STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43935 Based on observation and interview, the facility failed for two Residents (#47 and #133), to ensure the Residents had the ability to exercise their right to smoke, or make reasonable accommodations of such, out of a total sample of 30 residents. Findings include: 1. Resident #47 was admitted to the facility in May 2021. Review of the Minimum Data Set (MDS) assessment, dated 8/13/21, indicated Resident #47 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15. Section J, question J1300 regarding tobacco use was not completed. During an interview on 11/04/21 at 10:17 A.M., Resident #47 said he/she was not happy and felt that the facility was refusing to let him/her smoke and that he/she was offered the patch, but refused saying, I will not let them drug me for their convenience while they violate my rights. Review of the medical record failed to indicate any progress notes educating the Resident or their representative to their right to smoke being temporarily removed. Review of the medication administration record indicated Resident #47 received a nicotine patch at a dose of 21 milligrams (mg) on November 3, 2021 only. Further review of the medical record indicated the Resident to be assessed as a current smoker on 5/19/21, and there was a blank smoking evaluation in the record dated 8/6/21. There was no indication anywhere in the record that Resident #47's right to smoke was suspended. 2. Resident #133 was admitted to the facility in August 2021. Review of the MDS assessment, dated 10/1/21, indicated Resident #133 was cognitively intact, with a BIMS score of 14 out of 15. Section J, question J1300 regarding tobacco use was not completed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/21 at 10:11 A.M., Resident #133 said his/her rights had been removed and he/she had not been allowed to smoke for the last four to five weeks based on a decision by the administration because the facility had COVID-19 cases. He/she said he/she was offered no accommodation or alternative to smoking to help curb his/her cravings. A review of the medical record failed to indicate any progress notes educating the Resident to their right to smoke being temporarily removed, physician orders for smoking cessation medications, or education regarding the use of smoking cessation medications related to this instance. Further review indicated the Resident to be assessed as a current smoker with a smoking careplan in place. There was no indication on the careplan that the right to smoke was suspended. During an interview on 11/04/21 at 10:47 A.M., Nurse #1 said Resident #133 was very verbal about not smoking, but the rule was that no resident could smoke while the facility was in an outbreak for any reason and they would not be brought out for any smoking activity. She said she believed this had been in place since about the middle of October. During a follow up interview on 11/09/21 at 10:30 A.M., Resident #133 said he/she had still not been allowed to smoke and it was related to COVID-19 in the facility. He/she said they had not received any updates on this and his/her goal was to resume smoking as soon as possible and that he/she wanted to smoke every day and was not interested in quitting. He/she said he/she chose to smoke and felt his/her rights were being violated by the facility denying them the right to go out and do this. During an interview on 11/09/21 at 4:48 P.M., Nurse #4 said the administrator and infection nurse told the staff there would be no resident smoking while the facility had any COVID-19 positive residents in it. She said she knew it upset the residents, but it was the rule that had been in place since the start of the outbreak sometime around October 12, 2021. During an interview on 11/9/21 at 4:55 P.M., the infection prevention nurse said no residents were allowed outside to smoke. She said having all the residents in the elevator together at the same time and in the smoking area together at the same time would prevent social distancing and would not be safe. She further said there was no thought or discussion about changing the process to accommodate the smokers during this time and she realized now it was a resident rights violation. She said no accommodations were made, but there should have been. During an interview on 11/10/21 at 10:02 A.M., the Administrator said there were no discussions or accommodations made or considered to continue resident smoking. She said stopping resident smoking was a violation of the residents' rights and should not have occurred the way it did.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 27189 Based on observations, record review, policy review, and interviews, the facility failed to ensure that one Resident (#27) was assessed by the Interdisciplinary Team (IDT) for the self-administration of medications, out of a total sample of 30 residents. Specifically, the facility failed to ensure that Resident #27 was assessed to self- administer the over-the-counter medication Airborne (Immune support supplement that contains Vitamin C plus 13 other vitamins, minerals and herbs). Findings include: Review of the facility's policy titled Self-Administration of Medications, dated July 2015, indicated but was not limited to the following: -Residents are afforded the right to self-administer their own medications, upon request, and after determination the practice is safe. If the resident elects to self-administer his/her own medications, an evaluation of their cognitive, physical and visual ability to perform this task is conducted to ensure accurate and safe medication management. -Complete the self-administration Evaluation and document whether the resident can safely self-medicate or is unable to safely self-medicate. If the resident can't safely self-medicate, document the reasons why. -Inform the resident/responsible party of the decision. -If approved, obtain a physician's order for self-administration of medications. -Up-date the care plan for self-medication to include where the medications will be stored, documentation of self-administration and location of the drug administration. -Perform resident education of all required self-medication protocols and document any education. Resident #27 was admitted to the facility December 2019 with diagnoses including traumatic brain injury, vitreous hemorrhage, and cerebral vascular accident. During an interview on 11/08/21 at 10:45 A.M., the Resident said how important it was to take Vitamin C, especially with COVID-19-19-19-19-19-19 being so prevalent in the facility. The Resident said that he/she feels that the extra Vitamin C helped so that the symptoms of COVID-19-19-19-19-19-19 were not as pronounced. The Resident then went to his/her bedside cabinet and showed the surveyor a box of Airborne. The Resident said that he/she takes it daily. Record review indicated that the Resident had never been assessed to self-administer the above medication, there was no physician's order in place for the self-administration of the medication or care plan addressing the Resident's ability to self-administer the above medications as per the facility's policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/21 at 12:38 P.M., Unit Manager #2 indicated she was going up to speak with the Resident as she was not aware that the Resident had the Airborne in the bedside cabinet and that the Resident was self-administering the medication daily. During an interview on 11/15/21 at 12:38 P.M., the Director of Nursing and Unit Manager #2 said that there had been no self administration assessment on this Resident as per the facility policy/protocol for the self-administration of the medication Airborne.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42742 Based on observation, interview, and record review, the facility failed to ensure staff met the needs of one Resident (#83), out of a total sample of 30 residents, by ensuring his/her call bell was within reach. Findings include: Resident #83 was admitted to the facility with diagnoses including multiple sclerosis (MS) (potentially disabling disease of the brain and spinal cord), neuropathy (weakness, numbness, and pain from nerve damage usually in the hands and feet), and right-sided hemiplegia (paralysis of one side of the body). Review of the Minimum Data Set (MDS) assessment, dated 9/12/21, indicated Resident #83 required total assistance with bed mobility. Review of the Physical Therapy Care Plan, initiated 11/3/21, indicated Resident #83 demonstrated decreased functional mobility and required a call button to be placed within reach on his/her bed. Review of the facility's policy titled Call Light, Use Of, dated April 2015, included but was not limited to the following: - All .resident/patients will have a call light or alternative communication device within his/her reach when unattended. - When providing care to residents/patients be sure to position the call light conveniently, telling/showing resident/patient where the call light is located. On 11/4/21 at 12:36 P.M., the surveyor observed Resident #83's right wrist in a fist. His/her call bell was located above his/her head underneath folded bed linens. The call bell was not within Resident #83's reach. During an interview on 11/4/21 at 12:36 P.M., Resident #83 said he/she had MS and needed the call bell within reach on his/her lap to get help from staff when needed. He/she said, I'm very limited in what I can do. On 11/16/21 at 10:05 A.M., the surveyor and Nurse #5 observed Resident #83's call bell underneath his/her bed linens. The call bell was not within Resident #83's reach. During an interview on 11/16/21 at 10:05 A.M., Resident #83 said his/her call bell was not within reach. During an interview on 11/16/21 at 10:05 A.M., Nurse #5 said the call bell should have been within Resident #83's reach, but was not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/21 at 4:01 P.M., the Director of Nurses said Resident #83's call bell should have been within his/her reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 27189 Based on record review and interview, the facility failed to ensure that advanced directives were updated and accurate for one Resident (#125), out of a total sample of 12 residents. Findings include: Resident #125 was admitted to the facility in April 2018 with diagnoses including quadriplegia and disorder of the autonomic nervous system. Review of the Minimum Data Set (MDS) assessment, dated 12/10/21, indicated Resident #125 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Record review indicated the Resident had a recent hospitalization in February 2022. Review of the hospital discharge summary indicated the Resident had requested to be a Do Not Attempt Resuscitation (DNAR) and Do Not Intubate (DNI). A DNAR/DNI means that no Cardiopulmonary Resuscitation (chest compressions, cardiac drugs, or placement of a breathing tube) will be performed. Record review of the Resident's advanced directives prior to the hospitalization was that the Resident had requested to be a Full Code (all resuscitation procedures will be provided) since 2018. As per the hospital discharge summary, the wishes of the Resident had changed during the hospital stay and the hospital discharge summary had not been reviewed upon the Resident's return to the facility. The advanced directives in the Resident's record were inaccurate according to the most current wishes of the Resident, as the record still indicated that Resident #125 was a Full Code. During an interview on 3/8/22 at 11:30 A.M., Unit Manager (UM) #1 reviewed the hospital discharge summary which had indicated there had been a change in the Resident's advanced directives. UM #1 alerted Social Services. Review of the Social Services note, dated 3/8/22 at 1:09 P.M., included but was not limited to: Social Worker was informed that the Resident would like to update his/her code status. Resident updated to DNR, DNI. Form left for physician (MD) to review. During an interview on 3/9/22 at 8:10 A.M., the Director of Nursing said the Resident's advanced directives should have been updated/honored and were not, until after surveyor intervention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27189 Based on record review, policy review, and interview, the facility failed to ensure that one Resident (#125), out of a total sample of 30 residents, was free from neglect and abuse. Specifically, the facility A) Failed to use two staff to get the Resident out of bed, per the care plan and the facility's policy; B) Failed to provide the Resident Activities of Daily Living (bathing and showers), per the Resident's choice; and C) Failed to complete a thorough skin assessment after hospitalization s with the most recent hospitalization , resulting in multiple pressure areas on the Resident's skin that were not identified until observed by the surveyor. Findings include: Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, included but was not limited to the following: -Every [NAME] facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect, exploitation, and misappropriation of his or her personal property. ABUSE PREVENTION: -It will be the facility's responsibility to identify, correct and intervene in situations where abuse, mistreatment, neglect, exploitation and or misappropriation of resident property occur, DEFINITIONS: Abuse/Potential Abuse: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction with a suprapubic catheter (tube that drains urine from your bladder) in place. A. Review of the Minimum Data Set (MDS) assessment, dated 9/24/21, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. It also indicated that the Resident was totally dependent with bed mobility, transfers, bathing, personal hygiene, and dressing and required the assist of two. Review of Resident #125's Care Plan indicated: Transfer Device Mechanical lift (2 staff). During an interview on 11/10/21 at 1:00 P.M., Resident #125 told the surveyor about an incident with a Certified Nursing Assistant (CNA) who was attempting to use the Hoyer (a mechanical lift used to transfer a resident out of bed; always used by 2 staff members, no exceptions) independently. Resident #125 said this happened a couple months ago and that he/she told the CNA that he could not use the Hoyer alone and that he needed two people to use the Hoyer as that is the protocol. Resident #125 said that the CNA told the Resident that he was exempt, and he could do it himself. Resident #125 said the CNA continued to use the Hoyer lift independently and that the CNA then pulled the Resident's wrist so hard that Resident #125 stated he/she heard a pop in his/her shoulder. Resident #125 stated that he told the Administrator. Review of the facility's policy titled Total Lift, dated March 2013, included but was not limited to the following: Overview. The use of a total lift allows nursing staff to safely transport residents that require maximum assistance from one location to another without involving weightlifting. Procedure. 2. Identify yourself and your staff assistant, explain the procedure, provide privacy, and perform hand hygiene. 3.To transfer a resident from a bed to a chair you should: j. Gently lower the resident into the chair while the staff assistant guides the resident to ensure that no entrapment occurs, 4. To put the resident back to bed, you should: e. The staff assistant guides the resident to ensure no entrapment occurs. B. During an interview on 11/10/21 at 1:00 P.M., the Resident asked the surveyor to look at his/her fingernails on the right hand. The surveyor observed that all the fingernails on the right hand were extremely long. The nail on the index finger appeared long and ready to fall off, and the nail on the ring finger was purple, extremely long, and lifting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #125 requested the surveyor look at the suprapubic catheter site. The surveyor observed a brown colored drainage on the skin surrounding the insertion site which had no dressing in place to absorb the drainage, some of the drainage had crusted and dried on the Resident's skin. The surveyor observed Resident #125 had dried blood on the left hand, which the Resident stated was from the hospital and that it has not been washed off since his/her return to the facility on three days ago. Resident #125 requested the surveyor look at his/her feet. The surveyor observed the left foot had dry, dirty scaly skin and in between the Resident's toes was a dirty, yellow colored, moist substance that had a foul odor that could be detected even through the surveyor's N95 mask. Resident #125 told the surveyor that he was supposed to have a shower at least once a week and said since he has not received a shower in long time; and when staff give him a bed bath, the staff don't wash his feet, that's why they look like they do. The surveyor also observed scabs on both knees of Resident #125 and the skin surrounding the areas were reddened and slightly warm to the touch. Resident #125's right heel had a border dressing (large white cloth Band-Aid). Record review indicated that there was no physician's order for this dressing and no documentation as to why the border dressing had been applied. Review of the Resident's care plan indicated the Resident is to be showered twice a week. Review of the ADL flow sheet indicated Resident #125 received a shower weekly in August (showered on 8/28, then on 11/11/21 by the DON), the Resident did not receive any showers in September 2021, and only received a shower on 10/1/21. Resident #125 received no bathing from 10/26/21 through 10/31/21. On 11/1/21, Resident #125 received a partial sponge bath and on 11/6/21 received a bed bath, and then not until 11/11/21 when the Resident was showered by the DON. C. On 11/10/21 at 3:30 P.M., the surveyor notified the Director of Nursing (DON) and with the Resident's permission, the DON, with the surveyor present, did a head-to-toe skin inspection. The DON said she was concerned with the findings the surveyor had brought to her attention. During the DON's assessment, the surveyor observed: -The right index fingernail had fallen off and there was a Band-Aid covering the area (per Resident #125, a Certified Nursing Assistant (CNA) applied a Band-Aid). - The DON removed the border dressing revealing the skin on the right heel to have a Deep Tissue Injury (DTI) ulcer. Record review indicated no documentation or physician's order addressing of any of the above areas. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Upon leaving the Resident's room, the DON said that Resident #125 would have a shower in the morning (DON said would give the Resident the shower herself). The DON further said that tomorrow morning an extensive head to toe skin assessment, with measurements of all the areas would be completed and would ensure that the proper treatments were in place addressing the areas. Review of the Pressure Injury Evaluation, dated 11/11/21 with date of origin 11/10/21, included but was not limited to the following: -Right Heel- Pressure Injury, facility acquired, DTI- 7.0 centimeters (cm) x 6.5 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage surrounding skin is intact. -Left Buttocks-Stage II pressure, facility acquired 2.5 cm x 1.0 cm small amount of drainage, 75% is healthy tissue and 25% is unhealthy tissue, surrounding skin is intact -Right toes-Pressure Injury, facility acquired, DTI- 7.3 cm x 4.0 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact -Left lower leg (front)-Pressure Injury, facility acquired-DTI-3.0 cm x 2.8 cm x 0.2 cm, 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact -Left lower leg (rear)-Pressure Injury, facility acquired-DTI-2.5 cm x 1.6 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact -Other (bruised area on Left toe) -Pressure Injury, Facility acquired-DTI-1.5 cm x 1.0 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact The physician was contacted regarding the above areas, treatments and preventative measures were ordered by the physician. Review of the facility's policy titled Prevention and Management of Pressure Injuries, dated July 2017, included but was not limited to the following: Policy: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Protocol: Assessment: Ulcer/Risk Factors 1. On admission/readmission, a comprehensive assessment of the resident will be completed which will include the following * A head-to-toe skin assessment in a manner that respects the resident's dignity. * A comprehensive clinical assessment to identify specific physical and functional risks associated with pressure injury development. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	2. The resident is assessed for pressure injury risk factors on admission then weekly x three weeks, quarterly, annually and with any significant change in condition. 3. The resident's skin is observed daily with care. 4. Residents will have a weekly body audit completed by the licensed staff. Review of the Hospital Discharge Summary, dated November 2021, indicated the right heel was noted to have a pressure injury, that the treatment performed to the area was an adhesive border foam dressing, due to be changed on 11/10/21. It further indicated that the Resident's skin was not intact and that there was a pressure injury present. Upon return to the facility, review of the November 2021 Nurse's notes indicated that an assessment was done with Vital Signs-Within Normal Limits, no changes in skin integrity prior to leaving Rehab. Resident in stable condition. Record review indicated no documentation that the physician was called upon Resident #125's return to the facility, that the discharge summary had been reviewed and that medications/treatments were checked for any changes and that a head-to-toe skin assessment was completed as per the facility policy. During an interview on 11/15/21 at 9:30 A.M. the DON said the facility failed to provide care and services for Resident #125 by not identifying the pressure injuries upon return to the facility on [DATE] and providing proper ADL care as requested by Resident #125.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 36542 Based on observations, interviews, record review, and policy review, the facility failed to ensure two Residents (#136 and #118), out of a total sample of 30 residents, were free from physical restraints. Specifically, 1. Resident #136 was placed in a reclined geriatric chair (Geri-chair) to prevent rising and wandering; and 2. Resident #118 was not evaluated for the need for a physical restraint (bilateral full-length side rails) and was unable to exit the bed. Findings include: 1. Review of the facility's policy titled Restraint Management, revised August 2018, indicated the following: A. When a resident's condition indicates that an intervention is necessary for safety or positioning, all alternatives to restraints will be tried first and documented in the nurses notes and/or in the careplan. These alternatives are discussed by the interdisciplinary team (IDT). B. When all appropriate alternatives outlined in the careplan are unsuccessful, the Restraint evaluation will be completed by the IDT, prior to initiating the use of restraint. C. It defines a physical restraint as any manual, mechanical or physical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily. Resident #136 was admitted to the facility in March 2018 with a diagnosis of dementia and was on hospice services. Review of the Minimum Data Set (MDS) assessment, dated 10/4/21, indicated Resident #136 was ambulatory with an assist of one person. Review of the medical record indicated on 11/2/21 the hospice services nurse ordered a Geri-chair. On 11/4/21 at 9:39 A.M., the surveyor observed Resident #136 reclining in a Geri-chair near the nurses' station. On 11/4/21 at 11:16 A.M., the surveyor observed Resident #136 in his/her room ambulating with the assist of Nurse #8. On 11/4/21 at 1:37 P.M., the surveyor observed Resident #136 in his/her room alone, reclined in a Geri-chair and actively trying to push his/her self up, but was unable due to the reclined position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/21 at 9:38 A.M., Hospice Staff #1 said the facility staff reported Resident #136 was awake at night and restless with increased weakness in his/her legs. She said the order for the Geri-chair was to have the Resident up out of bed when lethargic, such as over nights. She said the Resident did not have to be reclined in the Geri-chair so that he/she could stand up when he/she wanted to. She said the expectation was to utilize the Geri-chair only as needed and she had relayed the information to Unit Manager #2. She said if Resident #136 was awake and attempting to get up the staff should not have him/her reclined in the chair. On 11/12/21 at 1:00 P.M., the surveyor observed Certified Nursing Assistant (CNA) #13 assisting Resident #136 with eating. Resident #136 was observed to continue to try to stand up from the chair. CNA #13 and CNA #9 were then observed to recline Resident #136 in the Geri-chair and continue to feed him/her. On 11/12/21 at 1:12 P.M., the surveyor heard CNA #13 say to CNA #5 that she felt she could not leave Resident #136 alone reclined in the Geri-chair because he/she was going to fall. The surveyor observed the Resident attempt to lift his/her trunk from the reclined chair. The surveyor heard CNA #5 respond that Resident #136 was probably going to fall as it had happened before and it would happen again. On 11/12/21 at 1:18 P.M., the surveyor observed Resident #136 reclining in the Geri-chair and rocking back and forth attempting to get out of the chair. The regional Food Service Director ran over to the Resident and called CNA #9 over for assistance. CNA #9 said someone needed to sit with Resident #136, but there was not enough staff. During an interview on 11/12/21 at 1:20 P.M., CNA #13 said she reclined Resident #136 in the Geri-chair because he/she kept trying to stand up. On 11/12/21 at 3:19 P.M., the surveyor observed Resident #136 reclining in the Geri-chair and rocking back and forth in front of the nurses' station. Nurse #7 told the staff to get Resident #136 out of the Geri-chair because if the Resident was attempting to get out of the chair and could not, then it would be considered a restraint. During an interview on 11/16/21 at 8:26 A.M., the Director of Nurses said if a resident was reclined in a Geri-chair and attempting to get up then that would be considered a restraint. 