During an interview on 2/13/26 at 11:12 A.M., the LMHC said Resident #84 had a cognitive decline over the last few months and he had continued therapeutic sessions with the Resident to offer support. He said Resident #84 had previously alluded to trauma in regard to drug use and living on the streets. He said the Resident cries a lot and would talk about very difficult things including the people he/she associated with during the drug use. He said he had not reached out to the family of Resident #84 regarding the trauma and had not heard if the facility staff had either. He said he communicates with the unit staff regarding residents, including the Unit Manager. During an interview on 2/13/26 at 11:40 A.M., the Unit Manager said she was aware Resident #84 had a history of substance use disorder but did not hear anything about a history of trauma. During an interview on 2/13/26 at 12:00 P.M., the LMHC said he had reached out to the sister of Resident #84 who said Resident #84 had a history of being physically abused. He said with the Resident's cognitive decline, the Resident may be thinking he/she was currently in the unsafe situation, making accepting care difficult. During an interview on 2/13/26 at 12:26 P.M., the Director of Nurses said the history of trauma should have been on the Social Service Evaluation and should have been care planned with interventions. |

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| | 225284 | A. Building<br>B. Wing | 02/13/2026 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Properly label and date food products in the main kitchen walk-in refrigerator, and store food products in the walk-in refrigerator off the floor; and 2. Ensure in two of two kitchenettes, resident food was discarded after three days, and food storage cabinets were kept clean. Findings include: Review of the facility's policy titled Food and Supply Storage, last revised 6/2018, indicated but was not limited to the following:-Food and food supplies are stored to minimize exposure to splash, dust, and other contamination; and stored away from the walls and six inches off the floor and eighteen inches below ceiling and fire sprinkler system.-Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and use by date.-Discard food that exceeds their use by date or expiration date, is damaged, is spoiled, has the time and temperature danger zone requirements, or incorrectly stored such that it is unsafe or its safety is uncertain. On 2/9/26 at 7:21 A.M., the surveyor observed the following in the main kitchen: -One metal container containing sliced tomato and lettuce with a pinkish discoloration, Prep date 1/30/26, and a use by date of 2/4/26.-One metal container, holding four small clear plastic containers dated 1/21 containing white chopped onions.-Two trays with prepared cole slaw and plastic containers, undated.-One pouch of whipped cream, not dated with an open date.-Four boxes containing juice cups stored on the floor, under the bottom shelf. On 2/11/26 at 9:34 A.M., the surveyor observed the following in the main kitchen:Walk-in refrigerator:-Two boxes of half gallon milk products stored on the floor of the walk-in refrigerator (where the four boxes of juice cups were stored on 2/9/26). During an interview on 02/12/26 at 9:00 A.M., the Food Service Manager (FSM) said the boxes of food should not have been stored on the floor in the refrigerator and the food should be discarded after three days. 2. Review of the facility's policy titled Food Brought into Facility, last revised 4/2019, indicated but was not limited to:- It is the policy of the Company that visitors or family members are permitted to bring food to a resident and are encouraged to limit food to those that meet patient's meal plan and safe food handling practices.- Perishable food must be stored and identified with resident's name, food item and use by date.- These can be stored in the nursing unit kitchen nourishment refrigerator. - The nursing staff is responsible for discarding perishable foods on or before the use by date.On 2/12/26 at 8:08 A.M., the surveyor made the following observations in the resident's kitchenette on the second-floor unit:-In the refrigerator was a white takeout container with a resident's name, which was dated 2/7/26. -In the bottom left shelf cabinet was a plastic food container that was soiled with some type of sauce, dirty fork, and particles of debris on the shelf. On 2/12/26 at 8:18 A.M., the surveyor made the following observations in the resident's kitchenette on the first-floor unit:-In the refrigerator was a white bag labeled with a resident's name, which was dated 2/6/26. In the bag was a black banana, white Styrofoam container which contained a piece of cake, various other pre-packaged items orange juice, cake, fruit cups, and numerous packages of condiments. On 2/13/26 at 10:10 A.M., the surveyor and the FSM observed both the first and second floor resident kitchenettes and observed the same resident food as observed on 2/12/26 still in the refrigerator and the same dirty container on the bottom shelf of the second-floor kitchenette. During an interview on 2/13/26 at 10:14 A.M., the FSM said when the staff check the refrigerator temperatures in the morning, they should remove any food stored that is older than three days. He said the cabinets should be kept clean. