Department of Health & Human Services Centers for Medicare & Medicaid Services

Printed: 12/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2021	
NAME OF PROVIDER OR SUPPLIER Plymouth Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 123 South Street Plymouth, MA 02360		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required the use of adaptive equipment, (an air mattress which included an air mattress cover), the Facility failed to ensure staff inspected the air mattress cover for wear and tear, that the air mattress cover straps were secured and intact, in an effort to maintain a safe environment to prevent incidents or accidents that could result in injury. On 11/29/21, Resident #1 had an unwitnessed fall out of bed and was found on the floor with half of the bed air mattress cover underneath him/her. The straps that held the air mattress cover onto the air mattress, were found to be torn and frayed, and could not hold the air mattress cover securely in place over the air mattress. Resident #1 sustained an acute left femoral head dislocation, an abrasion to the left forehead, a skin tear to the right lateral elbow, a bruise to the right hip bone and right side of face. Findings include: Review of the SUPRA APL Air Mattress Overlay/Replacement Mattress Operating Manual, undated, indicated to read all instructions before use. The Manual indicated to use the straps at the end of the mattress and stretch them around the mattress to prevent it from unraveling and to check the mattress cover for signs of wear or damage. Resident #1 was admitted to the Facility in March 2021, medical diagnoses included pathological fracture of left hip, dementia and diabetic foot ulcer. A Quarterly Minimum Data Set (MDS) Assessment, dated 10/13/21, indicated that Resident #1 had severe cognitive impairment, contractures of the lower extremities and required extensive assist of one staff member for bed mobility. Review of Resident #1's Fall Risk Assessment, dated 10/08/21, indicated that he/she was at high risk for falls.			

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 225207

If continuation sheet Page 1 of 3

Department of Health & Human Services Centers for Medicare & Medicaid Services

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			NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2021	
NAME OF PROVIDER OR SUPPLIER Plymouth Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 123 South Street Plymouth, MA 02360		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0689 Level of Harm - Actual harm Residents Affected - Few				

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STATEMENT OF DEFICIENCIES		1		
AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
Plymouth Rehabilitation & Health Care Center		123 South Street Plymouth, MA 02360		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
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