43935 2. Resident #118 was admitted to the facility in March 2021 with diagnoses including myoclonus (quick, involuntary muscle jerks). Review of the MDS assessment, dated 9/24/21, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive impairment. Further, the MDS indicated there were no restraints in use for the Resident. On 11/04/21 at 7:57 A.M. and 2:38 P.M., the surveyor observed Resident #118 awake and lying flat in bed with full bilateral siderails up and padded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/09/21 at 9:52 A.M., 1:28 P.M., and 2:03 P.M., the surveyor observed Resident #118 awake lying in bed, moving around in a flailing manner, restless and kicking his/her legs with full bilateral siderails up and padded. Review of the Resident's medical record indicated in nurses' notes the Resident had his/her legs over the edge of the bed/siderails and was pulling at padded side rails on 10/13/21, 10/14/21, and 11/9/21. The record failed to indicate any evidence that the full siderails had been assessed as a potential restraint, a physician order for the use of the full siderails, or a careplan indicating use of full siderails and alternatives used prior to the implementation of those full siderails. Further review indicated an incomplete siderail evaluation with an effective date of 9/18/21; the evaluation was blank. During an interview on 11/09/21 at 2:22 P.M., the Director of Rehabilitation Services said she was aware Resident #118 had full siderails which were padded but rehab was not involved with the siderails or their implementation and said that would be a nursing thing. During an interview on 11/09/21 at 4:01 P.M., the Director of Nurses said her expectation was no resident should have full siderails period. She went on to say if, for some reason, full siderails were warranted the record would have a completed siderail assessment, restraint assessment, consent and care plans that specified the reason for the full siderails and all previous attempted devices or interventions. On 11/09/21 at 4:46 P.M., the surveyor observed Resident #118 lying flat in bed with full bilateral padded siderails in the upright position. During an interview on 11/09/21 at 4:46 P.M., Nurse #4 reviewed the Resident's medical record with the surveyor and said there was no restraint assessment in the chart related to the use of full siderails and she could not find any documentation of a physician's order or alternatives used prior to the siderails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27189 Based on interview, record review, and policy review, the facility failed to ensure an allegation of abuse was immediately reported to the Department of Public Health within two hours in accordance with federal guidelines and to the State Survey Agency within five working days of the incident and per the facility policy for one Resident (#125), out of a total sample of 30 residents. Findings include: Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, included but was not limited to the following: -Every [NAME] facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect, exploitation, and misappropriation of his or her personal property. DEFINITIONS: Abuse/Potential Abuse: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. The Administrator shall assume the overall responsibility to ensure that incident reports are accurately completed, and personnel statements are obtained timely, to ensure proper completion of the Internal Facility Investigation. The Administrator shall ensure that the appropriate agencies are notified in writing, as warranted, of abuse allegations. Immediate Action: - Notify the nursing supervisor. The supervisor or designee will: - Notify the Administrator and/or DNS. - Notify involved parties per Reporting requirements. REPORTING/DOCUMENTATION REQUIREMENTS: The Administrator, Director of Nursing or their designee assumes responsibility for the immediate verbal notification of the incident to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The resident or his/her conservator/responsible party. 2. The physician of record and/or the facility medical director if physician of record not available. 3. The Department of Public Health: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later that 24- hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including to the State Survey Agency and protective services where state law provides for jurisdiction in Long-term care facilities) in accordance with State law through established procedures. 4. Reporting the results of all investigations to the Administrator, Director of Nursing or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction. Review of a Minimum Data Set (MDS) assessment, dated 9/24/21, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS also indicated the Resident was totally dependent with bed mobility, transfers, bathing, personal hygiene, and dressing, required the assist of two persons. Review of the Resident's care plan indicated: Transfer Device Mechanical lift (2 staff). During an interview on 11/10/21 at 1:00 P.M., Resident #125 said he/she had some concerns. The Resident told the surveyor about an incident with a Certified Nursing Assistant (CNA) who was attempting to use the Hoyer Lift (a mechanical lift used to transfer a resident out of bed. The Hoyer lift is to always be used by two staff members, no exceptions) independently. Resident #125 said this happened a couple of months ago and that he/she told the CNA that he could not use the Hoyer alone and that he needed two people, as that is the protocol. Resident #125 said that the CNA told the Resident that he was exempt, and he could use the Hoyer lift by himself. Resident #125 said that the CNA continued to use the Hoyer lift without another staff member present. During the transfer, Resident #125 said that the CNA pulled the Resident's wrist so hard that Resident #125 stated he/she heard a pop in his/her shoulder. Resident #125 identified the CNA as CNA #4 and told the surveyor he/she still sees CNA #4 working on his/her Unit. Resident #125 stated that the Administrator was aware of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/21 at 2:30 P.M., the surveyor spoke with the Administrator and inquired about the incident and asked for any documentation she may have on the incident. The surveyor told the Administrator what Resident #125 had relayed to her. The surveyor told the Administrator that there was no report in the Health Care Facility Reporting System (HCFRS) regarding Resident #125's allegation of CNA #4 pulling his wrist so hard that it caused a pop. The Administrator told the surveyor that she did not remember the incident but would get back to her and would look for any documentation on the incident. On 11/15/21, the surveyor reviewed the information in HCFRS, and there was no initial reporting of the alleged abuse by Resident #125, nor was there reporting after the surveyor brought the incident to the attention of the Administrator on 11/10/21. Reporting to HCFRS had not been initiated per the facility policy. During an interview on 11/15 21 at 9:20 A.M., the Director of Nursing (DON) told the surveyor that the Resident had been stating to several staff members that CNA #4 had pulled his arm and Hoyer transferred him with one person. The DON indicated that it should have been reported and was not. The DON stated that CNA #4 told her that the incident did occur and that he did transfer Resident #125 with the Hoyer lift by himself. He further stated that at the time the incident occurred (August 2021) he went down and spoke to the Administrator about the incident. Review of the statement from Nurse #4 indicated that she had reported the incident to Unit Manager #2 at the time of the incident but was unaware/unsure of the date. During an interview on 11/16/21 at 11:41 A.M., Unit Manager #2 said the incident occurred prior to the Resident's hospitalization in August 2021. Unit Manager #2 said she reported the incident to the Administrator and had given her all the documents that she had completed/received concerning the alleged abuse. During an interview on 11/16/21 at 10:31 A.M., the Administrator said she had not located any of the original documentation. The Administrator said that she should have reported the allegation initially but did not. The Administrator said she did not report an allegation of abuse to the Department of Public Health within two hours in accordance with federal guidelines and to the State Survey Agency within five working days of the incident and according to the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27189 Based on interview, record review, and policy review, the facility failed to ensure an allegation of abuse was investigated per federal and state guidelines and per the facility policy for one Resident (#125), out of a total sample of 30 residents. Findings include: Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, included but was not limited to the following: -Every [NAME] facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect, exploitation, and misappropriation of his or her personal property. DEFINITIONS: Abuse/Potential Abuse: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. The Administrator shall assume the overall responsibility to ensure that incident reports are accurately completed, and personnel statements are obtained timely, to ensure proper completion of the Internal Facility Investigation. The Administrator shall ensure that the appropriate agencies are notified in writing, as warranted, of abuse allegations. PROTECTION OF RESIDENTS FROM HARM: Immediate Action: 1. Remove the resident from the alleged abuser or remove the abuser from the resident. 2. Notify the nursing supervisor. 3. Perform a physical assessment of the resident if physical abuse is suspected. 4. Provide any necessary interventions to ensure the resident's safety and well-being. 5. Provide emotional support and reassurance to the resident. The supervisor or designee will: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Notify the Administrator and/or DNS. 2. Interview the resident when possible. 3. Obtain a written statement of the event from the employee if one is involved. This statement should be dated and signed, whenever possible. 4. Obtain statements from any alert/oriented residents that may have witnessed the event. 5. Place the employee on administrative leave pending completion of the investigation. 6. Notify involved parties per Reporting requirements. Any allegation of abuse will be thoroughly investigated. REPORTING/DOCUMENTATION REQUIREMENTS: The Administrator, Director of Nursing or their designee assumes responsibility for the immediate verbal notification of the incident to the following: 1. The resident or his/her conservator/responsible party. 2. The physician of record and/or the facility medical director if physician of record not available. 3. The Department of Public Health: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later that 24- hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including to the State Survey Agency and protective services where state law provides for jurisdiction in Long-term care facilities) in accordance with State law through established procedures. 4. Reporting the results of all investigations to the Administrator, Director of Nursing or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment, dated 9/24/21, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS also indicated the Resident was totally dependent with bed mobility, transfers, bathing, personal hygiene, and dressing, required the assist of two persons. Review of the Resident's Care Plan indicated: Transfer Device Mechanical lift (2 staff). During an interview on 11/10/21 at 1:00 P.M., Resident #125 said he/she had some concerns. The Resident told the surveyor about an incident with a Certified Nursing Assistant (CNA) who was attempting to use the Hoyer Lift (a mechanical lift used to transfer a resident out of bed. The Hoyer lift is to always be used by 2 staff members, no exceptions) independently. Resident #125 said this happened a couple of months ago and that he/she told the CNA that he could not use the Hoyer alone and that he needed two people, as that is the protocol. Resident #125 said that the CNA told the Resident that he was exempt, and he could use the Hoyer lift by himself. Resident #125 said that the CNA continued to use the Hoyer lift without another staff member present. During the transfer, Resident #125 said that the CNA pulled the Resident's wrist so hard that Resident #125 stated he/she heard a pop in his/her shoulder. Resident #125 identified the CNA as CNA #4 and told the surveyor he/she still sees CNA #4 working on his/her Unit. Resident #125 stated the Administrator was aware of the incident. During an interview on 11/10/21 at 2:30 P.M., the surveyor spoke with the Administrator and inquired about the incident and asked for any documentation she may have on the incident. The Administrator told the surveyor that she did not remember the incident but would get back to her and would look for any documentation on the incident. During an interview on 11/15 21 at 9:20 A.M., the Director of Nursing (DON) said that CNA #4 told her that the incident did occur and that he did transfer Resident #125 with the Hoyer lift by himself. He further stated that at the time the incident occurred (August 2021) he went down and spoke to the Administrator about the incident. During an interview on 11/16/21 at 11:41 A.M., Unit Manager #2 said the incident occurred prior to the Resident's hospitalization in August 2021 and she had started the initial investigation. Unit Manager #2 said that she reported the incident to the Administrator and had given her all the documents that she had completed/received concerning the alleged abuse. During an interview on 11/16/21 at 10:31 A.M., the Administrator said she had not located any of the original documentation for the investigation. The Administrator said that she should have initiated an investigation but did not. On 11/30/21 at 1:35 P.M., the Administrator said neither she nor Unit Manager #2 could locate the original statements for the allegation of abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27189 Based on observation, record review, and staff interview, the facility failed to ensure that staff developed an individualized comprehensive care plan for one Resident (#83), out of a total sample of 30 residents. Findings include: 42742 Resident #83 was admitted to the facility with diagnoses including multiple sclerosis (MS) and right hemiplegia (paralysis on one side of the body). Review of the Minimum Data Set (MDS) assessment, dated 9/12/21, indicated Resident #83 required total assistance with bed mobility. Review of the medical record indicated an interdisciplinary care plan for an activities of daily living (ADL) deficit, initiated 9/19/19, that included, but was not limited to: Focus - Resident has an ADL deficit related to .weakness, MS Goal - Resident will participate in ADL's as able Interventions - Patient to wear right hand cone splint during the daytime up to five hours, initiated 4/30/21 - Patient to wear right hand splint at night up to six hours, initiated 4/1/21 Further review of Resident #83's medical record indicated an Occupational Therapy (OT) Treatment Discharge Summary, dated 4/30/21, that included but was not limited to: Interventions Provided - Patient has trialed his/her hand cone splint and resting hand splint. Caregivers in-serviced on donning (putting on) the cone splint during the daytime and wearing resting hand splint at nighttime. Pt is able to tolerate prefabricated (prefab) hand splint better than the customized resting hand splint at this time. Patient Response (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Patient has been motivated to participate, however is limited by decreased memory. She will rely on caregivers to don hand cone splint and prefab splint daily. On 11/4/21 at 12:36 P.M., the surveyor observed Resident #83's right hand in a fist. He/she was not wearing his/her daytime right cone splint and it was not visibly located in his/her room. During an interview on 11/4/21 at 12:36 P.M., Resident #83 said he/she had MS and needed help from staff. He/she said, I'm very limited in what I can do. On 11/9/21 at 12:31 P.M., the surveyor did not observe Resident #83 wearing his/her daytime right hand cone splint and it was not visibly located in his/her room. During an interview on 11/10/21 at 8:26 A.M., the surveyor observed Resident #83 not wearing his/her daytime right hand cone splint and it was not visibly located in his/her room. Resident #83 said he/she wore the splints because of his/her MS and staff had not been putting them on him/her. He/she said his/her right hand felt worse if he/she was not wearing the splints. During an interview on 11/10/21 at 11:05 A.M., Nurse #5 said she was not sure who was supposed to put on Resident #83's right hand splints, but she had not been instructed to do so. She further said it was not located on the Treatment Administration Record (TAR) so, How would I know? On 11/15/21 at 8:54 A.M., the surveyor did not observe Resident #83 wearing his/her daytime right hand cone splint and it was not visibly located in his/her room. During an interview on 11/15/21 at 9:36 A.M., Certified Nursing Assistant (CNA) #16 said she had never seen the splints, and it was not on her Resident Care Card (CNA care instructions). On 11/15/21 at 2:40 P.M., the surveyor did not observe Resident #83 wearing his/her daytime right hand cone splint and it was not visibly located in his/her room. During an interview on 11/15/21 at 4:01 P.M., the Director of Nurses (DON) said if the wrist splints were on the interdisciplinary care plan, then there should have been an order that was carried over to the Treatment Administration Record (TAR), but there was not. During an interview on 11/16/21 at 11:50 A.M., Director of Rehabilitation (DOR) provided the surveyor with a telephone order written on 9/9/21 indicating Resident #83 was to wear a right resting hand splint up to four hours daily and a right-hand cone splint as tolerated daily. The DOR further said the order should have been carried over to the Medication Administration Record (MAR) or TAR by nursing, but was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 27189 Based on record review and interview, the facility failed to review and revise the resident's care plans based on changing needs/status for one Resident (#125), out of a total sample of 30 residents. Specifically, the facility failed to discontinue a focus area related to a nephrostomy tube (a thin tube inserted through the skin into the kidney to drain urine). Findings include: Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction. Review of Resident #125's Care Plans indicated the Resident has a nephrostomy tube, with an initiation date of 6/3/21. Review of a Nurse's Note, dated 9/28/21, indicated the nephrostomy tube had been pulled out yesterday by the Medical Doctor (MD) and the Suprapubic (S/P) catheter was patent and draining urine. Review of Resident #125's Comprehensive Care Plan indicated the focus area of the nephrostomy tube had not been discontinued. During an interview on 11/16/21 at 5:00 P.M., the Director of Nursing said the facility failed to review and revise Resident #125's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27189 Based on observation, record review, policy review, and interview, the facility failed to ensure that staff provided care and services according to accepted standards of clinical practice for seven Residents (#125, #30, #69, #85, #66, #29, and #139), out of a total sample of 30 residents. Specifically, the facility failed 1. For Resident #125, to a) Ensure that medication reconciliations were completed upon re-admission to the facility after four hospitalization s; b) Ensure that all information provided to the facility upon re-admission was reviewed; and c) Ensure the physician was notified for clarification; 2. For Resident #30, to a) Ensure that medication reconciliation was completed upon re-admission to the facility after a hospitalization ; b) Ensure that weights were obtained as ordered by the physician; c) Ensure that treatments ordered by the physician were completed as ordered; and d) Ensure the physician was notified for a fingerstick blood sugar (FSBS) less than 150 as ordered; 3. For Resident #69, to ensure that medications were administered as per the physician's orders; 4. For Resident #85, to a) Ensure the Resident had a current physician's order to administer oxygen; and b) Ensure the Resident received Continuous Positive Airway Pressure (CPAP) machine as ordered by the physician; 5. For Resident #66, to ensure professional standards of practice were followed for anticoagulation treatment; 6. For Resident #29, to provide prescribed treatments to a Stage 4 pressure injury (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) as ordered by the physician; 7. For Resident #139, to provide medications as ordered on days the Resident attended their scheduled hemodialysis; and 8. To ensure medications were stored in a safe manner for administration, as identified during a medication cart inspection. Findings include: Review of the facility's policy titled Medication Reconciliation, dated 4/2015, included but was not limited to the following: Medication Reconciliation is a formal process for creating the most complete and accurate list possible of a resident's current medications and comparing the list to those in the resident's medical record or medication orders. (The Joint Commission 2013). -Process: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Any changes in medications will be documented in the Medication Reconciliation. *The nurse will then contact the physician regarding potential discrepancies identified during the medication reconciliation assessment as warranted. *Any discrepancies found between resident/patient medication list will be clarified in a physician order and noted on the Medication Reconciliation. -Procedure when the resident is readmitted from outside inpatient setting: Upon readmission from a setting outside the nursing home, the nursing home receives *Hospital records of medications ordered and given. *Physician orders that list of medications the resident is to take upon readmission to the nursing home. *The admitting charge nurse reviews all available information as well as medications the resident was taking at the nursing home prior to admission to the hospital or other setting and reconciles the medication regime. *The physician is notified for clarification as warranted. 1. Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction with a suprapubic (S/P) catheter (tube which drains urine from your bladder) in place. Record review indicated Resident #125 was hospitalized on ce each month from August 2021 through November 2021. Further review failed to indicate that after each hospitalization follow-up recommendations were reviewed upon return to the facility as follows: Review of the August 2021 Hospital Discharge Summary indicated: -Recommendation made for a follow-up with the Urologist for consideration preventative therapy of acetic acid irrigations (for S/P catheter) to reduce the risk of recurrent infections. -IV antibiotic (Meropenem IV) should be administered every six hours for 13 more days and then the midline catheter can be discontinued. Review of the August 2021 Infusion Medication Administration Record (MAR) indicated the IV antibiotic was started at the facility on 8/23/21 and was completed on 9/5/21, 14 days and not 13 days as indicated by the Hospital Discharge Summary. Record review indicated that on 9/8/21 the Midline remained in place as there had been no order obtained from the Resident's physician to discontinue the midline catheter after the IV antibiotics had been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review indicated there was no documentation/follow-up by the physician or nursing staff upon return from the hospitalization that the irrigations of acetic acid were addressed by a Urologist as per the discharge orders, the timeframe of the IV antibiotics, and the removal of the midline catheter when the antibiotics were completed. Review of the September 2021 Hospital Discharge Summary indicated: -Recommendation made for a follow-up with the Urologist for consideration of acetic acid irrigations (for S/P catheter) to reduce the risk of recurrent infections. Record review indicated there was no documentation/follow-up by the physician or nursing staff indicating a follow-up appointment with a Urologist was made upon return from the hospitalization to address the irrigations of acetic acid to reduce risk of urinary tract infections. Review of the October 2021 Hospital Discharge Summary indicated: -Resident #125 was to continue Cefepime IV (IV Antibiotic) for a total of 7 days. Review of a Nurse's Note, dated 10/2021 at 3:50 P.M., included but was not limited to the following: -Patient was readmitted however all the discharge papers were left at the hospital. Patient has a midline at the antecubital fossa. Review of a Nurse's note, dated 11/1/21, indicated may remove midline catheter from right antecubital, competed course of IV antibiotics, a telephone order per MD. Review of a Nurse's note, dated 11/7/21 at 1:24 A.M., included but was not limited to the following: -Resident #125 indicated to the nursing staff that he/she did not feel right and stated that he/she was hallucinating and that something is wrong. Resident #125 was transferred to the hospital. Review of a Nurse's note dated 11/7/21 at 4:16 P.M. included by was not limited to the following: -Hospital called to report that the Resident was found to have a Urinary Tract Infection (UTI) and they will be keeping the Resident overnight. Resident is to return tomorrow on IV antibiotic therapy. Record review indicated that a Physician's Interim/Telephone order (dated 10/13/21) for the following: -Discontinue the hour of sleep Gabapentin (used to treat pain) 600 milligrams (mg) -Start the hours of sleep Gabapentin 800 mg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the October 2021 Hospital Discharge Summary and the Medication Administration Record (MAR) indicated the Resident had an order in place for an as needed antipsychotic (Seroquel). The MAR indicated Resident #125 could be administered Seroquel 50 mg tablet, one tablet every four hours as needed for anxiety, agitation. Prior to the hospitalization , Resident #125 was not receiving this medication and the as needed antipsychotic did not include a time frame/re-evaluation date as required (limited to 14 days). Record review indicated that because the process for medication reconciliation and that all available information was not reviewed upon return to the facility by the nursing staff or the physician, the following was not addressed: -Resident #125 did not receive the IV antibiotic as the hospital physician had ordered. -Gabapentin 800 mg at hour of sleep had not been reconciled and implemented per the physician's order prior to the hospital admission and Resident #125 continued to receive Gabapentin 600mg. Review of the November 2021 Hospital Discharge Summary indicated: -The right heel was noted to have a pressure injury; the treatment performed to the area was an adhesive border foam dressing, due to be changed on 11/10/21. -Resident's skin was not intact and there was a pressure injury present. Record review indicated that upon return to the facility, a Nurse's note indicated that an assessment was done with Vital Signs-Within Normal Limits, no changes in skin integrity prior to leaving Rehab. Resident in stable condition. The pressure injury noted on the hospital discharge summary was not identified upon return to the facility. Record review indicated no documentation that the physician was called upon Resident #125's return to the facility, that the discharge summary had been reviewed and that medications/treatments were checked for any changes and that a head-to-toe skin assessment was completed as per the facility policy. During an interview on 11/15/21 at 9:45 A.M., the Director of Nursing (DON) provided the surveyor with copies of the above discharge summaries and said that there had been no reconciliations done from any of the hospitalization s. The DON said that the staff did not ensure that Medication Reconciliations were performed as per the Medication Reconciliation policy/protocol and that staff failed to provide care and services according to accepted standards of clinical practice. 2. Resident #30 was admitted to the facility January 2019 with diagnoses of insulin dependent diabetes mellitus, chronic diabetic ulcer of the left heel, and dementia. A. Record review indicated that on 10/20/21 Resident #30 was started on Zoloft (antidepressant) 25 mg tablet. Give one tablet by mouth daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/21 at 6:20 A.M., Resident #30 was found on the floor. Resident #30 indicated that she/he had hit her/his head. Resident #30 was sent to the hospital and returned to the facility in November 2021. Review of the Physician's Orders, dated 11/3/21, indicated the Zoloft that had been initiated on 10/20/21 prior to Resident #30's hospitalization had not been resumed. Record review indicated that Resident #30 had a chronic diabetic ulcer of the left heel. Record review indicated that prior to the hospitalization the following treatment was being performed: -Left heel treatment- Normal Saline wash, pat dry. Apply Alginate (type of dressing that can absorb wound fluid and can provide a dry wound with a physiologically moist environment and minimize bacterial infections) followed by gauze and wrap with Kerlix. Change daily and as needed. Further review indicated the above treatment was not restarted upon readmission to the facility in November 2021. On 11/5/21 a Physician's Interim/Telephone indicated to resume prior treatment to left heel. Review of the November 2021 Treatment Administration Sheet (TAR) indicated the above treatment was not initiated until 11/6/21, resulting in a three day delay in providing wound care. Further record review indicated there was no documentation in the medical record upon return to the facility on ,d+[DATE] that all the information available and medication reconciliation had been completed as per the facility policy/protocol. There was no Nurse's note in the medical record indicating that the Resident had returned to the facility and that the physician was contacted. During an interview on 11/16/21 at 12:18 P.M., the DON and Unit Manager #2 said the facility failed to reconcile the medications resulting in the Zoloft 25 mg daily and the wound care not being resumed upon re-admission, resulting in a delay in resuming the treatment. B. Record review indicated a Physician's order, dated 9/14/21, to obtain daily weights for seven days to establish a baseline. Further record review indicated a weight was obtained on 9/15/21, with no further weights until 9/22/21. There no weights obtained on 9/16, 9/17, 9/18, 9/19, 9/20, and 9/21/21. During an interview on 11/16/21 at 12:18 P.M., the DON and Unit Manager #2 said the facility failed to weigh Resident #30 for the seven days as per the physician's order. C. Review of the Physician's Orders and Treatment Administration Sheet (TAR) for September 2021 and October 2021 indicated the following: 1c. Left heel treatment-Normal Saline wash, pat dry. Apply Alginate dressing followed by gauze and wrap with Kerlix. Change daily and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the TAR for September 2021 and October 2021 indicated: -September 2021: the treatment was not documented as being performed 9/1/21 through 9/7/21, 9/9, 9/12, 9/14, 9/15, 9/17, 9/19, 9/20, 9/27, 9/28 and 9/30/21. -October 2021: the treatment was not documented as being performed 10/1/21 through 10/5/21, 10/11, 10/12, 10/17/21 through 10/28/21. 2c. Treatment to Left Lower Extremity (LLE): Monitor Unna Boot every shift for placement and slippage. Notify Wound nurse if occurs. Review of the 10/2021 TAR indicated the treatment was not documented as being performed: 7:00 A.M. to 3:00 P.M. shift-10/4/, 10/5, 10/9/21 through 10/14/21 and 10/17/21 through 10/28/21. 3:00 P.M. to 11:00 P M. shift-10/4, 10/10, 10/11, 10/12, and 10/20/21 through 10/28/21. 3c. Skin Checks on Thursdays on the 3:00 P.M. to 11:00 P.M. shift and document in Point Click Care (PCC-this is the facilities Electronic Medical Record (EMR)). Review of the 10/2021 TAR indicated that the weekly skin checks were not documented as done, but review in the EMR/PCC indicated that were completed as ordered. Review of the 9/2021 TAR indicated that 9/16, 9/23, and 9/30 the weekly skin checks were documented as done on the TAR. Review of the EMR/PCC indicated that although a nurse had initialed the skin check as done, there were no weekly skin audit/check entered. The EMR/PCC indicated that a weekly skin check was completed on 8/26/21 and then the next one was on 10/7/21. D. Review of the October 2021 Physician's Orders indicated the following order: -FSBS four times daily with coverage using Novolog Insulin according to the sliding scale. -FSBS were scheduled for 7:30 A.M., 11:30 A.M., 4:30 P.M., and 8:00 P.M. -If the FSBS is less than 150, notify the MD. Further review of the MAR indicated that the following FSBS: -10/1/21 at 7:30 A.M.-96; 11:30 A.M.-96; 4:30 P.M.-103; 8:00 P.M.-108 -10/4/21 at 7:30 A.M.-109; 11:30 A.M.-128 -10/25/21 at 7:30 A.M.-103; 11:30 A.M.-100 Record review indicated that there was no documentation by the Nurse that the physician had been notified regarding the FSBS below 150 as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/16/21 at 12:20 P.M., the Director of Nursing and Unit Manager #2 said the facility failed to document treatments (wound care and skin checks) as per the physician's orders and failed to notify the physician for a FSBS below 150 as per the physician's order. 3. Resident #69 was admitted to the facility November 2018 with obesity, Type 2 Diabetes, and muscle wasting and atrophy. Record review of the October 2021 Physician's Orders indicated the following: Vitamin D3 capsule, 50,000 units. One capsule by mouth every month on the 15th. Review of the October 2021 MAR indicated the Vitamin D3 capsule, 50,000 units, was not documented as given as per the physician's orders. During an interview on 11/16/21 at 12:20 P.M., the Director of Nursing and Unit Manager #2 said the facility failed to administer the Vitamin D3 as ordered by the physician. 4. Review of the facility's policy titled Oxygen Administration, dated 4/2015, included but was not limited to the following: POLICY To deliver low flow oxygen rates and concentration, per the physician's order PROCEDURE Set the oxygen liter flow to the prescribed liters flow per minute. Resident #85 was admitted to the facility in March 2021 with diagnoses including obesity and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe). Record review indicated a current Physician's Order (dated 11/2021) for the following: -Continuous Positive Airway Pressure (CPAP) applied per MD orders at bedtime and off in the morning. -There was no current physician's order to administer oxygen On 11/08/21 at 8:06 A.M., the surveyor entered Resident #85's room, and observed oxygen tubing on the floor and not in use by the Resident. The surveyor observed the date written on the piece of tape was 9/19. During an interview on 11/8/21 at 8:06 A.M., Resident #85 told the surveyor that the oxygen was not in use because he/she only uses the oxygen during the night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor then asked Resident #85 where his CPAP machine was located. Resident #85 told the surveyor that when he was transferred from the Mayflower Unit to the Hopkins Unit, none of his/her belongings were sent with him/her, which included the CPAP machine. Resident #85 then told the surveyor that he/she is better with the oxygen and would rather use the oxygen than the CPAP machine. On 11/10/21 at 11:20 A.M., the CPAP machine still had not been delivered to Resident #85. The surveyor observed Resident #85 residing on the Hopkins Unit on 11/4/21 through 11/10/21 and during this time, Resident #85 did not have the CPAP machine and it was not in use as per the physician's order. During an interview on 11/10/21 at 11:43 A.M., the DON said the CPAP machine was not brought with the Resident when he was transferred resulting in the CPAP machine not being administered as per the physician's orders and Resident #85 did not have a current physician's order for the administration of oxygen. 36542 5. Resident #66 was admitted to the facility in August 2021 with a history of cardiovascular accident (CVA) and a mitral mechanical valve replacement. Review of the medical record for Resident #66 indicated the Resident was taking Coumadin (a blood thinner) and the dose was determined by INR (international normalized ratio) laboratory results. Review of the medical record, including the Medication Administration Record (MAR), telephone physician orders, nursing progress notes and laboratory results indicated the following timeline: -9/29/21 INR result was 1.87 (low) and an order was written for Coumadin 2 mg (milligrams) and to recheck INR on 10/2/21. The Coumadin 2 mg was not administered on 10/1/21. -10/2/21 INR laboratory test was not obtained as ordered and the test results from 9/29/21 were reported to the physician as being new results and the physician ordered Coumadin 3 mg and to recheck the INR on 10/5/21. -10/5/21 INR result was 1.14 (low) and an order was written for Coumadin 5 mg and to recheck INR on 10/8/21. -10/8/21 INR laboratory test was not obtained, Coumadin 5 mg was given on 10/8/21, 10/9/21, 10/10/21 with no order to change the laboratory date or continue the Coumadin dosage. -10/11/21 INR result was 1.14 (low) and an order was written for Coumadin 8 mg and to recheck the INR on 10/12/21. Coumadin 8 mg was not documented as administered on 10/11/21 as ordered. -10/12/21 INR laboratory test was not obtained as ordered, a new order to administer Coumadin 7.5 mg was written and to recheck the INR on 10/15/21. The nursing progress note indicated the lab result from 10/11/21 of 1.14 was reported to the physician. -INR results and Coumadin were administered as ordered from 10/15/21 through 10/21/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/21/21 INR result was 2.11 (therapeutic range) and an order was written for Coumadin 12 mg and to recheck the INR on 10/25/21. A review of the MAR indicated the Coumadin was not administered on 10/22/21 and 10/23/21. -10/25/21 INR laboratory test was not obtained as ordered, no Coumadin was administered on 10/25/21 and the order for Coumadin 12 mg continued without any indication it was reviewed by a physician. -10/29/21 Coumadin 12 mg was administered, an INR result of 2.3 (therapeutic range) was obtained and a new order was written for Coumadin 12 mg and to recheck INR on 11/2/21. An additional dose of Coumadin 12 mg was administered on 10/29/21, for a total of 24 mg in one day. A review of the MAR indicated the Coumadin was not administered on 11/1/21. -11/2/21 INR result was 4.05 (high) and an order was written to hold Coumadin and recheck the INR on 11/6/21. -11/6/21 INR result was 1.21 (low) and an order was written to hold Coumadin one night and to recheck the INR on 11/7/21. - 11/7/21 INR result was 1.09 (low) and an order was written for Coumadin 2 mg and to recheck the INR on 11/10/21. -11/10/21 INR laboratory test was not obtained as ordered During an interview on 11/12/21 at 11:30 A.M., the Director of Nurses said she had reviewed the medical record for Resident #66 and had found the physician's orders were not followed for laboratory testing, for administering Coumadin as ordered, and standards of practice were not followed for reporting laboratory results correctly to a physician and obtaining new orders for Coumadin with a missing laboratory result. 43935 6. Resident #29 was admitted to the facility in October 2021 with diagnoses including quadriplegia and a pressure ulcer of the sacral region. Review of the current treatment orders for November 2021 indicated a current order for the sacral wound as: Dakins (H-chlor 12) 1/4 (quarter) strength 0.125% to sacral wound: normal saline wash, pat dry cover with gauze damp with Dakins. Order was scheduled to be changed daily as documented on the Treatment Administration Record (TAR). Review of the October 2021 TAR failed to indicate evidence of the dressing being signed off as completed for 6 out of 24 days the Resident was in the facility. During an interview on 11/16/21 at 10:53 A.M., the Director of Nurses (DON) reviewed the TAR for October 2021 with the surveyor and said any day the treatment sheet was not signed off indicated the nurse did not complete the treatment. 7. Resident #139 was admitted to the facility in October 2020 with diagnoses including end stage renal disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's MAR indicated Resident #139 had prescribed medications scheduled to be administered at 6:00 A.M., 10:00 A.M., 4:00 P.M., 8:00 P.M., And 10:00 P.M. daily. Record review indicated Resident #139 attended hemodialysis offsite on Tuesdays, Thursdays and Saturdays weekly with a 7:45 A.M. pick up time. During an observation with interview on 11/4/21 at 11:47 A.M., the Resident was not available. Nurse #1 said Resident #139 had not yet returned from dialysis and was usually back by lunch time. During an observation with interview on 11/9/21 at 11:15 A.M., the Resident was not available. Nurse #2 said Resident #139 was still out at dialysis and the Resident would receive his/her 10:00 A.M. scheduled medications once he/she returned from dialysis. During a follow up interview on 11/10/21 at 11:01 A.M., Nurse #1 said the Resident usually returned from dialysis around 12:00 P.M. She said on the Resident's scheduled dialysis days the medications scheduled for 10:00 A.M., were administered to the Resident upon his/her return to the facility at that time. During an interview on 11/10/21 at 1:37 P.M., Dialysis nurse #1 said Resident #139 arrives on Tuesday, Thursday and Saturdays weekly for hemodialysis at approximately 7:45 A.M. and leaves the dialysis center at approximately 11:40 A.M. each day to return to the facility. During an interview on 11/16/21 at 1:46 P.M., the DON said the medications should be timed to accommodate dialysis times and the Resident should not be receiving them more than an hour after their scheduled time. She said the medications were administered late and it was not appropriate and did not follow the standard of practice; the times of the medications would need to be adjusted. 8. During an observation with interview on 11/10/21 at 4:26 P.M. on the Mayflower North unit, the surveyor inspected Nurse #5's medication cart for medication storage. Nurse #5 opened the top drawer and there was a small plastic cup, unlabeled, with four pills inside of it. She said the medications belonged to a resident on the unit and that she poured the medications to administer them and then stored them in the drawer when she left to answer the phone. She said, We are not supposed to be doing that; it is against the rules. During an interview on 11/10/21 at 5:02 P.M., the DON said the expectation was that the nurses do not store pre-poured medications unsecured in the medication cart for any reason. She said the practice of doing so was unacceptable and against the professional standard of nursing practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36542 Based on interviews and record review, the facility failed to ensure quality care was provided to one Resident (#136), out of a total sample of 30 residents. Specifically, the facility failed to assess and treat the Resident's identified skin impairment, resulting in difficulty ambulating and the Resident reporting tenderness for a few weeks. Findings include: Resident #136 was admitted to the facility in March 2018 with a diagnosis of dementia and was on hospice services. Review of the Hospice Communication Book indicated: -On 10/15/21 Hospice requested podiatry for toenails and to look at the area on the bottom of the Resident's foot. -On 10/22/21 the right foot callous was still present. Review of a Hospice Recommendation, dated 10/19/21, indicated to consider a foam cushion with wound window cut out to bottom of right foot and to secure with tape; followed by slipper socks to change as needed; and continue until seen by the wound doctor on 10/25/21. Review of a Hospice Recommendation, dated 11/2/21, indicated to follow up with the wound doctor or podiatrist regarding area on foot. The recommendation form indicated the infection control preventionist, who was responsible for wound care, was aware. Review of the October 2021 and November 2021 Treatment Administration Records (TAR) did not include any treatments orders to the bottom of the right foot. Review of the medical record indicated a Weekly Skin Audit (assessment of skin areas) was conducted on 10/3/21 with no areas and the next Weekly Skin Audit was not conducted until 11/1/21. The Weekly Skin Audit, dated 11/1/21, did not include any information regarding an area to the bottom of the right foot. During an interview on 11/9/21 at 2:40 P.M., the Infection Control Preventionist said she was unaware of the recommendation hospice made on 10/19/21 for a foam wound dressing. She said she reviewed the nursing documentation and was unable to find a skin evaluation to indicate the wound had been assessed and evaluated by the facility staff. She said Resident #136 was not seen by the podiatrist or wound doctor until 11/8/21 (20 days after first identified by hospice). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Wound Care History and Physical, dated 11/8/21, indicated Resident #136 had a neuropathic ulcer with a thick callus on the plantar surface of the right foot. The consultation indicated the Resident had been complaining of the tender callused area on the right foot for a few weeks and ambulation had been difficult. The wound assessment indicated there was a thick callused area on the right mid plantar distal foot, measuring approximately 3 centimeters (cm) x 3 cm x 0.5 cm. The wound doctor wrote a treatment plan for Iodosorb gel (or Anasept gel) into the wound bed; foam dressing changed approximately every two to three days. During an interview on 11/12/21 at 11:26 A.M., the Director of Nurses said she had just obtained the consultation from 11/8/21 and did not know if the treatment was implemented to the area in the four days since. Review of the medical record, including the TAR, on 11/12/21 at 12:10 P.M., failed to include a treatment to the right foot area, as indicated by the wound consultant on 11/8/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 27189 Based on observation, interview, policy review, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice to promote healing, prevent new ulcers from developing, and provide ongoing assessment and treatment of pressure ulcers for three Residents (#125, #93, and #6), out of a total sample of 30 residents. Specifically, the facility 1.) Failed to complete a head-to-toe skin assessment as per the facility policy, upon return to the facility from two hospitalization s, resulting in numerous pressure areas that were not identified, for Resident #125; 2.) Failed to complete weekly skin assessments which would identify skin impairments, failed to provide bilateral booties as ordered for prevention and failed to document and evaluate a pressure area to the left lateral forefoot, for Resident #93; and 3.) Failed to complete weekly skin assessments per the physician's order to monitor and assess Resident #6's Stage II pressure area. Findings include: 1. Review of the facility's policy titled Prevention and Management of Pressure Injuries, dated July 2017, included but was not limited to the following: Policy: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Protocol: Assessment: Ulcer/Risk Factors 1. On admission/readmission, a comprehensive assessment of the resident will be completed which will include the following: * A head-to-toe skin assessment in a manner that respects the resident's dignity. * A comprehensive clinical assessment to identify specific physical and functional risks associated with pressure injury development. 2. The resident is assessed for pressure injury risk factors on admission then weekly x three weeks, quarterly, annually and with any significant change in condition. 3. The resident's skin is observed daily with care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	4. Residents will have a weekly body audit completed by the licensed staff. Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction with a suprapubic catheter (tube that drains urine from your bladder) in place. During an interview on 11/10/21 at 1:00 P.M., Resident #125 requested the surveyor look at his/her feet. The surveyor observed the following on the resident's lower extremities: - scabs on both knees and the skin surrounding the areas were reddened and slightly warm to the touch - right heel had a border dressing (large white cloth Band-Aid). Record review indicated there was no physician's order for this dressing and no documentation as to why the border dressing had been applied. On 11/10/21 at 3:30 P.M., the surveyor notified the Director of Nursing (DON) of her observations. The DON said she was concerned with the findings the surveyor had brought to her attention. With the Resident's permission, and the surveyor present, the DON performed a head-to-toe skin inspection. During the DON's assessment, the surveyor observed the following: - The right index fingernail had fallen off and there was a Band-Aid covering the area (per Resident #125, the Band-Aid was applied by a Certified Nursing Assistant). - The DON removed the border dressing on the right heel revealing a Deep Tissue Injury (DTI) ulcer (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm mushy, boggy, warmer, or cooler as compared to adjacent tissue). Record review indicated no documentation or physician's order addressing any of the above areas. Upon leaving the Resident's room, the DON said Resident #125 would have an extensive head to toe skin assessment and measurements of all the areas would be completed. The DON said that she would ensure that the proper treatments were in place addressing the areas. Review of the Pressure Injury Evaluation, dated 11/11/21 with Date of origin 11/10/21, included but was not limited to the following: - Right Heel- Pressure Injury, facility acquired, -DTI-7.0 centimeters (cm) x 6.5 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage surrounding skin is intact. - Left Buttocks-Stage II pressure, facility acquired 2.5 cm x 1.0 cm small amount of drainage, 75% is healthy tissue and 25% is unhealthy tissue, surrounding skin is intact - Right toes-Pressure Injury, facility acquired-DTI--7.3 (cm) x 4.0 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	- Left lower leg (front)-Pressure Injury, facility acquired-DTI-3.0 cm x 2.8 cm x 0.2 cm, 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact - Left lower leg (rear)-Pressure Injury, facility acquired-DTI-2.5 cm x 1.6 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact - Other (bruised area on Left toe) -Pressure Injury, Facility acquired-DTI-1.5 cm x 1.0 cm 75% is healthy tissue and 25% is unhealthy tissue, no drainage, surrounding skin is intact - The physician was contacted regarding the above areas, treatments and preventative measures were ordered by the physician. Record review indicated the following: - Resident #125 was admitted to the hospital in October 2021, and upon return to the facility, no comprehensive skin assessment was completed. Upon return to the facility in October 2021, the Nurse's notes indicated the Resident was readmitted to the facility, however the hospital discharge papers were left at the hospital. Vital signs as follows; Blood pressure 121/89, Temperature 97.9, Oxygen saturation 95% on room air, Pulse 73. Suprapubic catheter intact, patent Colostomy. Patient has a Midline at the antecubital fossa. Patient is stable condition and can make needs known. There was no reference to the Resident's skin integrity. - Resident #125 was admitted to the hospital in November 2021, and upon return to the facility, no comprehensive skin assessment was completed. Review of the Hospital Discharge Summary, dated November 2021, indicated the right heel was noted to have a pressure injury; that the treatment performed to the area was an adhesive border foam dressing, due to be changed on 11/10/21. It further indicated that the Resident's skin was not intact and that there was a pressure injury present. Upon return to the facility, November 2021 Nurse's notes indicated that an assessment was done with Vital Signs-Within Normal Limits, no changes in skin integrity prior to leaving Rehab. Resident in stable condition. Record review indicated no documentation upon Resident #125's return to the facility following hospitalization in October 2021 and November 2021 that a head-to-toe skin assessment was completed as per the facility policy and that the discharge summary been reviewed in November 2021. Record review indicated the last weekly skin assessment was completed on 9/23/21. During an interview on 11/15/21 at 9:30 A.M., the Director of Nursing (DON) said the facility failed to provide necessary care and treatment consistent with professional standards of practice for Resident #125. The DON said that the facility failed to ensure a complete a head-to-toe skin assessment as per the facility policy upon return to the facility from two hospitalization s resulting in numerous pressure areas that were not identified and had no treatment orders upon return to the facility in November 2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	36542 2. Resident #93 was admitted to the facility in June 2021 with contractures (shortening and hardening of tissues leading to the rigidity of joints). Review of the Physician's Orders for October and November 2021 indicated an order for bilateral soft booties, which can be removed for hygiene. On 11/9/21 at 8:09 A.M., the surveyor observed Resident #93 lying in bed; there were no booties on the Resident. Review of the Treatment Administration Record (TAR) for October 2021 indicated the weekly skin checks were not signed off as completed on 10/15/21, 10/22/21, and 10/29/21. Review of the electronic medical record did not indicate a weekly skin audit was completed on 10/8/21 and then not again until 11/5/21, four weeks later. During an interview on 11/9/21 at 2:37 P.M., the Infection Control Preventionist, who provides oversight of the residents with wounds, said skin checks should be conducted weekly for all residents on shower days and an evaluation would be initiated in the electronic medical record. She said she was unaware that weekly skin checks were not being completed until this morning. During an interview with observation on 11/10/21 at 8:53 A.M., the surveyor observed Resident #93 lying in bed with no booties on. The surveyor observed Unit Manager #2 check the skin of the Resident. Unit Manager #2 observed an area to the left lateral forefoot and said the area was non-blanchable (when applying pressure with one's finger on an area the blood is forced out of the capillaries and the skin does not become pale or white); she said this indicated it was a pressure area. During an interview on 11/10/21 at 8:55 A.M., Certified Nursing Assistant (CNA) #9 said she had not been placing booties on the bilateral lower extremities of the Resident and she did not know where booties would be. On 11/10/21 at 3:26 P.M., the surveyor observed Resident #93 in bed, not wearing booties, as ordered. During an interview on 11/12/21 at 9:00 A.M., Unit Manager #2 said she had not completed a skin evaluation form or measured the observed area on the foot of Resident #93. She said she only identified the area of skin impairments. Review of the medical record on 11/16/21 indicated a Weekly Skin Audit was conducted on 11/12/21 and there were no new skin impairments since the previous skin assessment on 11/5/21. On 11/16/21 at 10:01 A.M., the surveyor observed Resident #93 lying in bed not wearing booties; the area to the left lateral forefoot was observed. During an interview on 11/16/21 at 10:30 A.M., Unit Manager #2 said she had not completed a skin evaluation regarding the pressure area observed on 11/10/21, six days prior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/16/21 at 1:45 P.M., Unit Manager #2 provided the surveyor with a Weekly Skin Audit, dated 11/14/21, which indicated new skin areas including a non-blanchable area on the right outer ankle and a scabbed area on the left outer ankle. There was no documentation regarding the left lateral forefoot area observed by the Unit Manager, the CNA, and two surveyors on 11/10/21. 42742 3. Resident #6 was admitted to the facility with a diagnosis of hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the left non-dominant side. Review of the Minimum Data Set (MDS) assessment, dated 10/15/21, indicated Resident #6 required extensive assistance for bed mobility and transfer and was at risk for developing pressure ulcers. Review of the medical record for Resident #6 indicated a current Physician's Order, initiated 2/28/20, to perform weekly skin checks on Mondays during the 7:00 A.M.-3:00 P.M. shift. Review of Nursing Progress Notes, dated 11/4/21, indicated a 3 x 3 (unit of measurement undefined) reddened area on the coccyx. Review of the Weekly Skin Audit, dated 11/5/21, failed to indicate a new suspected pressure ulcer or deep tissue injury. During an interview on 11/9/21 at 12:53 P.M., Hospice Nurse #2 said she had just seen Resident #6 and he/she had a Stage II (partial-thickness skin loss) pressure ulcer on his/her coccyx that had been there for about a week now. During an interview on 11/10/21 at 9:20 A.M., Nurse #5 said Resident #6 developed a Stage II pressure ulcer on his/her coccyx one to two weeks ago and a skin evaluation had not been done yet, but should have been. On 11/10/21 at 4:27 P.M., the surveyor observed a wound assessment with Nurse #5 who said the wound was not improving and she was waiting for new treatment orders from the hospice nurse. Review of the skin care plan indicated interventions toward the goal for Resident #6's skin to remain intact including assessing the Resident's skin condition at 24 hours then weekly, initiated 1/21/20. The care plan failed to indicate Resident #6 had a pressure ulcer. Review of the TARs, dated 10/1/21 through 10/31/21, with the Director of Nurses (DON) failed to indicate weekly skin checks were completed during the 7:00 A.M. - 3:00 P.M. shift for 2 out of 4 weeks as well as for 1 out of 3 weeks on the 11/1/21 through 11/30/21 TAR. On 11/16/21 at 1:11 P.M., the DON said a skin evaluation should have been done immediately after nursing staff discovered it on 11/4/21, but was not. She further said the weekly skin check completed the following day should have included an assessment of the wound, but did not. The DON said the medical record did not contain further documentation of the pressure ulcer after it had developed and weekly skin checks should have been consistently performed, but were not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observation, interview, and record review, the facility failed to ensure four Residents (#89, #128, #84, and #110), out of a total sample of 30 residents, and 1 out of 5 resident care units were provided with an environment free of accident hazards. Specifically, the facility failed to: 1. Provide fall prevention interventions for Resident #89, resulting in a hip fracture; 2. Provide fall prevention interventions for Resident #128 resulting in multiple falls; 3. Ensure there was an Ambu bag (used for ventilation) on the [NAME] Unit emergency code cart; and 4. Provide emergency tracheostomy (tube in neck for breathing) equipment for Residents #84 and #110. Findings include: 1. Review of the policy for Falls Management, dated as revised August 2018, indicated the interdisciplinary team will develop, initiate and implement an appropriate individualized care plan based on the fall risk evaluation score. Resident #89 was admitted to the facility in April 2018 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 6/11/21, indicated Resident #89 needed extensive assist of one with transferring between surfaces, walking in room, walking in corridor and locomotion on unit. Review of the Progress Notes for Resident #89 indicated the Resident fell on [DATE], 7/23/21, and 8/5/21 as follows: Fall 7/6/21: -Review of the Fall Incident Report for 7/6/21 indicated Resident #89 fell at 1:15 P.M. while bending over in the dining room, without injury. -Review of the Fall Risk Assessment, dated 7/6/21, indicated the Resident was at risk for falls, had one to two falls in the past three months, was ambulatory, with balance problems while standing, balance problems while walking, decreased muscular coordination, jerking or unstable when making turns. -Review of the Care Plan indicated an intervention of taking naps after lunch. -Further review of the Care Plan indicated a similar intervention of offering a rest period after lunch was implemented on 4/6/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall 7/23/21: -Review of the Fall Incident Report for 7/23/21 indicated Resident #89 fell at 10:00 A.M. in his/her room after making jerking movements, without injury. The report indicated the intervention to prevent further occurrence was a medication review for assessment. -Review of the Fall Risk Assessment, dated 7/23/21, indicated the Resident was at risk for falls, had one to two falls in the past three months, was ambulatory, with balance problems while standing, balance problems while walking, change in gait pattern when walking through doorway, jerking or unstable when making turns. -Review of the Care Plan indicated an intervention dated 7/29/21 of a medication review. Fall 8/5/21: -Review of the Fall Incident Report for 8/5/21 indicated Resident #89 fell at 5:55 A.M. while near the nurses' station. The fall investigation indicated at 5:30 A.M. the Resident was washed, dressed, toileted and brought out to the nurses' station. The Resident was found on the ground with immediate signs of pain in the left lower extremity, which was shorter than the right and had left foot externally rotated. -Review of the Hospital Discharge Paperwork indicated the Resident had a left hip fracture that required surgical intervention. Review of the Physician's Progress Notes indicated physician visits on 6/23/21 and 8/18/21. There was no indication the physician completed a medication review following the fall on 7/23/21, prior to the next fall on 8/5/21. Review of the Pharmacy Progress Notes in the medical record failed to include a medication review was completed between the falls on 7/23/21 and 8/5/21. During an interview on 11/16/21 at 12:54 P.M., the Director of Nurses said there was no medication review located as part of the fall investigation or part of the medical record and could not determine if a medication review had been conducted following the fall for Resident #89. She said there were no other interventions implemented following the fall on 7/23/21 and the facility policy was for an immediate intervention to be added to the care plan to prevent further falls. 42742 2. Resident #128 was admitted to the facility with diagnoses including neuromuscular disorder, traumatic cerebrovascular accident (CVA) with right hemiparesis (paralysis on one side of the body), seizure disorder, legal blindness in the left eye, neurocognitive disorder with aggression and agitation, and impulse control disorder. Review of the MDS assessment, dated 10/4/21, indicated Resident # 128 required extensive assistance with toileting and locomotion on the unit, and used a walker and wheelchair. Review of the Fall Risk Assessment, dated 9/22/20, indicated Resident #128 was at risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Falls Care Plan, initiated 9/23/20, indicated Resident #128 was at risk for a fall related injury due to traumatic CVA with right hemiparesis, seizure disorder, legal blindness in the left eye, neurocognitive disorder with aggression and agitation, and impulse control disorder. The goal was Resident #128 would not sustain a fall related injury by utilizing fall precautions. Interventions to achieve this goal were as follows: - Continual supervision while ambulating in hallways - Edge defining mattress in place at all times - Educate Resident to call for assistance to use the bathroom - Provide/monitor use of adaptive devices; walker and wheelchair with assist Review of the clinical record indicated Resident #128 sustained 13 falls between February 2021 and November 2021 without major injury. Seven of the falls were unwitnessed, and six were witnessed. The Resident was transferred to the emergency room for further evaluation after one of the 13 falls. Review of the Resident Care Card (Clinical Nursing Assistant (CNA) care instructions) for Resident #128 indicated he/she required an assist x 1 for toileting and ambulation. On 11/8/21 at 8:33 A.M., the surveyor observed Resident #128 walk out of his/her room down the hall to the nurses' station unsupervised without a walker. His/her right foot was catching/dragging on the floor and caused him/her to stumble multiple times. Nurse #7 instructed Resident #128 to go back to his/her room, but did not supervise or assist the Resident. On 11/8/21 at 1:15 P.M., the surveyor observed Resident #128 sitting at the side of his/her bed. The call bell was located on the floor underneath his/her bed. It was not within reach of the Resident. He/she then walked unsteadily to the bathroom without calling for help from staff. During an interview on 11/8/21 at 1:20 P.M., Nurse #5 entered the room with the surveyor and said Resident #128's call bell was not within reach, but should have been. She said the Resident was supposed to call for help but did not, and was not supposed to be ambulating independently. On 11/9/21 at 8:12 A.M., the surveyor observed Resident #128 walk out of his/her room down the hall to the nurses' station unsupervised without a walker. His/her right foot was catching/dragging on the floor and caused him/her to stumble multiple times. CNA #17 instructed Resident #128 to go back to his/her room, but did not supervise or assist the Resident. During an interview on 11/9/21 at 8:12 A.M., CNA #17 said Resident #128 did not require assistance with ambulation, only if he/she was in his/her wheelchair. During an interview on 11/9/21 at 8:40 A.M., the surveyor reviewed the resident care card with CNA #17 who said she did not know it said Resident #128 was an assist with ambulation. She said she should have referred to it to determine his/her level of care, but did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/15/21 at 8:28 A.M., the surveyor observed Resident #128 ambulating without assistance in his/her room. He/she then walked out of his/her room down the hall to the nurses' station unsupervised without a walker. His/her right foot was catching/dragging on the floor and caused him/her to stumble multiple times. Nurse #15 was in a resident's room. CNA #16 was passing breakfast trays. No other staff was present at the time. Resident #128 remained standing at the nurses' station and then walked back to his/her room without assistance. Nurse #15 exited another resident's room and asked the surveyor who Resident #128 was and did not assist him/her back to his/her room. During an interview on 11/15/21 at 8:31 A.M., Nurse #15 said it was her first day working in the facility so she did not know who the residents were, and did not have access to the electronic medical record yet to look them up. She further said she did not receive any safety/fall risk information about Resident #128 during verbal report prior to her shift, thus, did not know Resident #128 required assistance and continual supervision with ambulation to prevent falls. During an interview on 11/16/21 at 10:41 A.M., Nurse #5 said there was no plan she knew of to prevent future falls for Resident #128. She said he/she was very impulsive and non-compliant and was worried he/she would sustain a serious injury. She further said usually there was only one nurse and one aide working each shift. Nurse #5 said there was not enough staff to continually supervise Resident #128 to keep him/her safe, especially if she was in another resident's room and could not hear his/her feet shuffling. By that time, she said, it would be too late. During an interview on 11/15/21 at 4:13 P.M., the Director of Nurses (DON) said fall risk interventions should have been implemented to prevent falls, but were not. She further said, You cannot expect the staff to continually supervise if you only have one nurse and one aide. During an interview on 11/16/21 at 1:01 P.M., the surveyor reviewed the Falls Weekly Risk Meeting notes from February 2021 to present with the DON. The DON said not all of Resident #128's falls were addressed or documented in the risk minutes, but should have been. She further said the facility did not have risk minutes for any resident after July 2021, but should have. 41107 3. Review of the facility's Tracheostomy (breathing tube in neck) Care Policy, undated, by Pro2Caire, failed to indicate any information about emergency equipment that should have been located at the bedside of a resident with a tracheostomy tube. Further review indicated that, if the outer cannula did come out (decannulation), a hemostat (surgical tool that may be used to open the airway and allow ventilation) could be used to keep the airway open. Review of Tracheostomy Care ([NAME]), dated 2014, indicated the following emergency supplies that should be immediately available at the tracheostomy patient's bedside: - a tracheostomy (trach) tube of the same type and size as the one currently in place as well as a trach tube one size smaller -suction equipment -bag-valve mask (Ambu bag-used to provide ventilation) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation with interview on 11/9/21 at 9:44 A.M., the surveyor observed two Residents (#84 and #110) on the [NAME] unit with tracheostomy tubes with Nurse #16. Nurse #16 said neither Resident had an Ambu bag, suction tubing, or spare trach tubes a size smaller at the bedside, which she would expect to see. Nurse #16 said she should not have to hunt for emergency supplies, they should be right at the bedside, but were not. The surveyor and Nurse #16 then observed the Code Cart for the [NAME] Unit. She said there should be an Ambu bag on every code cart to be used emergently for any resident requiring breathing support, but there was not one on the [NAME] Unit code cart. Nurse #16 reviewed the November Code Cart Checklist with the surveyor and said it indicated the Ambu bag was present, but it was not. During an interview on 11/9/21 at 11:10 A.M., Nurse #17 said he worked the 3:00 P.M. to 11:00 P.M. shift, and the Ambu bag on the code cart on the [NAME] Unit had been used for an emergency about a week and a half ago. He said he had not had a chance to replace it with a new one after the emergency. Nurse #17 said staffing had been horrid recently and there had been times when he was the only staff member on the [NAME] unit, so there was no time for extra tasks. He further said the 11:00 P.M. to 7:00 A.M. shift nurse was responsible for taking inventory of the code cart every night. Nurse #17 said he had had another emergency on the Hopkins Unit recently and the back board was not with the code cart, so he had to break a tray table in half in order to give Cardiopulmonary Resuscitation to a resident. During an interview on 11/9/21 at 2:34 P.M., Nurse #12 said she worked the overnight shift on the [NAME] Unit. She said it was her duty to check the code cart every night. She said she had not checked every part of the code cart on 11/8/21 during the 11:00 P.M. to 7:00 A.M. shift because there had not been enough time. She said she could not be sure the Ambu bag was on the emergency code cart, but she said she knew it used to be there. She further said it may have been used during an emergency on 10/31/21. 4. On 11/10/21 at 10:00 A.M., the surveyor observed Residents #84 and #110 with the Director of Nurses (DON). She said she would have expected to see the same size and type of trach tube and a size smaller at the bedside of every tracheostomy resident. She said Resident #110 had only one spare trach at his/her bedside, which was the same size. She said Resident #84 had only one spare trach above his/her bed, but she said she could not determine if the spare trach above Resident #84's bed was the same size or a size smaller since she was unable to find an order that indicated the type and size of the trach the Resident currently had in. The DON said there should have been an order for trach tube type and size, but there was not. She also said emergency equipment including an Ambu bag, suction equipment, and a hemostat should have been located at the bedside of every resident with a tracheostomy, including two spare trach tubes (same size and a size smaller), but was not. Resident #84 was readmitted to the facility in October 2021. Review of a Physician's Interim/Telephone order dated 11/10/21, indicated Resident #84 had a Portex 6 millimeter (mm) cuffed (balloon on outer cannula used to prevent aspiration when inflated) trach tube. The order was not signed by the physician, and there was no previous order for the type and size of the trach tube. Resident #110 was admitted to the facility in July 2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of November 2021 Physician's Orders, indicated Resident #110 had a Portex size 8 mm trach tube with a size 7.0 mm inner cannula (smaller, removable tube within trach outer cannula). During an interview on 11/15/21 at 11:24 A.M., Nurse #11 said someone told her this past weekend that the spare trach tube at a resident's bedside should be one size larger than the one the resident has in place. During an interview on 11/15/21 at 11:29 A.M., Consultant Staff #4 said the same size trach tube should be attached to the wall in case a spare trach is needed emergently. During an interview on 11/16/21 at 12:57 P.M., the DON said she found an interim/telephone order in Resident #84's medical record, dated 11/10/21, for trach type and size. She further said, as far as she was concerned, each resident with a tracheostomy should always have two spare trach tubes at the bedside, one the same size and one a size smaller, an Ambu bag, suctioning equipment and a hemostat, but neither Resident (#110 nor #84) did.