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>Based on record review and interview, the facility failed to ensure the Arbitration Agreement presented to residents as part of the admission packet included the required information for three Residents (#75, #85, and #59), out of a sample of three records reviewed. Specifically, the facility failed to ensure the agreement explicitly granted Residents thirty days after signing to rescind the Agreement and failed to explicitly state that the residents (or representatives) were not required to sign as a condition for admission. Findings include:During the entrance conference interview on 2/9/26 at 8:22 A.M., the Administrator said the facility has asked residents to enter into a binding arbitration agreement. 1. Resident #75 was admitted to the facility in January 2026. During an interview on 2/10/26 at 3:37 P.M., Resident #75 said no one had explained any of the paperwork to him/her when they were admitted . He/she said they were handed paperwork and asked to sign it. Review of the Arbitration Agreement signed by Resident #75 on 1/8/26 failed to explicitly state that the Resident could rescind the agreement within 30 days and failed to indicate the Resident was not required to sign as a condition of admission. 2. Resident #85 was admitted to the facility in December 2025. During an interview on 2/10/26 at 3:43 P.M., Resident #85 said no one had told him/her about arbitration or having 30 days to rescind the agreement, but that hearing it from the surveyor made sense. The Resident said no one had reviewed the admission paperwork with him/her, but he/she had told the staff that he/she understood it. Review of the Arbitration Agreement signed by Resident #85 on 12/16/25 failed to explicitly state that the Resident could rescind the agreement within 30 days and failed to indicate the Resident was not required to sign as a condition of admission. 3. Resident #59 was admitted to the facility in January 2026. During an interview on 2/10/26 at 3:47 P.M., the representative of Resident #59 said someone had reviewed the admission paperwork with her and she did recall reviewing the Arbitration Agreement. Review of the Arbitration Agreement signed by the representative of Resident #59 on 1/23/26 failed to explicitly state that the Resident could rescind the agreement within 30 days and failed to indicate the Resident was not required to sign as a condition of admission. During an interview on 2/10/26 at 4:10 P.M., the Administrator said she was responsible for reviewing admission packets with residents and representatives and had been reviewing Arbitration Agreements as well. The Administrator provided the surveyor with a blank copy of an admission packet that she had been providing to residents, which included Attachment M: Arbitration Agreement. The Administrator reviewed the Arbitration Agreement for all three Residents and said she was unable to find where it stated the Residents could rescind the Agreement within 30 days after signing or where it stated that the Residents (or representatives) were not required to sign as a condition for admission. She said she goes over this information verbally with residents because she knows it is part of the regulation. She said she was not sure why two of the Residents had said no one had gone over the information with them. She said this was the most up to date Arbitration Agreement. During an interview on 2/11/26 at 8:30 A.M., the Administrator said there was a more up to date Arbitration Agreement that was developed in February 2025, but she had not been using the correct one. She said the required components were not listed on the Agreements signed by Residents #75, #85 and the representative for #59. |

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| F 0848<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide a neutral and fair arbitration process and agree to arbitrator and venue.<br><br>Based on record review and interview, the facility failed to ensure the Arbitration Agreement presented to residents as part of the admission packet included the required information for three Residents (#75, #85, and #59), out of a sample of three records reviewed. Specifically, the facility failed to ensure the agreement provided for the selection of a neutral arbitrator agreed upon by both parties and the selection of a venue that was convenient to both parties. Findings include:During the entrance conference interview on 2/9/26 at 8:22 A.M., the Administrator said the facility had asked residents to enter into a binding arbitration agreement. 1. Resident #75 was admitted to the facility in January 2026. Review of the Arbitration Agreement signed by Resident #75 on 1/8/26 failed to indicate both parties would agree to a neutral arbitrator and agree to a venue that was convenient to both parties. 2. Resident #85 was admitted to the facility in December 2025. Review of the Arbitration Agreement signed by Resident #85 failed to indicate both parties would agree to a neutral arbitrator and agree to a venue that was convenient to both parties. 3. Resident #59 was admitted to the facility in January 2026. Review of the Arbitration Agreement signed by the representative of Resident #59 on 1/23/26 failed to indicate both parties would agree to a neutral arbitrator and agree to a venue that was convenient to both parties. During an interview on 2/10/26 at 4:10 P.M., the Administrator said she was responsible for reviewing admission packets with residents and representatives and had been reviewing Arbitration Agreements as well. The Administrator provided the surveyor with a blank copy of an admission packet that she had been providing to residents, which included Attachment M: Arbitration Agreement. The Administrator reviewed the Arbitration Agreement for all three Residents and said she was unable to find where it indicated both parties would agree to a neutral arbitrator and would agree to a venue that was convenient to both parties. She said this was the most up to date Arbitration Agreement. During an interview on 2/11/26 at 8:30 A.M., the Administrator said there was a more up to date Arbitration Agreement that was developed in February 2025, but she had not been using the correct one. She said the required components were not listed on the Agreements signed by Residents #75, #85 and the representative for #59. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen (O2) equipment was maintained in a sanitary manner to help decrease the risk of potential contamination and infection for two Residents (#21 and #15), out of a total sample of 20 residents. Findings include:Review of the World Health Organization: Care, Cleaning and Disinfection of Oxygen Concentrators Checklist (2022) indicated:-Inspect and clean air intake filter (1-2 times per week)1. Pull the filter gently out and replace with spare one.2. Put the filter in cool, soapy water and swirl gently to remove debris.3. Remove from soapy water and place it in [NAME] area until completely dry.4. Store the spare filter until next cleaning is needed. Review of the National Library of Medicine (NLM), dated 1/19/22, indicated but was not limited to:-One of the main issues affecting the oxygen concentrators, is that related to the filters, which are designed to filter out dust, particles, bacteria.https://pmc.ncbi.nlm.nih.gov/articles/PMC8768026/ A. Resident #21 was admitted to the facility in October 2024 with diagnoses including chronic obstructive pulmonary disease (COPD, a progressive, irreversible lung disease that causes severe airflow obstruction and breathing difficulties,) and shortness of breath. Review of the Minimum Data Set (MDS) assessment, dated 1/23/26, indicated Resident #21 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, shortness of breath or trouble breathing with exertion and when lying flat, and utilized oxygen therapy. Review of the User's Technical Manual, dated November 2009, for Resident #21's oxygen concentrator indicated but was not limited to:-Cleaning the Cabinet Filter (external filter)-DO NOT operate the concentrator without the filter installed.- NOTE: There is one cabinet filter located on the back of the cabinet.-Remove the filter and clean at least once a week depending on environmental conditions.-Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. Review of Resident #21's Physician's Orders indicated but were not limited to:- Administer Oxygen at 2 liters (L)/minute continuously via nasal cannula every shift, dated 10/4/2024-Change oxygen every Tuesday on the night shift. Wipe down concentrator and clean filters, dated 10/25/2025 The surveyor observed Resident #21's oxygen concentrator running and in use without a filter and gray dust-like debris where the filter should have been as follows:-2/9/26 at 10:00 A.M.-2/10/26 at 8:49 A.M. and 4:07 P.M.-2/11/26 at 11:26 A.M. and 2:44 P.M.-2/12/26 at 7:12 A.M. and 12:20 P.M. Review of Resident #21's February Treatment Administration Record (TAR) indicated his/her oxygen concentrator had been wiped down and the filter cleaned on 2/3/26 and 2/10/26. During an interview with observation on 2/11/26 at 2:44 P.M., Nurse #1 and the surveyor observed Resident #21 sitting in his/her wheelchair utilizing his/her oxygen. Nurse #1 said Resident #21 utilized oxygen continuously. Nurse #1 and the surveyor inspected Resident #21's oxygen concentrator. Nurse #1 said she had changed Resident #21's oxygen tubing on 2/3/26 and wiped down their oxygen concentrator. Nurse #1 said she did not know if Resident #21's oxygen concentrator needed a filter. Nurse #21 said the area over the internal filter of the oxygen concentrator had gray dust-like debris over it. During an interview with Nurse #1 present on 2/11/26 at 2:53 P.M., Resident #21 said he/she had utilized oxygen therapy since being admitted to the facility. Resident #21 said his/her oxygen concentrator should have an external filter on it, but it did not. During an observation and interview with Resident #21 present on 2/12/26 at 12:36 P.M., Nurse #3 said the 11:00 P.M. to 7:00 A.M. shift was responsible for changing tubing and cleaning the filters on oxygen concentrators weekly. Nurse #3 observed Resident #21's oxygen concentrator and said she was not sure if it should have had a filter. Resident #21 said there should have been a filter in place on his/her oxygen concentrator but there had not been a filter in place in some time. During an interview with observation 2/12/26 at 1:40 P.M., the Staff Development Coordinator/Infection Preventionist said the filters on oxygen concentrators were cleaned weekly on the overnight shift. He observed Resident #21's oxygen concentrator and said the area where the filter belonged was<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | covered with gray dust-like debris and the filter was not present. B. Resident #15 was admitted to the facility in January 2023 with diagnoses including dependence on supplemental oxygen, COPD, chronic respiratory failure, and shortness of breath. Review of the MDS assessment, dated 12/5/25, indicated Resident #15 had a moderate cognitive deficit as evidenced by a BIMS score of 10 out of 15, had trouble breathing on exertion and when lying flat, and utilized oxygen therapy. Review of the User's Technical Manual, dated July 2022, for Resident #15's oxygen concentrator indicated but was not limited to:- Cleaning the Cabinet Filter-CAUTION! Risk of Damage: To avoid damage to the internal components of the unit: - DO NOT operate the concentrator without the filter installed or with a dirty filter.-There are two cabinet filters located on each side of the cabinet.- Remove the filter and clean as needed. -Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to high dust, air pollutants, etc.-Clean the cabinet filter with a vacuum cleaner or wash with mild liquid dish detergent and water. Rinse thoroughly.-Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Replace filter if any damage is found.-Reinstall the cabinet filter. Review of Resident #15's Physician's Orders indicated but were not limited to:- Administer Oxygen at 3 liters (L)/minute continuously via nasal cannula as needed, dated 9/10/2024-Change oxygen every Tuesday on the night shift. Wipe down concentrator and clean filters, dated 11/12/2024 The surveyor observed Resident #15's oxygen concentrator running and in use with the filters on the left and right side of the oxygen concentrator covered with a thick layer of gray dust-like debris on each side on:-2/9/26 at 9:31 A.M. and 11:19 A.M.-2/10/26 at 8:44 A.M.-2/12/26 at 7:13 A.M. Review of Resident #15's February TAR indicated his/her oxygen concentrator had been wiped down and filter was cleaned on 2/3/26 and 2/10/26. During an interview with observation on 2/12/26 at 12:26 P.M., Nurse #4 said oxygen concentrators were monitored by maintenance. Nurse #4 said the overnight shift was responsible for changing the oxygen tubing weekly and changing and cleaning the filters weekly. Nurse #4 and the surveyor inspected the filters on Resident #15's oxygen concentrator and said they did not look too bad. During an interview with observation 2/12/26 at 1:40 P.M., the Staff Development Coordinator/Infection Preventionist said the filters on oxygen concentrator were cleaned weekly on the overnight shift. He observed Resident #15's oxygen concentrator and said those filters are dirty and should be cleaned. During an interview on 2/12/26 at 1:53 P.M., the Director of Nursing said the 11:00 P.M. to 7:00 A.M. shift was responsible for cleaning the oxygen concentrators and washing the oxygen filters with soap and water weekly. She said she was notified about Resident #15's oxygen filters being dirty and Resident #21's filter being missing and the area where the filter should have been being dirty. She said the expectation was each oxygen concentrator should be clean and have a clean filter in place. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, record review, and interview, the facility failed to ensure one Resident (#21), out of a total sample of 20 residents, was assessed by the Interdisciplinary Care Team for self-administration of all their medications and had a physician's order to self-administer medications.Findings include:Review of the facility's policy titled Self-Administration of Medications, last revised September 2024, indicated but was not limited to:-Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.-As part of their overall evaluation the staff and/or provider will assess each resident's mental and physical abilities to determine whether self-administering medications are clinically appropriate for the resident. -The staff and/or provider will document their findings and the choices of the residents who are able to self-administer medications.Resident #21 was admitted to the facility in October 2024 with diagnoses including chronic obstructive pulmonary disease (COPD, a progressive, irreversible lung disease that causes severe airflow obstruction and breathing difficulties) and shortness of breath.Review of the Minimum Data Set (MDS) assessment, dated 1/23/26, indicated Resident #21 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview with observation on 2/9/26 at 10:00 A.M., the surveyor observed Resident #21 sitting on the edge of his/her bed with the following:- A wash basin on his/her