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41107 Based on observation, record review, policy review, and interview, the facility failed to provide treatment and services for 2 out of 7 Residents (#100 and #83) with indwelling catheters (tube inserted into the bladder to drain urine), out of a total sample of 30 residents. Specifically, the facility failed to: 1. Provide Foley catheter care and Urology follow up for catheter changes and ongoing assessment, in order to prevent recurrent catheter-related urinary tract infections requiring hospitalization s, for Resident #100; and 2. Provide consistent suprapubic catheter care per physician's orders and consistent monitoring of urinary output per the care plan for Resident #83. Findings include: 1. During an interview on 11/5/21 at 9:18 A.M., Resident #100 said his/her urinary catheter hurt. During an interview on 11/9/21 at 12:37 P.M., Resident #100 said his/her urinary catheter hurt. Resident #100 was admitted to the facility in September 2020 with diagnoses including Benign Prostatic Hyperplasia (BPH- prostate gland enlargement) without lower urinary tract symptoms, retention of urine, and neuromuscular dysfunction of the bladder. Review of the Urology Office Visit Report, dated 9/13/21, the physician indicated the following: -patient presents with clogged catheter -no documentation from the Skilled Nursing Facility of the last time the catheter was changed -last time it had been changed by urology was August 2020 -excessively calcified tip of Foley catheter consistent with not being changed for an extended period of time -In the Notes section of the report the physician documented the following: -spoke directly with the Director of Nurses at rehab (facility) -discussed how completely unacceptable it was that there was no documentation of the last time the Foley catheter was changed, that no one noticed it had not been changed for an extended period of time, and the state that it was in when it was removed today Review of Resident #100's medical record indicated, he/she had been admitted to the hospital: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	-September 2021 with a diagnosis of catheter-associated urinary tract infection (CAUTI) -October 2021 with a diagnosis of CAUTI Review of the August 2021 Treatment Administration Record (TAR) indicated the Foley catheter protocol was to be implemented. This included, but was not limited to: -Foley catheter care every shift Further review of the August 2021 TAR failed to indicate that Foley catheter care had been provided on 22 out of 93 occasions during the month of August 2021. Review of the September 2021 TAR indicated the Foley catheter protocol was to be implemented. This included, but was not limited to: -Foley catheter care every shift Further review of the September 2021 TAR failed to indicate that Foley catheter care had been provided 34 out of 90 times in the month of September 2021. Review of the October 2021 TAR indicated the Foley catheter protocol was to be implemented. This included, but was not limited to: -Foley catheter care every shift Further review of the October 2021 TAR failed to indicate that Foley catheter care had been provided 44 out of 93 times in the month of October 2021. Review of a Nurse's Note, dated 10/12/21, indicated Resident #100 had an appointment with the Urologist on 10/18/21 for Foley replacement. During an interview on 11/16/21 at 12:25 P.M., Nurse # 11 said Resident #100 had a Urology appointment scheduled for 10/18/21, but it had been rescheduled and she was not sure why. She also said she was unable to determine if the appointment had actually been rescheduled or not, since there was no documentation, and nothing was written on the calendar. During an interview on 11/16/21 at 3:33 P.M., the Director of Nurses (DON) said it was the facility's responsibility to ensure Resident #100 was followed by urology and it had not been done, but it should have been. She said she was unable to determine the last time the catheter had been changed prior to the Urology appointment on 9/13/21. The DON further said, there was no way to ensure catheter care had been done for the Resident, if it had not been marked off on the TAR, and catheter care should have been done on every shift in order to help prevent urinary tract infections. 42742 2a. Resident #83 was admitted to the facility with diagnoses including urinary tract infections (UTI's), multiple sclerosis (MS), and neuromuscular dysfunction of the bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #83's current Physician's Orders, dated 11/1/21 through 11/30/21, indicated an order for catheter care with soap and water every shift and as needed. Review of Nursing Progress Notes, dated 9/23/21, indicated Resident #83 had a suprapubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal flow) placed on 9/22/21. On 11/15/21 at 8:54 A.M., the surveyor observed Resident #83's suprapubic catheter bag draining yellow urine. Resident #83 said the catheter was relatively new. On 11/15/21 at 2:40 P.M., the surveyor and Nurse #15, with Resident #83's permission, observed the suprapubic catheter insertion site which was draining a small amount of serosanguinous (both blood and a clear yellow liquid known as blood serum) fluid. Resident #83 said a nurse looked at it that day and said it looked okay, but never returned to clean it with soap and water. Review of the TAR, dated 11/15/21, indicated catheter care for the 7:00 A.M.-3:00 P.M. shift was completed as evidenced by documentation of nursing initials. During an interview on 11/15/21 at 2:55 P.M., Nurse #15 said she signed off that she completed Resident #83's catheter care treatment during her 7:00 A.M.-3:00 P.M. shift, but did not do it. She further said she should not have documented that she completed the treatment when, in fact, she did not. Further review of the TAR from 10/1/21 through 10/31/21 indicated suprapubic catheter care was not completed on 17 of 93 shifts. Review of the TAR from 11/1/21 through 11/15/21 indicated suprapubic catheter care was not completed on 14 of 45 shifts. During an interview on 11/16/21 at 1:00 P.M., the DON said there should have been consistent documentation for catheter care, but there was not. She further said Nurse #15 should not have signed off that she completed suprapubic catheter care if she had not done it. 2b. Review of the Neurogenic Bladder Care Plan, initiated 12/29/20, indicated Resident #83 was at risk for urinary infection. Interventions included monitoring the amount of urinary output. Review of Resident #83's Intake and Output Worksheets for 11/2/21, 11/3/21, and 11/5/21 through 11/12/21 failed to indicate consistent documentation of urinary output. During an interview on 11/15/21 at 4:01 P.M., the surveyor reviewed the worksheets with the DON who said urinary output should have been consistently documented, but was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, record reviews, and policy review, the facility failed to ensure five Residents (#50, #66, #93, #29 and #110) maintained their nutritional status, out of a total sample of 30 residents. Specifically, 1. For Resident #50, the facility failed to ensure the resident received A.) adequate nutrition through food by mouth; B.) tube feeding as ordered; and C.) house supplement as ordered to maintain nutritional status; 2. For Resident #66, the facility failed to ensure a bolus feed and water were administered as ordered and weights were obtained weekly to ensure monitoring of any changes; 3. For Resident #93, the facility failed to ensure tube feedings were administered as ordered and weights were obtained weekly to monitor for changes, as ordered; 4. For Residents #29 and #110 the facility staff failed to ensure weights were obtained weekly to ensure monitoring of any changes. Findings include: 1. Resident #50 was admitted to the facility in May 2019 with a history of anoxic brain injury and aspiration pneumonia. Review of the Nutrition Assessment, dated 11/9/21, indicated Resident #50 would meet their nutrition needs through food by mouth and a feeding tube, while maintaining a stable weight. The assessment indicated the last weight for the Resident was 138 pounds (lbs.) obtained on 10/13/21. A.) Review of the Minimum Data Set (MDS) assessment, dated 8/13/21, indicated Resident #50 was a supervision level of eating with oversight, encouragement or cueing. A review of the resident care card indicated Resident #50 was on aspiration precautions, was to be provided continual supervision in a one to eight (1:8) ratio, and ate in the main dining room. Review of the Care Plans indicated a focus of a swallowing difficulty with interventions including continual supervision during meals, provide safe swallow strategies of feeding slowly, alternating solids and liquids, small bites and sips, discouragement from talking during meals/snacks, and provide verbal/tactile cues when necessary to get Resident to swallow. Review of the Speech Therapy Discharge Summary, dated 10/29/20, indicated Resident #50 tolerated 75-100% of meal without overt signs or symptoms of aspiration. The Discharge Summary included a good prognosis with consistent staff follow through, a plan of taking liquids through teaspoon, alternating of liquids and solids, upright posture during meals and upright posture for at least 30 minutes after meals and to have 1:8 continual supervision for swallowing and self-feeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of the Physician's Order indicated a diet of pureed texture, honey thickened liquids via teaspoon only, all food in separate bowls, fortified cereal at breakfast, fortified potatoes at lunch, Magic Cup at dinner, and to be out of bed for all meals. On 11/4/21 at 11:00 A.M., the surveyor observed Resident #50 lying in bed; the Resident's breakfast tray was on the overbed table, with individual cups of untouched puree eggs, hot cereal and a light brown substance. There were two styrofoam cups on the tray with thickened liquids, one of them half empty, no other items on the tray had been touched. On 11/5/21 at 9:49 A.M., the surveyor observed Resident #50 lying in bed; the Resident's breakfast tray was on the overbed table, the cup of eggs was empty, the hot cereal was untouched, and another brown substance was untouched. The Resident had a large cup of thickened orange juice that had not been consumed. The Resident was not observed to be out of bed and there was no staff providing supervision. On 11/5/21 the surveyor observed: - At 1:24 P.M., Resident #50 with his/her eyes closed with the lunch tray on the overbed table. - At 1:45 P.M., Resident #50 sitting up, eyes open, not eating. - At 1:54 P.M., Resident #50 sitting up, not eating, there was no staff there for supervision. During an interview on 11/5/21 at 2:32 P.M., Certified Nursing Assistant (CNA) #6 said the staff had not been monitoring meal intake and they were unsure who needed supervision with eating. She said there was not enough staff to take care of all of these residents. She said there was a list of seven residents on the [NAME] unit who needed assistance with feeding and Resident #50 was not one of them. She said they did not monitor intake when picking up the meal trays after the meal. During an interview on 11/9/21 at 1:52 P.M., the Director of Rehabilitation said Resident #50 was to be served with individual meal items in small bowls and to eat with a teaspoon with supervision. She said the Resident was to be supervised to ensure he/she was using the teaspoon to decrease the risk of aspiration. She said Resident #50 may not have been eating his/her meals because he/she was not in the main dining room and seeing other residents eat as a cue for him/her to eat. B. Resident #50 had an order for feeding via gastrostomy (G)-tube (feeding tube in abdomen used to provide nutrition) of Jevity 1.5 at a rate of 55 ml (milliliters) per hour until 275 ml were infused. Review of the October 2021 Medication Administration Record (MAR) indicated the Jevity 1.5 tube feed was not signed off as administered on 10/26/21, 10/28/21, 10/29/21, 10/30/21, and 10/31/21. On 11/9/21 at 12:30 P.M., the surveyor observed a 1000 ml feeding tube bottle of Jevity 1.5 labeled 11/6/21 with approximately 500 ml left in the bottle. A feeding on 11/6/21, 11/7/21, and 11/8/21 should have administered 875 ml, with 175 ml left in the bottle, a difference of 325 ml. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	On 11/10/21 at 9:28 A.M., the surveyor observed the same feeding tube bottle, dated 11/6/21, to have approximately 225 ml left in the bottle, indicating the Resident was fed 275 ml as ordered on 11/9/21. Review of the precautions listed on the bottle of Jevity 1.5 cal, observed by the surveyor to be hanging at the beside of the Resident on 11/10/21, indicated to hang product for up to 48 hours after initial connection. The decrease in the amount of feeding in the bottle on 11/10/21 indicated the bottle dated 11/6/21 had been used on 11/9/21, three days after it was hung. On 11/12/21 at 3:35 P.M., the surveyor observed a new 1000 ml Jevity 1.5 bottle to be connected, which was dated 11/10/21 at 10:00 P.M. with 825 ml left in the bottle. If Resident #50 had been fed as ordered, on 11/10/21 225 ml would have been used from the bottle dated 11/6/21 and 50 ml would have been used from the bottle dated 11/10/21; then on 11/11/21 Resident #50 would have been fed 275 ml for a total of 325 ml from the bottle dated 11/10/21; which would have left 675 ml in the bottle that the surveyor observed on 11/12/21, a difference of 150 ml. C. Review of the Physician's Orders included a house supplement 120 ml at 8:00 A.M., 2:00 P.M., 6:00 P.M., and to contact the physician and dietitian if less than 50% was consumed. Review of the MARs indicated: - September 2021, the house supplement was not provided 36 out of 90 times; - October 2021, the house supplement was not provided 51 out of 93 times; and - November 2021 (11/1/21 through 11/10/21), the house supplement was not provided 19 out of 27 times. During an interview on 11/12/21 at 9:00 A.M., Registered Dietitian (RD) #1 said Resident #50 received nutrition through food by mouth, house supplements and through a feeding tube to support the nutritional goals. She said the staff should be monitoring the meal intake of this Resident as the supplemental support of drinks and the feeding tube are determined based on the Resident's meal intake, but there was not enough staff to monitor meal intake. She said she was not aware Resident #50 had not been eating, was not aware the Resident had not been receiving the house supplement as ordered, and had not been notified when less than 50% was consumed. She said the Resident should have been weighed weekly but there was not enough staff to monitor the weights. She said her assessment of Resident #50 completed on 11/9/21 had been based on a weight from the previous month. RD #1 further said a weight was obtained for Resident #50 on 11/11/21 and the Resident weighed 129.2 lbs., a significant loss of 6.38% in one month. 2. Resident #66 was admitted to the facility in August 2021 with a history of traumatic brain injury and required a feeding tube. Review of the medical record for Resident #66 included a medical nutrition therapy assessment dated [DATE]. The assessment indicated a diet of Jevity 1.5, 390 milliliters (ml) bolus four times per day for a total of 1560 ml per day, and water 240 ml four times per day, a weight of 168 pounds (lbs) on 10/13/21 and indicated the weight had no significant changes for 30 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of the Physician's Orders indicated an order to obtain the weight of Resident #66 weekly. Review of the medical record on 11/12/21 indicated the last weight was obtained on 10/13/21. Review of the October 2021 MAR indicated the order for Jevity 1.5 was not signed off as administered on 10/5/21 at 12:00 P.M., 10/8/21 at 12:00 P.M., 10/13/21 at 12:00 P.M., 10/14/21 at 6:00 P.M., 10/16/21 at 6:00 P.M., 10/17/21 at 12:00 P.M., 10/18/21 at 6:00 P.M., 10/19/21 at 12:00 A.M. and 6:00 A.M., 10/21/21 at 12:00 P.M., 10/26/21 at 6:00 A.M., 12:00 P.M., 6:00 P.M., 10/28/21 at 12:00 P.M., 10/29/21 at 6:00 P.M., and 10/31/21 at 12:00 P.M. and 6:00 P.M. Review of the October 2021 MAR indicated the order for 240 ml of water four times per day was not signed off as administered on 10/5/21 at 12:00 P.M., 10/8/21 at 12:00 P.M., 10/13/21 at 12:00 P.M. 10/14/21 at 6:00 P.M., 10/15/21 at 6:00 P.M., 10/16/21 at 6:00 P.M., 10/17/21 at 12:00 P.M., 10/18/21 at 6:00 P.M., 10/19/21 at 12:00 A.M. and 6:00 A.M., 10/21/21 at 12:00 P.M., 10/26/21 at 6:00 A.M., 12:00 P.M., 6:00 P.M., 10/28/21 at 12:00 A.M., 6:00 A.M., 12:00 P.M., 6:00 P.M., 10/29/21 at 6:00 P.M., and 10/31/21 at 6:00 A.M., 12:00 P. M. and 6:00 P.M. Review of the November 2021 MAR on 11/12/21 indicated the order for Jevity 1.5 was not signed off as administered on 11/1/21 at 12:00 P.M. and 6:00 P.M., 11/4/21 at 12:00 P.M., and 11/9/21 at 12:00 P.M. Review of the November 2021 MAR on 11/12/21 indicated the order for 240 ml of water four times per day was not signed off as administered on 11/1/21 at 12:00 P.M. and 6:00 P.M., 11/4/21 at 12:00 P.M., and 11/9/21 at 12:00 P.M. On 11/12/21 at 8:13 A.M., the surveyor observed Resident #66 lying in bed. There was a bottle of Jevity 1.5 on the nightstand. The bottle was dated 11/11/21 at 6:00 P.M. and there was approximately 400 ml gone from the bottle (one feeding). During an interview on 11/12/21 at 8:14 A.M., Resident #66 said he/she was hungry and had not received the bolus feed this morning (6:00 A.M.). During an interview on 11/12/21 at 8:53 A.M., RD #1 said Resident #66 was supposed to be weighed weekly and the last weight was one month prior. She said she was unaware staff was not signing off as administering the bolus feeds of Resident #66 and had not been checking the MAR. During an interview on 11/12/21 at 9:00 A.M., Unit Manager #2 said the bolus feed should be signed off for each feeding and if it was not signed off there was no way to determine if the Resident was fed. During an interview on 11/12/21 at 12:26 P.M., RD #1 said Resident #66 was weighed on 11/12/21 and weighed 158.5 lbs., a loss of 5.65% in one month (a significant weight loss). The RD said she had met with the Resident who informed her that he/she had feelings of hunger at times. She said the Resident should have been weighed weekly to monitor for any changes. 3. Resident #93 was admitted to the facility in June 2021 with a diagnosis of metabolic encephalopathy and required a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record for Resident #93 included a medical nutrition therapy assessment dated [DATE]. The assessment indicated a diet of Jevity 1.5 at a rate of 63 milliliters (ml) per hour until 1323 ml were infused, a weight of 130.9 pounds (lbs) on 8/24/21, and indicated the weight had stabilized. Review of an RD's Progress Note, dated 10/4/21, indicated Resident #93's weight was 129.8 lbs and was stable. Review of the Physician's Orders indicated weekly weights were to be obtained for four weeks following admission/re-admission and then monthly. Resident #93 was readmitted to the facility in October 2021. A review of the electronic medical record on 11/10/21 indicated the last weight obtained for Resident #93 was on 10/1/21 of 129.8 lbs. Review of the MAR for October 2021 indicated an order for Jevity 1.5 to be administered at a rate of 63 ml per hour for 21 hours, until 1323 ml were reached, to be turned on at 7:00 P.M. and off the following 4:00 P. M. A review of the October 2021 MAR indicated the nutritional feeding was not signed off as administered on 10/15/21, 10/21/21, 10/22/21, 10/25/21, 10/26/21, 10/27/21, 10/29/21, and 10/31/21. During an interview on 11/16/21 at 11:00 A.M., the Director of Nurses said if the feedings were not documented then it is assumed they were not done. During an interview on 11/12/21 at 8:38 A.M., RD #1 said Resident #93 was supposed to be weighed weekly and due to the lack of staffing the weights had not been obtained on a regular basis. She said she was unaware the ordered feedings had not been signed off as administered for eight days in October 2021. During an interview on 11/12/21 at 12:25 P.M., RD #1 said Resident #93 had a current weight of 122.3 lbs, indicating a significant weight loss of 5.78% since the previous weight on 10/1/21. The RD said the staff should have been obtaining weights for the resident weekly to monitor for weight loss to implement interventions prior to a significant weight loss. 41107 4a. Review of the Facility's Weights Policy, dated August 2015, indicated the following residents are weighed weekly x 4: -newly readmitted residents (unless clinically not indicated) -residents with a physician's order for weekly weights -thereafter, residents will be weighed monthly, unless clinically indicated Resident #29 was readmitted to the facility in October 2021. Review of a Nutrition Note, dated 10/11/21, indicated Resident #29 was readmitted to the facility and his/her most recent weight was 162.7 lbs from 8/10/21. The note also indicated the Resident had inadequate meal intakes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #29's medical record, under Weights and Vitals Summary, indicated the following weights, but was not limited to: -162.7 lbs on 8/10/21 -no readmission weight -no weekly weights following readmission Review of the November 2021 Physician's Orders indicated Resident #29 was to be weighed weekly. During an interview on 11/16/21 at 8:43 A.M., RD #1 said Resident #29 had not been weighed since 8/10/21, when he/she weighed 162.7 lbs. She said the nurse had just weighed Resident #29 twice and his/her current weight was 148.2 lbs. She further said the Resident should have been weighed weekly, but was not, so she was unaware of the 14.5 lb weight loss. b. Resident #110 was readmitted to the facility in July 2021 with diagnoses including anoxic brain injury and dysphagia (difficulty swallowing) with G-tube. Review of the November 2021 Physician's Orders indicated Resident #110 was to be weighed weekly. Review of Resident #110's medical record, under Weights and Vitals Summary, indicated the following weights, but was not limited to: - 148 lbs, on 7/21/21, six days after readmission - 148 lbs on 8/11/21 - no weights recorded after 8/11/21 During an interview on 11/16/21 at 9:21 A.M., RD #1 said Resident #110 had not been weighed since 8/11/21, when he/she weighed 148 lbs. She said a nurse had just weighed Resident #110, and his/her current weight was 137 lbs, which was an 11 lb. weight loss. She further said the Resident should have been weighed weekly, but was not, so she was unaware of the weight loss. During an interview on 11/16/21 at 2:12 P.M., RD #1 said that Residents #29 and #110 had not been weighed weekly as ordered by the physician, and/or at least monthly, as per facility policy. She further said without Residents' weights it is not possible to properly assess and monitor the Residents' nutritional status, and implement interventions as needed. Each time weights were not recorded, RD #1 said she asked the nurse, but was told there was not enough nursing staff to weigh the residents, and they had to prioritize things.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, and record review, the facility failed to ensure enteral nutrition and fluids provided via a gastrostomy tube (G-tube- a feeding tube in abdomen used to provide nutrition) were provided in accordance with professional standards and physician's orders and failed to provide appropriate services to maintain nutrition through oral eating skills for one Resident (#50), out of 17 residents in the facility with feeding tubes, and a total sample of 30 residents. Findings include: Resident #50 was admitted to the facility in May 2019 with a history of anoxic brain injury and aspiration pneumonia. Review of the Nutrition Assessment, dated 11/9/21, indicated Resident #50 would meet their nutrition needs through food by mouth and a feeding tube, while maintaining a stable weight. The assessment indicated the last weight for the Resident was 138 pounds (lbs.) obtained on 10/13/21. A) Review of the Minimum Data Set (MDS) assessment, dated 8/13/21, indicated Resident #50 was a supervision level of eating with oversight, encouragement or cueing. A review of the resident care card indicated Resident #50 was on aspiration precautions, was to be provided continual supervision in a one to eight (1:8) ratio and ate in the main dining room. Review of the Care Plans indicated a focus of a swallowing difficulty with interventions including continual supervision during meals, provide safe swallow strategies of feeding slowly, alternating solids and liquids, small bites and sips, discouragement from talking during meals/snacks, and provide verbal/tactile cues when necessary to get resident to swallow. Review of the Speech Therapy Discharge Summary, dated 10/29/20, indicated Resident #50 tolerated 75-100% of meal without overt signs or symptoms of aspiration. The Discharge Summary included a good prognosis with consistent staff follow through, a plan of taking liquids through teaspoon, alternating of liquids and solids, upright posture during meals and upright posture for at least 30 minutes after meals and to have 1:8 continual supervision for swallowing and self-feeding. Review of the Physician's Order indicated a diet of pureed texture, honey thickened liquids via teaspoon only, all food in separate bowls, fortified cereal at breakfast, fortified potatoes at lunch, Magic Cup at dinner, and to be out of bed for all meals. On 11/4/21 at 11:00 A.M., the surveyor observed Resident #50 lying in bed; the Resident's breakfast tray was on the overbed table, with individual cups of untouched puree eggs, hot cereal and a light brown substance. There were two styrofoam cups on the tray with thickened liquids, one of them half empty, no other items on the tray had been touched. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Actual harm Residents Affected - Few	On 11/5/21 at 9:49 A.M., the surveyor observed Resident #50 lying in bed; the Resident's breakfast tray was on the overbed table, the cup of eggs was empty, the hot cereal was untouched and another brown substance was untouched. The Resident had a large cup of thickened orange juice that had not been consumed. The Resident was not observed to be out of bed and there was no staff providing supervision. On 11/5/21 the surveyor observed: - At 1:24 P.M., Resident #50 with his/her eyes closed with the lunch tray on the overbed table; - At 1:45 P.M., Resident #50 sitting up, eyes open, not eating; - At 1:54 P.M., Resident #50 sitting up, not eating; there was no staff there for supervision. During an interview on 11/5/21 at 2:32 P.M., Certified Nursing Assistant (CNA) #6 said the staff had not been monitoring meal intake and they were unsure who needed supervision with eating. She said there was not enough staff to take care of all of these residents. She said there was a list of seven residents on the [NAME] unit who needed assistance with feeding and Resident #50 was not one of them. She said they did not monitor intake when picking up the meal trays after the meal. During an interview on 11/9/21 at 1:52 P.M., the Director of Rehabilitation said Resident #50 was to be served with individual meal items in small bowls and to eat with a teaspoon with supervision. She said the Resident was to be supervised to ensure he/she was using the teaspoon to decrease the risk of aspiration. She said Resident #50 may not have been eating his/her meals because he/she was not in the main dining room and seeing other residents eat as a cue for him/her to eat. B. Resident #50 had an order for feeding via G-tube of Jevity 1.5 at a rate of 55 ml (milliliters) per hour until 275 ml were infused. Review of the October Medication Administration Record (MAR) indicated the Jevity 1.5 tube feed was not signed off as administered on 10/26/21, 10/28/21, 10/29/21, 10/30/21, and 10/31/21. On 11/9/21 at 12:30 P.M., the surveyor observed a 1000 ml feeding tube bottle of Jevity 1.5 labeled 11/6/21 with approximately 500 ml left in the bottle. A feeding on 11/6/21, 11/7/21, and 11/8/21 should have administered 875 ml, with 175 ml left in the bottle, a difference of 325 ml. On 11/10/21 at 9:28 A.M., the surveyor observed the same feeding tube bottle, dated 11/6/21, to have approximately 225 ml left in the bottle, indicating the Resident was fed 275 ml as ordered on 11/9/21. On 11/12/21 at 3:35 P.M., the surveyor observed a new 1000 ml Jevity 1.5 bottle connected, which was dated 11/10/21 at 10:00 P.M. with 825 ml left in the bottle. If Resident #50 had been fed as ordered, on 11/10/21 225 ml would have been used from the bottle dated 11/6/21 and 50 ml would have been used from the bottle dated 11/10/21; then on 11/11/21 Resident #50 would have been fed 275 ml for a total of 325 ml from the bottle dated 11/10/21; which would have left 675 ml in the bottle that the surveyor observed on 11/12/21, a difference of 150 ml. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Actual harm Residents Affected - Few	C. Review of the Physician's Orders included a house supplement 120 ml at 8:00 A.M., 2:00 P.M., 6:00 P.M., and to contact the physician and dietitian if less than 50% was consumed. Review of the Medication Administration Records (MAR) indicated: - September 2021, the house supplement was not provided 36 out of 90 times; - October 2021, the house supplement was not provided 51 out of 93 times; and - November 2021 (11/1/21 through 11/10/21), the house supplement was not provided 19 out of 27 times. During an interview on 11/12/21 at 9:00 A.M., Registered Dietitian #1 said Resident #50 received nutrition through food by mouth, house supplements and through a feeding tube to support the nutritional goals. She said she was not aware Resident #50 had not been eating, was not aware the Resident had not been receiving the house supplement as ordered and had not been notified when less than 50% was consumed. She said the goal for Resident #50 was to be able to discontinue the feeding tube, as previously attempted, but oral intake would need to be able to maintain nutritional status first.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 27189 Based on record review, policy review, and interviews, the facility failed to ensure that care and treatment of a mid-line catheter (a venous access device (VAD) located directly in the basilic vein of the arm and terminates just below the axilla) was provided in accordance with the facility policy/protocols for one Resident (#125), out of a total sample of 30 residents. Specifically, for Resident #125, the facility failed to: -Ensure the mid-line dressing was changed; -Ensure the external length of the catheter was measured; -Ensure the IV tubing was changed every twenty-four hours; -Ensure the mid-line catheter was flushed before and after medication administration; and -Ensure there was documentation when the mid-line was removed. Findings include: Review of the facility's policies/ protocols titled; Midline Catheter-Dressing Change, Midline Catheter-Flushing, and Midline Catheter-Removal, dated 2012, included but not limited to the following: Transparent dressings are changed upon admission or 24 hours post midline insertion, every 7 days or sooner if the integrity of the dressing is compromised (wet, soiled, or loose). With each dressing change, the Licensed Nurse shall measure the external catheter length and notify physician if problem exists such as a deviation from the previous measurement. Document date/time of dressing change, site assessment, measurement of external catheter length, and resident response in the appropriate nursing document. Flushing with 0.9% Sterile Saline (NS) for Injection shall be performed before and after administration of incompatible medications/solutions, followed by Heparinized Saline per physician's order. Midline Catheter Removal Documentation: Document date/time of procedure, patient education, length of catheter removed and catheter integrity, resident's response to procedure, and catheter site assessment on appropriate nursing document. Record review indicated that Resident #125 was hospitalized twice in July 2021. Upon return to the facility, Resident #125 had a midline catheter in place for administration of antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review indicated the Resident initially was to receive Ceftazidime 2 grams three times a day via IV for 10 days. Resident #125 was re-hospitalized and returned on 7/25/21 with an order to discontinue the Ceftazidime and begin Meropenem 500 milligrams IV every six hours for seven days. Review of the Infusion Therapy Flowsheet indicated the initial dressing was changed on 7/23/21 and due to be changed again on 7/30/21. Record review and review of the Infusion Therapy Flowsheet indicated the dressing was not changed on 7/30/21 and it further indicated that on 7/23/21 and 7/30/21 there was no documentation of the measurements of the external catheter length. Review of the Infusion Medication Administration Record indicated the midline was to be flushed before and after the administration of the antibiotic with 10 milliliters (ml) of NS and then Flush with Heparin 5 mls (10units per ml). Further review of the Infusion Medication Record indicated that the above flush protocol was not administered every six hours as ordered for 5 days, 7/26/21 through 7/31/21. Review of a Nurse's Note, dated 8/1/21, indicated Resident #125's midline infiltrated (the medication was infusing into the tissue instead of the vein). An order was obtained to remove the midline catheter, discontinue the current IV Meropenem, and start oral Cipro, twice a day for three days. Further record review indicated no documentation of date/time the procedure was performed, patient education, length of catheter removed, catheter integrity, the Resident's response to procedure, and catheter site assessment. Record review indicated that Resident #125 was hospitalized in August 2021, and upon return to the facility, a midline catheter was in place and he/she was to receive IV antibiotics. Resident #125 had begun the course of initial antibiotics while hospitalized and returned with a physician's order for: Meropenem IV every six hours for 13 more days and then the midline catheter can be discontinued. Review of the Infusion Medication Administration Record for August 2021 indicated the IV antibiotic was started at the facility and was completed on 9/5/21. Further review of the Infusion Medication Administration Record indicated there was no dressing change on 8/22/21. There was a dressing change performed on 8/29/21, however there was no documentation of the catheter length on the Infusion Medication Administration during the entire course of antibiotic administration or within the medical record, no documentation that the midline catheter was flushed every six hours as ordered, or that the IV tubing had been changed every 24 hours. The recommendation from the hospital was to discontinue the midline upon completion of the IV antibiotics. Record review indicated that on 9/8/21 the midline catheter remained in place as there had been no order obtained from the Resident's physician to discontinue the midline catheter. Record review indicated the Resident was hospitalized in October 2021 and returned to the facility with a midline catheter in place. Resident #125 had the midline catheter in place from 10/25/21 through 11/1/21 with no dressing changes completed or measurements of the external catheter length. On 11/1/21 an order was obtained from Resident #125's physician to remove the midline catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review indicated that the documentation of the removal of the midline catheter did not include the integrity of the midline catheter that was removed. During an interview on 11/15/21 at 9:45 A.M., the surveyor informed the Director of Nursing of her concerns regarding the care of the midline catheter. The DON said the facility failed to ensure that care and treatment of a midline catheter was provided in accordance with the facility policies/protocols.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107 Based on observation, interview, record review, and policy review, the facility failed to provide adequate respiratory care for three Residents (#84, #110, and #66), out of a total sample of 30 residents. Specifically, the facility failed to: 1. Provide adequate care and services for the management of tracheostomy (breathing tube in neck) tubes for Residents #84 and #110; and 2. Ensure oxygen was administered at a flow rate recommended by a Pulmonologist for Resident #66. Findings include: 1. Review of Tracheostomy Care ([NAME]), dated 2014, indicated the following emergency supplies should be immediately available at the patient's bedside: - a tracheostomy tube of the same type and size as the one currently in place as well as a tracheostomy tube one size smaller -suction equipment -bag-valve mask (Ambu bag-used for ventilation) a. Resident #84 was readmitted to the facility in October 2021. On 11/4/21 at 11:25 A.M., the surveyor observed Resident #84 lying in bed. He/she had a tracheostomy (trach) tube. The surveyor observed a suction machine next to the bed, but no tubing or other equipment needed to perform suctioning was present. On 11/8/21 at 1:30 P.M., the surveyor observed Resident #84 lying in bed. There was a suction machine next to the bed, but no tubing or other equipment needed to perform suctioning was present. On 11/10/21 at 3:31 P.M., the Director of Nurses (DON) observed Resident #84 with the surveyor and said Resident #84 had a significant amount of secretions coming out of his/her trach tube and it was unacceptable to leave the Resident like this, so she would take care of the him/her. On 11/12/21 at 1:46 P.M., the surveyor observed Resident #84 lying in bed with a pillow under his/her head and neck which pushed his/her head significantly forward causing his/her neck to cover his/her trach tube. The surveyor was unable to visualize the trach tube because it was covered by the Resident's neck, due to poor positioning. The Resident was diaphoretic (sweating), and appeared to be in distress. The surveyor alerted Nurse #11 who entered the Resident's room and immediately repositioned the Resident. She said the Resident should not have been positioned like that. Review of Resident #84's Comprehensive Care Plan indicated he/she should be positioned to allow for maximum air flow. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the November 2021 Physician's Orders failed to indicate an order for a tracheostomy tube, including type and size. Review of the November 2021 Treatment Orders failed to indicated any orders related to Resident #84's trach tube. Review of the medical record and an Interim/Telephone order, dated 11/10/21 and not signed by the physician, indicated the following: -please add trach size/type to treatment orders -Portex 6 mm cuffed -may replace trach appliance if dislodged Review of the facility's Tracheostomy Care Policy by Pro2Caire, indicated that the outer tube (main trach tube) should be changed by a physician or licensed respiratory therapist only. Review of a Nurse's Note, dated 11/13/21, indicated Resident #84's tracheostomy tube was changed to a #6 (6 millimeter) Portex cuffed (balloon around the outer diameter of the trach tube, that when inflated, prevents aspiration (movement of secretions into lungs). Review of a Nursing Note, dated 11/14/21, indicated the following: -Resident #84's trach was noted to be abnormally placed and was semi-sideways and the cuff was deflated. -Resident #84 had increased coughing with abnormal breath sounds. -Resident #84 was sent to the emergency department. Review of discharge documentation from the emergency department, dated 11/14/21, indicated Resident #84 had been treated for a tracheostomy obstruction and the tracheostomy had been dislodged. During an interview on 11/15/21 at 11:29 A.M., Nurse Consultant #4 said she went to the facility to assess residents with trach tubes. She said Resident #84 had yellow drainage from his/her trach site, so she changed the trach tube to a 6 mm cuffed Portex tube. The surveyor asked Consultant Staff #4 about cuff inflation and she said the cuff had not been inflated. During an interview on 11/16/21 at 10:50 A.M., the DON said she was not sure what size or type of tracheostomy tube Resident #84 had prior to the trach change by Consulting Staff #4 on 11/13/21, since there had been no order prior to the Interim Order, dated 11/10/21. She further said there were no Treatment Orders for November related to the Resident's tracheostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/16/21 at 12:57 P.M., the DON said she found notes from the acute care hospital that Resident #84 had a 6 mm Portex uncuffed trach that was placed on 3/22/21. She said she could not find any documentation of any trach changes since the Resident's initial admission to the facility in July 2021, or why the Resident now had a cuffed trach. The DON further said, there had been no orders, prior to the Interim/Telephone order written on 11/10/21, for the size, type of trach, and whether or not it was cuffed, but there should have been. b. Resident #110 was admitted to the facility in July 2021 with diagnoses including acute/chronic respiratory failure. On 11/5/21 at 9:35 A.M., the surveyor observed Resident #110 lying in bed; he/she had a trach tube in place. He/she had thick yellow secretions at the end of the trach tube with audible congestion and visible labored breathing. There was a suction machine next to the Resident's bed, but there was no collection canister or suction tubing present. On 11/8/21 at 1:54 P.M., the surveyor observed Resident #110 lying in bed. He/she had brownish/yellow secretions coming from his/her trach tube. During an observation and interview on 11/9/21 at 9:44 A.M., Nurse #16 said Resident #110 did not have suction tubing in his/her room, but he/she should since staff could not suction the Resident without it. She further said she should not have to hunt for tracheostomy supplies, they should have been right at the bedside, but were not. On 11/9/21 at 12:41 P.M., the surveyor observer Resident #110 lying in bed with his/her head pressed against the metal bed rail. He/she had copious (significant) amounts of respiratory secretions coming from his/her trach tube which were all over the bed sheet. On 11/9/21 at 2:38 P.M., the surveyor observed Resident #110 lying in bed; his/her face was red, and the surveyor heard gurgling from the Resident's trach. The surveyor asked Nurse #16 if Resident #110 was typically suctioned and she said she did not know because the Resident's treatment sheets had been taken from the unit, and she did not have access to them. On 11/10/21 at 11:05 A.M., the surveyor observed Resident #110 lying in bed. He/she was gurgling and had a red face. The surveyor observed yellow secretions in the trach and on the Resident's chest. Review of the November 2021 Physician's Orders indicated the following: -Resident #110 had a 8.0 mm Portex trach tube with a 7.0 mm inner cannula -May replace trach as needed if it becomes dislodged -Change and date suction tubing weekly -suction with a 14 French (suction catheter size) as needed for increased secretions Review of the November 2021 Treatment Record failed to indicate that Resident #110's tracheostomy tube had been suctioned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	On 11/10/21 at 3:38 P.M., the DON observed Resident #110 with the surveyor and said the Resident had a significant amount of secretions and was gurgling, and it was unacceptable to leave the Resident like this. The DON said she was unsure as to whether or not the staff had suctioned the Resident, but there was an order to suction as needed for increased secretions. Review of a Nurse's note from Consulting Staff #4, dated 11/13/21, indicated Resident #110 had a slight blockage in his/her trach, and she changed the trach and used a size 8 mm Portex Blueline uncuffed trach tube. During an interview on 11/16/21 at 12:57 P.M., the DON said she had not known Consulting Staff #4 was coming to the facility to assess residents' trach tubes. She further said she did not know why Consulting Staff #4 had changed Resident #84's trach or Resident #110's trach. She said neither Resident had an order for a trach change. The DON further said after she observed the Residents with tracheostomies with the surveyor, she had contacted the respiratory contract company because the nursing staff needed training. 36542 2. Resident #66 was admitted to the facility in August 2021 with diagnoses of chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe), recurrent aspiration pneumonia, pulmonary emphysema and status post upper lobe resection. Review of the medical record for Resident #66 indicated a new order for a continuous pulse oximeter testing overnight on 9/4/21. Review of the Pulmonologist Consultation, dated 9/28/21, indicated a recommendation to continue oxygen at 2 L (liters) during the day and increase to 3 L at night due to significant hypoxemia (low oxygen) noted on the overnight oximetry. Review of a Nursing Progress Note, dated 9/28/21, indicated the recommendation from the Pulmonologist to increase the oxygen overnight was received. Review of the October 2021 and November 2021 Medication Administration Record (MAR) and Treatment Administration Record (TAR) included an order for oxygen as needed 2 L to 4 L. The administration records failed to include an order for 2 L of continuous oxygen and failed to include an order to increase to 3 L overnight. During an interview on 11/12/21 at 2:45 P.M., the DON said she had reviewed the pulmonary consult from 9/28/21. She said the information should have been reviewed with the physician and oxygen should have been provided to Resident #66 as indicated by the Pulmonologist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43935 Based on record reviews, policy review, and interviews, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, through ongoing communication and collaboration with the dialysis facility for one Resident (#139), out of two total residents receiving dialysis. Specifically, the facility 1) Failed to ensure the prescribed fluid restriction for Resident #139 was accurately monitored on an ongoing basis; and 2) Failed to ensure consistent communication between the facility and the dialysis center. Findings include: Review of the facility's policy titled Hemodialysis, dated April 2015, indicated the following: 1. If resident is placed on a fluid restriction, monitor intake. Allocate fluids to be given by nursing and dietary with amounts per shift. 2. Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consists of: A. Vital signs B. Copy of the medication administration record (MAR) C. Any change from last hemodialysis treatment such as falls, medications, behaviors, change in appetite or weight Resident #139 was admitted to the facility in October 2020 with diagnoses including end stage renal disease. Record review indicated Resident #139 attended hemodialysis offsite on Tuesdays, Thursdays and Saturdays weekly, and required a fluid restriction of 960 milliliters (ml) in a 24-hour period. The record lacked any evidence of specific intake monitoring or an allocation of fluids by discipline. On 11/10/21 at 11:01 A.M., the surveyor observed Resident #139 to have a cup of water in front of him/her at the bedside and indicated he/she had consumed the fluids from the cup. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/21 at 11:02 A.M., Nurse #1 said she could not locate a fluid intake monitoring sheet for the Resident, but did have a sign off on the MAR indicating the Resident was on a 960 ml fluid restriction and could receive 120 ml on the night shift, 420 ml on the day shift, and 420 ml on the evening shift. She said she was unsure how much fluid intake Resident #139 had already received for the shift because there was no fluid intake sheet, but could guess it was 360 ml so far for that shift. She said she could not find any evidence of fluid intake for Resident #139 for the month of November 2021 and it appeared the process for fluid restriction and documenting was not being followed. On 11/10/21 at 11:23 A.M., the surveyor observed Ambassador #1 bring the Resident two large, 16 ounce (473 ml) sized, styrofoam cups. One containing tea and the other containing ice. During an interview on 11/10/21 at 11:37 A.M., Ambassador #1 said she was aware of the residents' diets and restrictions from a weekly list provided by the kitchen. She supplied the surveyor with a copy of the list. Review of the list indicated Resident #139 did not have a fluid restriction on the print out used by the Ambassador. During an interview on 11/10/21 at 12:07 P.M., Nurse #1 said she updated the dietary list for the ambassadors and did so for Ambassador #1 that morning. Nurse #1 reviewed the list with the surveyor and said the list was accurate, although it lacked the fluid restriction information for Resident #139. On 11/10/21 at 12:42 P.M., the surveyor observed Resident #139 consuming his/her beverage provided by the Ambassador and his/her large cup of tea was noted to be half empty. The ice cup was also noted to be half empty. During an interview on 11/10/21 at 1:51 P.M., the surveyor made Nurse #1 aware of her observations. Nurse #1 said the Resident should not have been given those additional fluids and she should have given that information to the Ambassador. She said it appeared the Resident had gone over his/her prescribed fluid restriction. During an interview on 11/10/21 at 4:13 P.M., Unit Manager #1 said her expectation of the staff was to have intake sheets completed accurately for each resident on a fluid restriction. She said there was no way for the staff to know the accurate intake of Resident #139 that day since they did not initiate an intake sheet until halfway through the shift. 