bed containing two inhalers - Breztri Aerosphere (maintenance inhaler approved for long-term, twice-daily treatment of COPD), and - Salmeterol Inhaler (used to maintain control of COPD by relaxing airway muscles)Resident #21 said he/she would administer their own inhalers twice a day and preferred to do so themselves. Resident #21 said the nurses knew he/she had had their inhalers at their bedside.On 2/10/26 at 8:49 A.M. and 4:07 P.M., the surveyor observed Resident #21 sitting in his/her wheelchair with two Breztri Inhalers and one Salmeterol Inhaler next to him/her on the bed.On 2/11/26 at 11:19 A.M., the surveyor observed Resident #21 sitting in his/her wheelchair with one Breztri Inhaler next to him/her on the bed.Review of Resident #21's Physician's Orders indicated but was not limited to:- Breztri Aerosphere Inhalation Aerosol 160-9-4.8 micrograms (mcg) per activation inhale two puffs two times a day,1/10/26- Salmeterol Xinafoate Aerosol Powder Breath Activated 50 mcg dose inhale two times a day, dated 8/21/25- Albuterol Sulfate Inhalation Aerosol Solution (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness) 108 mcg inhale two puffs every four hours as needed, dated 8/16/25Review of Resident #21's medical record failed to indicate:- he/she had a care plan to self-administer their medications, and - a physician's order for self-administration of medications.During an interview with observation on 2/11/26 at 2:44 P.M., Nurse #1 and the surveyor observed one Breztri Inhaler and one Salmeterol Inhaler on Resident #21's bed. Nurse #1 said if a resident voiced a desire to self-administer their medications, they would need an assessment and physician's order, which indicated which medications he/she could self-administer. Nurse #1 said Resident #21 had not been assessed nor had an order to self-administer his/her medications. Nurse #1 said Resident #21 preferred to hold onto their inhalers and administer them himself/herself. Nurse #1 said she took one of Resident #21 Breztri Inhalers this morning and placed it in the medication cart. During an interview with observation on 2/12/26 at 12:24 P.M., the surveyor observed on Resident #21's bed one Breztri Inhaler, one Salmeterol Inhaler, and one Albuterol Inhaler. Resident #21 said he/she wanted to be able to hold onto his/her inhalers and be able to self-administer their own inhalers especially the Albuterol. Resident #21 said he/she did not want to wait on a nurse if they needed their rescue inhaler (Albuterol).During an interview with observation on 2/12/26 at 12:52 P.M., Nurse #3 and the surveyor observed one Breztri Inhaler, one Salmeterol Inhaler, and one Albuterol Inhaler. Nurse #3 said Resident #21 chose to administer their own inhalers. Nurse #3 said she had watched Resident #21 take their Breztri Inhaler and Salmeterol Inhaler this morning. Nurse #3 said Resident #21 did not have an order to self-administer his/her<br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inhalers and had not been evaluated to do so. During an interview on 2/12/26 at 1:53 P.M., the Director of Nursing said if a resident expressed a desire to self-administer his/her medications then they should have been assessed to self-administer their medications. In addition, they need a physician's order to do so prior to the nurses allowing him/her to administer them and prior to storing them in their room. |

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| | 225284 | A. Building<br>B. Wing | 02/13/2026 |

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

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure residents/resident representatives had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance for one Resident (#39), out of a total sample of 20 residents. Specifically, the facility failed to ensure staff followed their policy and procedure when Resident #39 voiced a complaint regarding music playing outside his/her room disrupting his/her ability to be comfortable in his/her room. Findings include: Review of the facility's policy titled Grievances, dated 2/2024, indicated but was not limited to the following:-The Administrator is identified as the grievance official responsible for oversight of the grievance process in the facility. This includes responsibility for reviewing and tracking grievances, necessary investigations, ensuring that grievances are addressed and response provided.-If a resident, and/or health care representative, or another interested family member of a resident has a complaint, a staff member will inform the person of the grievance process and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the grievance form as needed.-Grievances may be submitted orally or in writing.-Upon receipt of written grievance, the Administrator will refer it to the appropriate department head for investigation. The Department head will submit a responsive finding to the Administrator.-The Administrator will review the findings with the person investigating the grievance to determine what corrective actions need to be made.-The Administrator will document receipt of all grievances on the Grievance Log. The Grievance Log will be used for tracking and trending as part of the Facility Quality Performance Improvement Committee as warranted.-The resident, and/or health care representative, or person filing the grievance on behalf of the resident, will be informed of the findings of the investigation and actions that will be taken to correct any identified problems. This report will be completed by the Administrator within 7 working days of receipt of the grievance.-The grievance will be signed by the administrator and will be made available to the resident and/or health care representative, or person acting on behalf of resident. The reports are filed in a binder, labeled Grievances and maintained in the Administrator's office. Resident #39 was admitted to the facility in November 2025 with diagnoses which included depression and legal blindness. Review of the Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident #39 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact.During an interview on 2/9/26 at 10:30 A.M., Resident #39 said he/she keeps the door closed because the radio speaker in the hall is loud, it was turned off for a couple of days but is now turned back on. On 2/12/26 at 11:03 A.M., the surveyor observed Resident #39's door closed. Upon entering the room, the surveyor observed Resident #39 wearing headphones and resting. The surveyor observed the radio speaker in the hallway ceiling located directly outside Resident #39's room and heard the music playing. During an interview on 2/12/26 at 11:03 A.M., Resident #39 said he/she complained to the Administrator about the radio in the hallway ceiling coming on every day at 5:50 A.M. and staying on all day. Resident #39 said it's especially bothersome on the weekend when the music channel has a lot of [NAME]. Resident #39 said they are playing with his/her thyroid medication, and he/she is exhausted and can't sleep because the radio is on all day. Resident #39 said he/she must keep the room door shut all day and often must wear headphones to block out the music. Resident #39 said the Administrator hasn't done anything about it. Review of the facility's 2026 Grievance Log for January and February indicated there were no grievances for Resident #39 recorded for the music playing in the hallway. During an interview on 2/13/26 at 12:15 P.M., the Administrator said Resident #39 has brought up the music playing in the hallway ceiling (Central to whole building) as a complaint. The Administrator said she agreed the music at 6:00 A.M. was too early. She spoke with the Maintenance Director and told him to turn on the music at 9:00 A.M. and (continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | shut it off when he leaves for the day. The Administrator said she would have to follow up with the Maintenance Director to check if he is following the schedule for the music. The Administrator said if Resident #39 was still unhappy about the music, he/she would need to communicate that with her. The Administrator said the difference between a complaint and grievance is, if she addresses the complaint right away, it's not a grievance. The Administrator said this was a complaint from Resident #39, not a grievance. During an interview on 2/13/26 at 2:26 P.M., with Consultant Chief Clinical Officer (CCCO) present, Resident #39 said the Administrator never spoke to him/her about the Maintenance Director turning on the music at 9:00 A.M. Resident #39 said the music was on at 6:50 A.M. today. Resident #39 said he/she has spoken to the Administrator four times, and nothing has been done. Both the surveyor and CCCO heard the music coming from the speaker in the hallway. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>Based on record review and interview, the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) program for one Resident (#9), out of a total sample of 20 residents. Specifically, the facility failed to document Resident #9's bipolar disorder diagnosis in Section B at admission and did not initiate a new PASRR Level I Assessment following the addition of a schizoaffective disorder diagnosis to the clinical record. Findings include:Review of the MassHealth Nursing Facility Bulletin 186, dated June 2024, included but was not limited to the following:-Level I Screenings, including Post-admission Screenings, must be performed using the PASRR Level I Screening form via the PASRR Portal. Level I Screenings may not be performed using any other form or screening tool-Post admission Screening:A PASRR screening, using the Level I Screening form submitted via the PASRR Portal, of nursing facility residents that the nursing facility must conduct in the following instances:1) for an individual who is admitted to the facility under an Exempted Hospital Discharge (EHD) or a time-limited Categorical Determination (CD), if the facility determines that the admission will exceed the EHD or CD's permitted duration, or 2) for residents who experience a Significant Change or are newly identified as having a condition that may impact their PASRR status, the appropriateness of their nursing facility placement, or their need for Specialized Services.Resident #9 was admitted to the facility in September 2022 with