2. The facility uses a Dialysis Communication Book for ongoing communication with the Dialysis center. This is a form of written communication that occurs between the nursing facility and the Dialysis center that includes, but is not limited to, changes in resident condition, vital signs, contact information, and signature of the charge nurse sending the resident to dialysis. It also includes any recommendations made by the Dialysis center staff for the nursing facility to implement, resident condition before, during and after their dialysis treatment, dialysis access condition, any lab work completed, and the pre and post dialysis weight of the resident. Review of the Resident's Dialysis Communication Book indicated the last hemodialysis communication sheet was completed on 10/23/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/21 at 11:46 A.M., Nurse #1 reviewed the Resident's Dialysis Communication Book with the surveyor and said there were many days of communication sheets missing. She said the last completed communication sheet was on 10/23/21. She further said the process for completing the sheets was not followed. During an interview on 11/10/21 at 1:37 P.M., Dialysis Nurse #1 said the facility consistently sent the Dialysis Communication Book with the Resident, but there was not consistently any information from the facility for the Resident available in the book. During an interview on 11/10/21 at 3:42 P.M., the Director of Nurses said the communication process for dialysis was not followed. During an observation with interview on 11/6/21 at 8:29 A.M., the surveyor observed Resident #139's Dialysis Communication Book on the Mayflower North nurses' station. Nurse #6 said the Resident was out to dialysis and the communication book should have accompanied him/her. She reviewed the Dialysis Communication Book with the surveyor and said there were no initiated communication sheets for the Dialysis center completed on that day and she would contact the dialysis center and provide them a report. She said the policy is for the communication book to accompany the resident with a new communication sheet each dialysis day and the policy was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 27189 Based on record review, review of hospital discharge summaries and interview, the facility failed to ensure the physician included an evaluation of the resident's condition and total program of care, including medications and treatments, for one Resident (#125), out of a total sample of 30 residents. Specifically, the facility failed to ensure Resident #125's attending physician evaluated the total program of care including recommendations that were made by the Hospital providers after the Resident had six hospitalization s with multiple issues, and recurrent Urinary Tract Infections (UTI). Findings include: Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, disorder of the autonomic nervous system, and neuromuscular bladder dysfunction with a suprapubic catheter (a tube that drains urine from your bladder) in place. Record review indicated Resident #125 was hospitalized six times between July 2021 and November 2021 (twice in July and once in each subsequent month). Record review failed to indicate the physician reviewed the follow-up recommendations/hospital discharge summaries upon the Resident's return to the facility as evidenced by: Review of Physician's Progress Notes: - 8/4/21: Stable, Meds (medications) reviewed, continue same treatment and care (these areas were check of boxes). The box for recent hospitalization s was not checked. - 10/13/21: Stable, Meds (medications) reviewed, continue same treatment and care (these areas were check of boxes). The box for recent hospitalization s was not checked. During an interview on 11/10/21 at 1:37 P.M. the Medical Director/Attending physician said, I am connected to the facility by phone only. The MD further said that some weeks he is at the facility every day. The MD said, If someone is readmitted from the hospital they should be seen. If the resident is not stable, I come in the same day. If the resident is stable, then I come in the next day. Record review indicated there were no physician visits/notes after each hospitalization in the medical record and the notes that were reviewed for 8/4/21 and 10/13/21 did not address that the hospital discharge summaries were reviewed and that recommendations made by Hospital providers were addressed. The physician's progress notes did not reflect a comprehensive review of the Resident's medical care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 36542 Based on interviews and record review, the facility failed to ensure a Resident was seen by a physician once every 30 days for the first 90 days of admission for one Resident (#66), out of a total sample of 30 residents. Findings include: Resident #66 was admitted to the facility in August 2021 with diagnoses of chronic respiratory failure with hypoxia (low oxygen), chronic obstructive pulmonary disease (lung disease that block airflow and makes it difficult to breathe), brain shunt, seizures, and traumatic brain injury. Review of the medical record on 11/12/21 for Resident #66 indicated the Resident was seen by a physician on 8/19/21 and 8/20/21. There were no further visits from a physician. During an interview on 11/12/21 at 3:01 P.M., the physician said every resident should be seen every 30 days for the first 90 days following the admission and then every 60 days. The physician said any physician visits would be documented in the paper medical record. During an interview on 11/12/21 at 3:05 P.M., the Nurse Practitioner said she started at the facility one month prior and all of her documentation was in the paper medical record. She said the facility staff was supposed to provide her with a list of residents who needed to be seen and she had never received any list from any staff to ensure that residents were seen every 30 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and schedule review, the facility 1) Failed to maintain sufficient staffing to monitor the oral intake and weights for three Residents (#50, #66, #93) resulting in weight loss; 2) Failed to ensure there was clinical staff present to assure resident safety for one Resident (#128); 3) Failed to ensure there was sufficient staff available to provide nursing services and the adequate care required to meet the residents' needs and; 4) Failed to maintain sufficient staff to provide assistance with feeding and timely meal service, out of a total sample of 30 residents. Findings include: Review of the Facility Assessment Tool, dated January 2021, included but was not limited to the following: Resources needed to provide competent support and care for our resident population every day and during emergencies: Nursing: - [NAME] Unit: 0.5 Unit Manager, 1 Nurse (all three shifts), 4 Certified Nursing Assistants (CNAs) (first and second shift), and 1 CNA overnight - Mayflower: 1 Unit Manager, 2 Nurses (all three shifts), 6 CNAs (first and second shift), and 2 CNAs overnight - Hopkins: 0.5 Unit Manager, 1 Nurse (all three shifts), 3 CNAs (first and second shift), and 2 CNAs overnight - [NAME]: 0.5 Unit Manager, 1 Nurse (all three shifts), 5 CNAs (first and second shift), and 2 CNAs overnight - [NAME]: 0.5 Unit Manager, 1 Nurse (all three shifts), 3 CNAs (first and second shift) and 2 CNAs overnight 1A. Resident #50 was admitted to the facility in May 2019 with a history of anoxic brain injury and aspiration pneumonia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	Review of the Nutrition Assessment, dated 11/9/21, indicated Resident #50 would meet their nutrition needs through food by mouth and a feeding tube, while maintaining a stable weight. The assessment indicated the last weight obtained for the resident was on 10/13/21 for 138 pounds (lbs.). Review of the Minimum Data Set (MDS) assessment, dated 8/13/21, indicated Resident #50 required a supervision level of eating with oversight, encouragement or cueing. Review of the resident care card indicated Resident #50 was on aspiration precautions, was to be provided continual supervision in a one to eight (1:8) ratio, and ate in the main dining room. Review of the Speech Therapy Discharge Summary, dated 10/29/20, indicated a good prognosis with consistent staff follow through, a plan of taking liquids through teaspoon, alternating of liquids and solids, upright posture during meals and upright posture for at least 30 minutes after meals and to have 1:8 continual supervision for swallowing and self-feeding. Review of the Physician's Order indicated a diet of pureed texture, honey thickened liquids via teaspoon only, all food in separate bowls, fortified cereal at breakfast, fortified potatoes at lunch, Magic Cup at dinner, and to be out of bed for all meals. On 11/4/21 at 11:00 A.M., the surveyor observed Resident #50 lying in bed. The Resident's breakfast tray was on the overbed table with individual cups of untouched puree eggs, hot cereal, and a light brown substance. There were two Styrofoam cups on the tray with thickened liquids, one of them half empty, and no other items on the tray had been touched. On 11/5/21 at 9:49 A.M., the surveyor observed Resident #50 lying in bed. The Resident's breakfast tray was on the overbed table, the cup of eggs was empty, the hot cereal was untouched, and another brown substance was untouched. The Resident had a large cup of thickened orange juice that had not been consumed. The Resident was not observed to be out of bed and there were no staff providing supervision. On 11/5/21 at 1:24 P.M., the surveyor observed Resident #50 with his/her eyes closed with the lunch tray on the overbed table. At 1:45 P.M., the Resident was observed to be sitting up, eyes open, and not eating. At 1:54 P.M., the Resident was observed to be sitting up, not eating, and there was no staff there for supervision. During an interview on 11/5/21 at 2:32 P.M., Certified Nursing Assistant (CNA) #6 said staff had not been monitoring meal intake and they were unsure who needed supervision with eating. She said there were not enough staff to take care of all of these residents. She said there was a list of seven residents on the [NAME] unit who needed assistance with feeding and Resident #50 was not one of them. She said they did not monitor intake when picking up the meal trays after the meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	During an interview on 11/12/21 at 9:00 A.M., Registered Dietitian (RD) #1 said Resident #50 received nutrition through food by mouth, house supplements, and through a feeding tube to support the nutritional goals. She said the staff should be monitoring the meal intake of this resident as the supplemental support of drinks and the feeding tube were determined based on the Resident's meal intake, but there was not enough staff to monitor meal intake. She said she was not aware Resident #50 had not been eating, was not aware the Resident had not been receiving the house supplement as ordered, and had not been notified when less than 50% was consumed. She said the Resident should have been weighed weekly, but there was not enough staff to monitor the weights. RD #1 said a weight was obtained for Resident #50 on 11/11/21 and the Resident weighed 129.2 lbs., a loss of 6.38% in one month. B. Resident #66 was admitted to the facility in August 2021 with a history of traumatic brain injury and required a feeding tube. Review of the medical record for Resident #66 included a Medical Nutrition Therapy assessment dated [DATE]. The assessment indicated a diet of Jevity 1.5, 390 milliliters (ml) bolus four times per day for a total of 1560 ml per day, and water 240 ml four times per day, a weight of 168 lbs. on 10/13/21, and indicated the weight had no significant changes for 30 days. Review of the Physician's Orders indicated an order to obtain the weight of Resident #66 weekly. As of 11/12/21, the last weight in the medical record was obtained on 10/13/21. Review of the October 2021 Medication Administration Record (MAR) indicated the order for Jevity 1.5 was not signed off as administered 17 out of 124 times. Review of the November 2021 MAR on 11/12/21 indicated the order for Jevity 1.5 was not signed off as administered 4 out of 44 times. During an interview on 11/12/21 at 8:53 A.M., RD #1 said Resident #66 was supposed to be weighed weekly and the last weight was one month prior. She said there was not enough staff to obtain the weights and, therefore, the weight was unable to be monitored for changes. During an interview on 11/12/21 at 12:26 P.M., RD #1 said Resident #66 was weighed on 11/12/21 and weighed 158.5 lbs., a loss of 5.65% in one month. C. Resident #93 was admitted to the facility in June 2021 with a diagnosis of metabolic encephalopathy and required a feeding tube. Review of the medical record for Resident #93 included a Medical Nutrition Therapy assessment dated [DATE]. The assessment indicated a diet of Jevity 1.5 at a rate of 63 ml per hour until 1323 ml were infused, a weight of 130.9 lbs. on 8/24/21, and indicated the weight had stabilized. Review of an RD's progress note, dated 10/4/21, indicated Resident #93's weight was 129.8 lbs. and was stable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	Review of the Physician's Orders indicated weekly weights were to be obtained for four weeks following admission/re-admission and then monthly. Resident #93 was readmitted to the facility in October 2021. Review of the electronic medical record on 11/10/21 indicated the last weight obtained for Resident #93 was on 10/1/21 of 129.8 lbs. Review of the MAR for October 2021 indicated an order for Jevity 1.5 to be administered at a rate of 63 ml per hour for 21 hours, until 1323 ml were reached, to be turned on at 7:00 P.M., and off the following 4:00 P. M. A review of the October 2021 MAR indicated the nutritional feeding was not signed off as administered on 10/15/21, 10/21/21, 10/22/21, 10/25/21, 10/26/21, 10/27/21, 10/29/21, and 10/31/21. During an interview on 11/12/21 at 8:38 A.M., RD #1 said Resident #93 was supposed to be weighed weekly and, due to the lack of staffing, the weights had not been obtained on a regular basis. She said she was unaware the ordered feedings had not been signed off as administered for eight days in October 2021. During an interview on 11/12/21 at 12:25 P.M., RD #1 said Resident #93 had a current weight of 122.3 lbs., indicating a weight loss of 5.78% since the previous weight on 10/1/21. 2. Resident #128 was admitted to the facility with diagnoses including neuromuscular disorder, traumatic cerebrovascular accident (CVA) with right hemiparesis (paralysis on one side of the body), seizure disorder, legal blindness in the left eye, neurocognitive disorder with aggression and agitation, and impulse control disorder. Review of the Minimum Data Set (MDS) assessment, dated 10/4/21, indicated Resident # 128 required extensive assist with toileting and locomotion on the unit, and used a walker and wheelchair. Review of the Falls Care Plan, initiated 9/23/20, indicated Resident #128 was at risk for a fall related injury due to traumatic CVA with right hemiparesis, seizure disorder, legal blindness in the left eye, neurocognitive disorder with aggression and agitation, and impulse control disorder. The goal was Resident #128 would not sustain a fall related injury by utilizing fall precautions. Interventions to achieve this goal were as follows: - Continual supervision while ambulating in hallways - Provide/monitor use of adaptive devices; walker and wheelchair with assist Review of the clinical record indicated Resident #128 sustained 13 falls between February 2021 and November 2021 without major injury. Seven of the falls were unwitnessed, and six were witnessed. The Resident was transferred to the emergency room for further evaluation after one of the 13 falls. On 11/8/21 at 8:33 A.M., the surveyor observed Resident #128 walk out of his/her room down the hall to the nurses' station unsupervised without a walker. His/her right foot was catching/dragging on the floor and caused him/her to stumble multiple times. Nurse #7 instructed Resident #128 to go back to his/her room, but did not supervise or assist the Resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	On 11/15/21 at 8:28 A.M., the surveyor observed Resident #128 ambulating without assistance in his/her room. He/she then walked out of his/her room down the hall to the nurses' station unsupervised without a walker. His/her right foot was catching/dragging on the floor and caused him/her to stumble multiple times. Nurse #15 was in a resident's room. CNA #16 was passing breakfast trays. No other staff was present at the time. Resident #128 remained standing at the nurses' station and then walked back to his/her room without assistance. Nurse #15 exited another resident's room and asked the surveyor who Resident #128 was and did not assist him/her back to his/her room. Review of the Mayflower North Unit nursing schedules for the months of August 2021 through November 2021 indicated the following: 8/11/21 fall at 11:00 A.M. - 1 nurse, 2 CNAs 9/16/21 fall at 6:13 P.M. - 1 nurse, 1 CNA 10/5/21 fall at 6:15 P.M. - 1 nurse, 1 CNA 11/6/21 fall at 3:02 P.M. - 1 nurse, 2.5 CNAs During an interview on 11/16/21 at 10:41 A.M., Nurse #5 said Resident #128 was very impulsive and non-compliant and was worried he/she would sustain a serious injury from falls. She further said usually there was only one nurse and one aide working each shift. Nurse #5 said there was not enough staff to continually supervise Resident #128 to keep him/her safe, especially if she was in another resident's room and could not hear his/her feet shuffling. By that time, she said, it would be too late. During an interview on 11/15/21 at 4:13 P.M., the Director of Nurses (DON) said, You cannot expect the staff to continually supervise if you only have one nurse and one aide. 3A. During an interview on 11/5/21 at 2:30 P.M. CNA #6 said there was not enough staff on the unit to get the residents out of bed and the staff was doing the best they could to keep the residents washed. She said the CNAs were unable to complete any documentation regarding their care of the residents. B. On 11/12/21 at 1:00 P.M., the surveyor observed CNA #13 assisting Resident #136 with eating. Resident #136 was observed to continue to try to stand up from the chair. CNA #13 and CNA #9 were then observed to recline Resident #136 in the Geri-chair and continue to feed him/her. On 11/12/21 at 1:12 P.M., the surveyor heard CNA #13 say to CNA #5 that she felt she could not leave Resident #136 alone, reclined in the Geri-chair because he/she was going to fall. The surveyor observed the Resident attempting to lift his/her trunk from the reclined chair. The surveyor heard CNA #5 respond that Resident #136 was probably going to fall as it had happened before and it would happen again. On 11/12/21 at 1:18 P.M., the surveyor observed Resident #136 reclining in the Geri-chair and rocking back and forth attempting to get out of the chair. The regional Food Service Director ran over to the Resident and called CNA #9 over for assistance. CNA #9 said someone needed to sit with Resident #136, but there was not enough staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	C. During an interview on 11/8/21 at 3:53 P.M., Nurse #5 said approximately twice a month she received a call at the end of her shift at 3:00 P.M. that she was being mandated to stay because the facility did not have enough staff. She said it was very last minute and was not ready for it. Nurse #5 further said the facility had a difficult time getting agency staff because the facility was not paying their bills and agency staff did not want to work there if they were not getting paid. D. During an interview on 11/9/21 at 7:59 A.M., the surveyor observed Nurse #18 sitting at the nurses' station on Mayflower North unit. She said her shift was supposed to end at 7:00 A.M. and was sitting there waiting for the day nurse to arrive. She said it was her first day working at the facility from an agency and tried calling the staff scheduler who did not answer. She said no one had called to confirm staffing for the shift and did not know who else to call. The surveyor observed two aides working on the unit. During an interview on 11/9/21 at 8:10 A.M., Nurse #18 said the staff scheduler called and said a nurse would arrive from another unit as the scheduled day nurse had worked a double yesterday and was not supposed to be on the schedule. On 11/9/21 at 8:43 A.M., the surveyor observed Nurse #18 giving report to Nurse #7 who had arrived from the [NAME] Unit. E. During an interview on 11/10/21 at 9:36 A.M., Minimum Data Set (MDS) Nurse said there was one licensed nurse and two CNAs on the [NAME] Unit for the 7:00 A.M. to 3:00 P.M. shift. She said she was new to the facility at the start of the COVID-19-19-19-19-19-19-19-19-19-19 outbreak in September and she was told to work on the unit that shift instead of her role as an MDS nurse due to lack of staffing. She said she was not oriented to the unit, but a corporate nurse was on the unit overseeing her care of the residents. 4A. On 11/9/21, the Mayflower North unit had one nurse, two CNAs, and another CNA who worked from 7:00 A.M. to 9:00 A.M. on the 7:00 A.M. to 3:00 P.M. shift. On 11/9/21 at 8:17 A.M. the breakfast meal trays arrived to the Mayflower North unit. On 11/9/21 at 8:43 A.M., the surveyor observed Resident #83 lying in bed waiting for his/her breakfast tray. Two CNAs were observed passing trays. Another CNA was answering call bells until 9:00 A.M. Nurse #18 was giving morning report to Nurse #7 who arrived from another unit. On 11/9/21 at 8:48 A.M., the surveyor observed Resident #6 lying in bed waiting for his/her breakfast tray. On 11/9/21 at 9:04 A.M., the surveyor observed CNA #17 deliver Resident #6's breakfast tray, 48 minutes after the food truck arrived to the unit. CNA #17 set the tray down on the Resident's overbed tray table, which was not within reach of the Resident, and exited the room. She walked down the hall then back entering the room next door to Resident #6 to answer a call bell. She exited the room then reentered to provide direct care to a resident. On 11/9/21 at 9:10 A.M., the surveyor observed Resident #83 had not received his/her breakfast tray yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	During an interview on 11/9/21 at 9:10 A.M., the surveyor asked CNA #2 if all the trays were delivered. She said yes and that the food truck was empty, but when CNA #12 looked inside, Resident #83's tray was in there. CNA #12 said she was only working 7:00 A.M. to 9:00 A.M. to answer call bells and had not assisted with delivering the breakfast trays. CNA #2 said there was not enough staff helping to deliver trays that day leaving only two CNAs to do so, and did not know Resident #83's tray was still in the food truck until CNA #12 looked. On 11/9/21 at 9:15 A.M., Resident #83's tray was delivered, 58 minutes after the food truck arrived on the unit. On 11/9/21 at 9:17 A.M., the surveyor observed CNA #17 return to Resident #6's room to assist with his/her feed, 13 minutes after the tray was first delivered to the Resident and one hour after the food truck arrived to the unit. During an interview on 11/9/21 at 9:17 A.M., CNA #17 said she was not sure if Resident #6's food was still warm and he/she was non-verbal. She proceeded to feed Resident #6. CNA #17 said they did not have enough staff helping to pass trays that day while also helping two residents who were feeds. CNA #17 said usually there was more help. During an interview on 11/9/21 at 9:21 A.M., Nurse #7 said she did not help pass the breakfast trays that morning because it was hard for her to do that if she was on the medication cart. During an interview on 11/9/21 at 9:24 A.M., Resident #83 said the French toast was cold when he/she put the syrup on it. During an interview on 11/10/21 at 11:01 A.M., Nurse #5 said on a normal day there was only one nurse and one aide with a census of 28-31 residents and there was not enough staff working in the kitchen. She further said there was no help and not enough staff to provide care to the residents. She said five residents were very demanding and she was frequently pulled away from the medication cart to answer call bells resulting in a delay of medication administration times. During an interview on 11/15/21 at 4:25 P.M., the DON said the delayed meal service and delayed assistance with feeding was unacceptable and there should have been more staff to assist in passing the trays. She further said there was a staffing concern and she had to assign more staff to help. B. On 11/5/21 at 12:34 P.M., the surveyor observed the lunch meal trays arrive on the [NAME] unit. At 12:56 P.M. three staff started passing the meal trays. During an interview on 11/5/21 at 2:00 P.M., CNA #11 said the staff were unsure which residents needed assistance with eating. The last lunch tray was distributed at 2:05 P.M. (90 minutes after it arrived on the unit). On 11/5/21 at 2:26 P.M., the surveyor observed both residents in room [ROOM NUMBER] to have their lunch