diagnoses including bipolar disorder, anxiety, and depression. Review of the PASRR assessment, completed 9/22/22, Section B: Screen for Serious Mental Illness (SMI) indicated that the resident had a SMI for anxiety. Further review, of Section B, mood disorder (e.g., Bipolar or Major Depression) was not selected on the intake form.Review of Physician's orders, dated 2/5/24, indicated to add a diagnosis of schizoaffective disorder.Review of the Resident's clinical record included a list of diagnoses which indicated:-bipolar disorder, current episode depressed, mild, dated 9/2022-schizoaffective disorder was added on 2/6/24 During an interview on 2/13/26 at 1:05 P.M., Regional Nurse (RN) #1 said the Social Worker (SW) would oversee the PASRR process. RN #1 said the SW was not available as she was away. RN #1 said the Administrator would be able to retrieve any PASRRs from the portal.During an interview on 2/13/26 at 1:06 P.M., the Administrator reviewed the PASRR Portal for an updated Level I PASRR and said a new Level I PASRR screen had not been submitted to include a diagnosis of bipolar disorder and capture a newly added diagnosis of schizoaffective disorder on 2/6/24. The Administrator said a Level I PASRR should have been completed.During an interview on 2/13/26 at 2:00 P.M., RN #1 said that the Resident should have had a new Level I PASRR screening done to include a SMI diagnosis of bipolar disorder. RN #1 said that a new PASRR Level I screen should have been submitted to the PASRR Portal on 2/6/24 when a diagnosis of schizoaffective disorder was added to the Resident's diagnosis list, but the PASRR screen had not been submitted. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on interview and record review, the facility failed to develop, implement and individualize comprehensive care plans for one Resident (#39), out of a total sample of 20 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed for the care needs and monitoring related to the diagnosis of Type II DM and the use of a continuous glucose monitoring system (CGM). Findings include: Review of the facility's comprehensive care plan titled Care Plans, Comprehensive Person-Centered, last Revised 1/2024, indicated but was not limited to the following:-A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the residents' physical, psychosocial and functional needs that are developed for each resident.-The residents comprehensive care plan will identify problem areas and their causes as warranted and develop interventions that are targeted and meaningful to the residents.-Evaluations of residents are ongoing and care plans are revised as information about the resident and the conditions change. Review of the manufacturer's guidelines for the use and care of the CGM system used by Resident #39, indicated but was not limited to the following:-Continuous Glucose Monitoring system has 2 main parts: A disposable sensor and either a handheld reader or a mobile app to wirelessly receive and display glucose readings from the sensor.-Failure to use the System according to the instructions for use may result in you missing a severe low blood sugar or high glucose event and/or making a treatment decision that may result in injury.-14-day wear duration.-Take standard precautions for transmission of bloodborne pathogens to avoid contamination.-Wash application site on the back of your upper arm using plain soap. Dry, and then clean with an alcohol wipe (Not included in the kit). Allow site to air-dry before proceeding.-Clean hands prior to sensor handling/insertion to help prevent infection.-Change the application site for the next sensor application to prevent discomfort or skin irritation.-Only apply the sensor to the back of the upper arm. If placed in other areas, the sensor may not function properly.-Do not touch inside sensor application as it contains a needle.-Applying the sensor may cause bruising or bleeding. Resident #39 was admitted to the facility in November 2025 with diagnoses which included: Type II diabetes mellitus with proliferative diabetic retinopathy with macular edema right eye and traction retinal detachment involving macular left eye, legally blind, and on long-term use of insulin. Review of Resident #39's Physician's Orders indicated but were not limited to the following orders:-Consistent/controlled carbohydrate diet (diabetic diet), effective 11/24/25-Resident has Continuous Glucose Monitoring device, before meals and at bedtime related to type II diabetes mellitus (DM) (sic), effective 11/24/25.-Jardiance oral tablet 25 milligrams (mg), give one tab by mouth in evening related to DM, effective 1/7/26.-Lantus Solostar subcutaneous solution pen injector, inject 18 units subcutaneously in the evening related to DM, effective 11/24/25.-Metformin tablet extended release 24-hour 750 mg. Give two tablets by mouth one time a day related to DM, effective11/24/25. Review of Resident #39's comprehensive care plans failed to indicate there was a care plan developed for Resident #39's care needs related to the diagnosis of Type II DM and the use of a CGM. During an interview on 2/13/26 at 2:13 P.M., the Director of Nurses (DON) said she would expect a resident with a diagnosis of Type II Diabetes to have a care plan for care and monitoring. The DON said Resident #39 should have a care plan to address their diabetic needs, including the CGM, and does not have one. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to ensure one Resident (#71), out of 20 sampled residents, received care and treatment to promote healing of a pressure ulcer. Specifically, the facility failed to follow physician's orders to offload his/her wound, float his/her heels when in bed, and follow wound orders. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Review of the facility's policy titled Dry/Clean Dressings, dated as revised 11/2024, indicated but was not limited to:-The purpose of this procedure is to provide guidelines for the application of dry, clean dressings-Preparation:1. Verify that there is a physician's order for this procedure2. Review the residents current orders and diagnosis to determine if there are special resident needs3. Assemble the equipment and supplies as needed4. Explain procedure to the resident and provide privacy-Guidelines:23. Apply the ordered dressing and secure or bordered dressing per order as ordered. Resident #71 was admitted to the facility in January 2026 with diagnoses which included dementia and pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence) of his/her left heel. Review of the Minimum Data Set (MDS) assessment, dated 1/16/26, indicated Resident #71 had one stage three (indicating full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present) unhealed pressure ulcer that was present on admission. Further review of the MDS indicated Resident #71 required a treatment/dressing to his/her feet. Review of Resident #71's Physician's Orders indicated but was not limited to:-offload wound every shift, 1/9/26 through 2/12/26-float heels in bed every shift, 1/19/26 through 2/12/26-left lateral heel: wash with normal saline, pat dry, apply iodosorb (a gel used to clean wounds and promote healing) and cover with boarder (sic) foam dressing (a sterile, conformable, and highly absorbent wound dressing made of polyurethane foam with an adhesive, often waterproof, border which acts as a barrier against bacteria and fluid and is suitable for partial- to full-thickness wounds) every day for wound care Review of Resident #71's care plans indicated but was not limited to:-Problem: Pressure Ulcer: Ulceration or interference with structural integrity of layers of skin, left lateral heel-Interventions: Treatment as ordered, 1/6/26 Review of the wound consultant recommendations, on the following dates, indicated part of his/her treatment plan included float heels in bed and offload wounds:-1/7/26,-1/12/26,-1/19/26,-1/27/26,-2/4/26, and- 2/9/26 Review of Resident #71's Treatment Administration Record (TAR) from February 2026 indicated his/her heels were floated in bed every shift and his/her wound was offloaded every shift. Further review of the TAR indicated his/her left lateral heel dressing had been changed as ordered on 2/10/26 and no as needed treatments were documented. On the following dates/times of the survey, the surveyor observed Resident #71:-2/9/26 at 10:28 A.M., lying in bed with both heels flat on his/her bed-2/10/26 at 3:45 P.M., sitting in his/her wheelchair with both feet resting on his/her foot buddy/leg supports-2/11/26 at 7:33 A.M. and 8:21 A.M., lying in bed heels flat on his/her bed-2/11/26 at 10:50 A.M., sitting in his/her wheelchair with both feet resting on his/her foot buddy/leg supports with a white bordered gauze dressing sticking from the top of his/her sock-2/11/26 at 2:40 P.M.: lying in bed with flattened pillow at the top of his/her calves with both heels touching the surface of the bed with a white bordered gauze dressing sticking from the top of his/her sock-2/12/26 at 7:38 A.M., lying in bed with both heels flat on his/her mattress On 2/11/26 at 2:40 P.M., the surveyor<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | observed Unit Manager #1 provide wound care with assistance from the Infection Control Nurse. The surveyor observed Unit Manager #1 remove a white boarded gauze dressing (a sterile, multi-layer, all-in-one adhesive island dressing designed for covering wounds with light to moderate drainage and consists of non-adherent, absorbent gauze pad surrounded by an adhesive border that secures the dressing in place) from the wound and provide wound care as ordered. During an interview on 2/11/26 at 2:59 P.M., Unit Manager #1 and the Infection Prevention Nurse said Resident #71's heels should be offloaded and not resting on the mattress. Unit Manager #1 said the incorrect dressing had been applied and should have been a bordered foam dressing not bordered gauze. During an interview on 2/12/26 at 8:23 A.M., Unit Manager #1 said Resident #71 had orders indicating his/her wound should be offloaded every shift and his/her heels should be floating while in bed. During an interview on 2/12/26 at 1:31 P.M., the Director of Nurses (DON) said physician's orders should be followed as indicated. The DON said heels should be offloaded and/or floating and the correct dressing should have been applied. |