trays on their overbed tables with the covers still on them. CNA #5 went into room [ROOM NUMBER] to retrieve the meals. During an interview, CNA #5 said neither resident had eaten their meals and had not been offered assistance with eating as they were not known to need assistance. CNA #5 said no one had asked either resident why they were not eating the food. During an interview on 11/5/21 at 2:30 P.M., CNA #6 said there was not enough staff on the unit to provide meals timely and offer feeding assistance to those not listed as needing assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Many	C. On 11/12/21 the [NAME] unit had 31 residents, one desk nurse, one medication cart nurse, and three CNAs. On 11/12/21 at 12:37 P.M., the surveyor observed the meal trays arrive on the [NAME] unit. The meal trays were passed starting at 12:47 P.M. through 1:34 P.M. by two CNAs. The medication nurse was observed to be giving medications at that time, the desk nurse was observed to be sitting at the nurses' station and one CNA was assisting a resident with eating. During an interview on 11/12/21 at 1:26 P.M., CNA #5 said there was not enough staff to pass the meal trays on time. D. On 11/5/21 the [NAME] unit had 36 residents, one nurse, and three CNAs. On 11/5/21 at 10:21 A.M., the surveyor observed CNA #11 bring a resident their breakfast. The CNA said the resident needed assistance with eating and the staff had just noticed the resident had not been given his/her breakfast meal. During an interview on 11/5/21 at 10:23 A.M., CNA #6 said there were seven residents who needed assistance with eating and only three CNAs and that was why they were unable to get their meals to them on time. During an interview on 11/4/21 at 4:30 P.M., the scheduler said there had been a lack of staffing in the facility for at least two months. She said she had been working with one staffing agency. She said she contacted additional agencies this week and last week, but had not contacted them prior. She said when she contacted the agencies they were unable to provide staffing due to lack of payment from the facility ownership to the agencies. She provided a list of 13 staffing agencies that were contacted over the past two weeks, despite a staffing shortage for months During an interview on 11/15/21 at 11:09 A.M., the scheduler said, I do not agree with the staffing. She said since July, she was lucky to get two aides per shift and by September she was lucky if she only got one. She said she was unable to get enough staff to work from the facility, sister facility, or agencies and facility staff were overworked with many holes left unfilled. During an interview on 11/16/21 at 1:50 P.M., the Administrator said she was aware that staffing agencies were unable to send staff to the facility due to outstanding bills and the facility was not operating at their designated staffing ratios identified in their facility assessment. She said the operating company/ownership handled all accounts payable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 27189 Based on review of the Facility Assessment, review of in-servicing records, and interview, the facility failed to ensure that nursing staff completed annual competencies with regard to care of the residents with a Tracheostomy (Trach-surgically created artificial opening through the neck into the trachea, usually for the relief of difficulty in breathing) and Intravenous (IV) Therapy annually as per the facility policy and the Facility Assessment. Findings include: Review of the Census and Condition document indicated the facility currently (11/4/21) had three residents with Tracheostomies and two residents receiving IV therapy. Review of the Facility Assessment, dated January 15, 2021, indicated that care provided included but was not limited to: -Medications-Intravenous (peripheral or central line) -Tracheostomy Care Review of a Competency Schedule (revised 3/12/20), given to the surveyor by the Regional Staff Development Coordinator (SDC), and the Clinical Competencies for Tracheostomy Care and IV Therapy indicated competencies are to be done during orientation and annually for the Licensed/Nursing staff for Trach care and IV therapy. Review of In-servicing records indicated the last time annual competencies were completed was June 2020. During an interview on 11/15/21 at 11:01 A.M., the Regional SDC said the expectation is that the nurses would go to receive initial training at the Pharmacy's main office for the initial IV certification course; however these classes are few and far between. The Regional SDC was not able to obtain the initial IV certificates for the nurses. The Regional SDC further said the expectation of the facility is that Trach care and IV care in-services are to be completed annually and upon orientation. During an interview on 11/15/21 at 11:20 A.M., the Regional SDC and the surveyor reviewed the in-servicing records for the Nursing staff and found that the Nursing staff has had no competencies completed since June 2020. The Regional SDC again stated the IV and Trach in-services are to be done annually. The Regional SDC said that because the only in-services that could be located were over a year ago (June 2020) that they probably were not completed as per the facility's policy. During an interview on 11/16/21 at 3:11 P.M., the Administrator reviewed the facility assessment with the surveyor and said the competencies had not been completed as required and documented for the specialty care this year. The Administrator could not provide any competencies after June 2020, and she was aware that it was over the 12 month mark, indicating that the competencies for Trach care and IV therapy had not been done annually as per the Facility Assessment and the facility's policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42742 Based on interview and document review, the facility failed to designate a registered nurse to serve as the Director of Nursing (DON) on a full-time basis for a period of one week in September 2021, two weeks in October 2021, and from November 2, 2021, to the time of survey entrance on November 4, 2021. Findings include: During an interview on 11/4/21 at 7:50 A.M., the Administrator said the previous DON left on 10/7/21, but Consulting Staff #3 had served as the interim full-time DON since that time. During an interview on 11/4/21 at 8:45 A.M., Consulting Staff #3 told the surveyors she was not the interim DON as the Administrator had said. She said she was providing clinical support only to the facility and was not asked to put my license on the wall. She further said the previous DON left unexpectedly over the past weekend and the Assistant Director of Nursing Services (ADNS) had been out on maternity leave. She said prior to this there was no DON on/off for approximately two months. On 11/4/21 at 9:18 A.M., during the entrance conference, the Administrator said the previous DON started on 10/18/21, but left on 11/1/21 and the facility had corporate support since that time. She further said the DON prior to that had been there for six weeks and the DON prior to that had been there for two months, but she was not sure of the dates. She said the ADNS was the acting DON right up until she left for maternity leave at the end of September. She said they were not without a full-time DON until 11/1/21. Review of the DON coverage document provided to the surveyor by the Administrator on 11/4/21 at 10:17 A. M. indicated the following: DON #1 - last day worked, 2/24/21 DON #2 - employed 4/21/21- 6/21/21 ADNS - last day worked, 9/7/21 DON #3 - employed 9/13/21-10/4/21 DON #4 - employed 10/18/21-10/29/21 (last day handwritten as 11/1/21) During an interview on 11/4/21 at 10:45 A.M., the surveyor reviewed the document with the Administrator which indicated no full-time DON coverage from 9/8/21-9/12/21, 10/5/21-10/17/21, and 10/30/21 to present. She said there was no full-time DON coverage during the above date ranges and Consulting Staff #3 had not been the interim DON since the ADNS left on 9/7/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 27189 Based on record review and staff interview, the facility failed to ensure that the licensed Pharmacist's medication regimen review recommendation was addressed for one Resident (#89), out of a total sample of 30 residents. Findings include: 36542 Resident #89 was admitted to the facility in April 2018 with diagnoses of dementia, post traumatic stress disorder, and major depressive disorder. During interview on 11/16/21 at 9:18 A.M., the Director of Nurses (DON) said the process for addressing pharmacy recommendations is that the DON/Assistant Director of Nursing (ADON) receives the recommendations from the pharmacist. The recommendations that require a physician's attention are put into a folder for the physician to accept or decline with the rationale. The DON said that once the pharmacist's recommendations are addressed by the physician, the recommendations are filed into the resident's record. Review of the Progress Notes indicated a Medication Record Review was completed for Resident #89 on 9/5/21 with recommendations. A review of the paper medical record did not include the recommendation. Review of an unsigned copy of a Pharmacy Recommendation, dated 9/6/21, indicated the need for nursing follow-up as Resident #89 did not receive their evening medications on 9/2/21 which included Zocor (to treat high cholesterol) and Valproic Acid (to treat mood disorder), with a note which indicated there are other omissions on the Medication Administration Record (MAR). During an interview on 11/12/21 at 11:22 A.M., the Director of Nurses said there was no follow up to this recommendation and it had not been reviewed by the facility. She said the process was for the Unit Managers to print the monthly recommendations and provide them to the physicians and said the pharmacy recommendations in September 2021 were not reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 43935 Based on interview, record review, and policy review, the facility failed to ensure for four Residents (#47, #70, #118, and #139), out of a total sample of 30 residents, that the medication regimen of these Residents were free from potentially unnecessary psychotropic medications. Specifically, for Residents #47, #70, #118, and #139, the facility failed to monitor for both the effectiveness of prescribed psychotropic medications and potential adverse consequences. Findings include: Review of the facility's policy titled Psychotropic medication management guidelines/behavior management guidelines, dated April 2015, indicated the following: 1. Develop behavior plans and medication regimens, when appropriate to optimize the functional abilities of the residents, while monitoring for adverse consequences and improved behaviors. 2. Review behavior monitoring records to ensure targeted behaviors are resident specific and approaches reflect the individual residents' needs. 1. Resident #47 was admitted to the facility in May 2021 with diagnoses including dementia, anxiety, and depression. Review of the current Physician's Orders indicated the Resident had the following psychotropic medications scheduled at least daily: Remeron (an antidepressant), Trazodone (an antidepressant), and Ativan (an anti-anxiety). Review of Resident #47's Care Plans indicated the following: A. Psychotropic medications related to depression and anxiety, with a goal of being free from signs and symptoms of adverse effects of psychotropic drug use. 1A. Interventions include: documentation of mood/behavior issues every shift (see behavior monitoring sheet), monitor for effectiveness of psychotropic drugs, and observe for any signs and symptoms of drug related adverse effects. B. Behavior problem related to diagnosis of dementia, socially inappropriate: yells out vulgar sayings and interrupting others, with a goal of the Resident will have fewer episodes of being socially disruptive. 1B. Interventions include: anticipate care needs, identify stressors that contribute to the behavior, redirect when appropriate, intervene as needed to protect the rights and safety of others: approach in a calm manner; divert attention, remove from the situation or take to another location as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated behavior monitoring sheets for the month of November 2021 were blank, further review lacked any documentation regarding monitoring for potential signs of adverse consequences of his/her prescribed psychotropic medications. During an interview on 11/09/21 at 2:43 P.M., Nurse #2 said the current behavior sheets for Resident #47 were incomplete and had no behaviors to monitor on them. She said nurses are to complete the sheets each shift and there is no other documentation that is done, unless a note is written. The surveyor and Nurse #2 reviewed the medical record and she confirmed the current orders for the psychotropic medications and the lack of behavior monitoring. She said there is nowhere to document monitoring for signs and symptoms of side effects (adverse consequences) of the psychotropic medications and that is not a process the facility has. 2. Resident #70 was admitted to the facility in February 2020 with diagnoses including manic depression and anxiety. Review of the current Physician's Orders indicated Resident #70 had the following psychotropic medications scheduled at least daily: Seroquel (an antipsychotic), Wellbutrin (an antidepressant), and Ativan (an anti-anxiety). Review of Resident #70's Care Plans indicated the following: A. Psychotropic drugs related to mood disorder and depression with a goal of will be free from signs and symptoms of adverse effects of psychotropic drug use. A1. Interventions include: document mood and behavior issues every shift (see behavior monitoring sheets), monitor for effectiveness of psychotropic drugs, and observe for any signs and symptoms of drug related adverse effects. B. Behavior problem related to bipolar disorder, mood disorder, anxiety and depression. Hoards clothing and other items, will throw things in room when upset, refuses labs and medical care, is accusatory. B1. Interventions include: administer and monitor the effectiveness and side effects of medications as ordered, anticipate care needs, address behavior and work to alleviate any underlying cause, explain care in advance. Review of the medical record indicated Resident #70 was being monitored for behaviors on his/her behavior monitoring sheets that included: verbally abusive, weepy/delusional, and anxiety, but only had that documentation completed on the sheet for the night shift and only on 11/1/21 - 11/4/21. Further review lacked any evidence of monitoring for signs and symptoms of side effects for the use of his/her antidepressant and antianxiety medications. During an interview on 11/09/21 at 9:49 A.M., Nurse #2 said the behavior monitoring sheets for Resident #70 were incomplete, and had no explanation for why. She further said there was no place that the nurses monitor or document for signs and symptoms of side effects related to the use of psychotropic drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #118 was admitted to the facility in March 2021 with diagnoses including myoclonus (quick, involuntary muscle jerks), schizoaffective disorder, major depressive disorder, and anxiety. Review of the current Physician's Orders indicated the Resident had the following psychotropic medications scheduled at least daily: Klonopin (a sedative), Prozac (an antidepressant), and Risperidone (an antipsychotic). Review of Resident #118's Care Plans indicated the following: A. Psychotropic drugs related to depression and anxiety, with a goal of will be free from signs and symptoms of adverse effects of psychotropic drug use. A1. Interventions include: document mood and behavior issues every shift (see behavior monitoring sheets), monitor for effectiveness of psychotropic drugs, and observe for any signs and symptoms of drug related adverse effects. B. Behavior problem related to diagnosis of total brain injury (TBI). Socially inappropriate, disrobing, screaming, calling staff or others names, often vulgar, sexually inappropriate requests and comments, strikes out towards others, instigates conflict. B1. Interventions include: administer and monitor the effectiveness and side effects of medications as ordered, anticipate care needs, intervene as needed to protect the rights and safety of others: approach in a calm manner; divert attention, remove from the situation or take to another location as needed. Review of the medical record indicated behavior monitoring sheets for the month of November 2021 were blank, further review lacked any documentation regarding monitoring for potential signs of adverse consequences of his/her prescribed psychotropic medications. During an interview on 11/09/21 at 12:51 P.M., Nurse #2 had no explanation as to why the behavior sheets were incomplete and said if they are not filled out the nurses simply did not do them. The surveyor and Nurse #2 reviewed the behavior sheet documentation binder for the unit. Nurse #2 said the sheets were incomplete for all of the residents on the unit. 4. Resident #139 was admitted to the facility in October 2020 with diagnoses including dementia, depression, and anxiety. Review of the current Physician's Orders indicated Resident #139 had the following psychotropic medications scheduled at least daily: Prozac (an antidepressant) and Trazodone (an antidepressant). Review of Resident #139's Care Plans indicated the following: A. Psychotropic drugs related to depression, with a goal of will be free from signs and symptoms of adverse effects of psychotropic drug use. A1. Interventions include: document mood and behavior issues every shift (see behavior monitoring sheets), monitor for effectiveness of psychotropic drugs, and observe for any signs and symptoms of drug related adverse effects. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Behavior problem related to diagnosis of dementia with behavioral disturbance, depression. Verbally abusive, yells out at staff and others, will swear and curse, throws linen on the floor. B1. Interventions include: administer and monitor the effectiveness and side effects of medications as ordered, anticipate care needs, explain care to Resident in advance. Review of the medical record indicated behavior monitoring sheets for the month of November 2021 were blank, further review lacked any documentation regarding monitoring for potential signs of adverse consequences of Resident #139's prescribed psychotropic medications. During an interview on 11/10/21 at 12:02 P.M., Nurse #1 said the night nurse on the night of monthly change over is suppose to set up all the behavior sheets and put them in the unit behavior sheet monitoring binder. The surveyor and Nurse #1 reviewed the binder and the numerous blank monitoring sheets. Nurse #1 said the behaviors are not being monitored. The surveyor and Nurse #1 discussed where the nurses document the monitoring for signs and symptoms of potential side effects for psychotropic medication use and she said there is nowhere the nurses document that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36542 Based on record review and staff interview, the facility failed to ensure residents who use psychotropic medications, as needed, were limited to 14 days, or extended beyond 14 days with a documented clinical rationale and duration, for two Residents (#136 and #125), out of a sample of 30 residents. Findings include: 1. Resident #136 was admitted to the facility in March 2018 with a diagnosis of dementia and was on hospice services. Review of the medical record for Resident #136 indicated a hospice recommendation on 11/2/21 for Ativan 0.5 milligrams (mg) every four hours as needed for increased anxiety and restlessness. The medical record included a telephone order for Ativan 0.5 mg one tab by mouth as needed for anxiety or agitation. The order did not include a 14 day limitation or an indication to re-evaluate the medication. During an interview on 11/16/21 at 9:42 A.M., Nurse #7 said she did not know if the Ativan order written on 11/2/21 had a time limitation to be re-evaluated. During an interview on 11/16/21 at 8:30 A.M., the Director of Nurses said the as needed Ativan order should have been written with a date for re-evaluation. 27189 2. Resident #125 was admitted to the facility in April 2018 with diagnoses including, quadriplegia, neuromuscular bladder dysfunction (Supra-Pubic catheter in place), and insomnia. Record review indicated the Resident was prescribed the following: -Seroquel 50 mg tablet. One tablet by mouth at bedtime. The Resident was subsequently hospitalized in October 2021 and the following medication was added to the Resident's medication regime upon return: -Seroquel 50 mg tablet. One tablet by mouth every four hours, PRN anxiety/agitation. Review of the medical record indicated there had been no communication with the physician as to the initiation of the PRN antipsychotic, Seroquel. The Seroquel initiated on 10/26/21 was not limited to 14 days and did not have an indication to re-evaluate the medication in 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/16/21 at 9:30 A.M., the DON said that the facility does not have a specific policy for the 14 day re-evaluation of PRN psychotropic's but, the facility follows the regulations. The DON said that the PRN Seroquel should have a date for re-evaluation or stop date on or before day 14 written with the order and did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on observation and policy review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access. Findings include: Review of the facility's policy titled Medication Storage Room/Medication Cart, dated February 2018, indicated the following: 1. Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nurses. 2. Storage for other medications will be limited to a locked medication room. 3. Medication cart is to be locked at all times when not in use by the nurse. The following observations were made on the [NAME] unit by the surveyor: -11/4/21 at 11:25 A.M., three medication cards with pills in them were left on top of the unattended medication cart -11/4/21 at 11:47 A.M., medication room with unlocked open door -11/4/21 at 12:29 P.M., medication cart left unlocked and unattended -11/4/21 at 3:43 P.M., medication room with door open -11/4/21 at 4:16 P.M., Nurse #9 entered open medication room, performed hand hygiene, and exited room leaving the door open -11/4/21 at 5:12 P.M., two residents sitting at the nurses' station with medication room door unlocked and open, no staff at the nurses' station -11/9/21 at 9:06 A.M., medication cart left unattended and unlocked in the hallway -11/16/21 at 3:08 P.M., treatment cart left unattended and unlocked During an interview on 11/4/21 at 11:47 A.M., Nurse #7 said the medication room should be closed and locked. During an interview on 11/16/21 at 3:08 P.M., Unit Manager #2 said the treatment cart contained medicated treatments and should be locked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 42742 Based on observation, interview, and record review, the facility failed to ensure staff promptly, within three days, referred one Resident (#6) with damaged dentures for dental services, out of a total sample of 30 residents. Findings include: Resident #6 was admitted to the facility with diagnoses including aphasia (loss of ability to understand or express speech), dysphagia (difficulty swallowing), and left hemiparesis (paralysis on one side of the body) following cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 10/15/21, indicated Resident #6 had difficulty with chewing, had broken or loosely fitting full or partial dentures, and received hospice services. Review of the facility's policy titled Dental Services/Dentures, revised September 2017, included but was not limited to the following: - Staff will assist residents in obtaining routine and emergency dental care. - The appropriate health care professional will document the provision of dental services and oral hygiene procedures in the resident's clinical record. - The facility must promptly, within three days, refer the resident with damaged dentures for dental services. - An investigation will be conducted to determine the cause for loss or damage to a resident's dentures. Review of the facility's policy titled Consultant Services, dated April 2015, included but was not limited to the following: - The licensed charge nurse will obtain an order for the consultant - For .dental .consults, all families will sign a release form upon admission indicating whether they do or do not want the center to make these arrangements - Once the consultant is identified by the physician and after the family has been notified and given the permission for the consult, the staff will call the consultant to notify him/her of the request and document response in the medical record Review of the comprehensive Dental Care Plan, initiated 1/29/20, indicated Resident #6 had upper and lower dentures with the goal that the Resident would have no difficulty chewing. Interventions included the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Actual harm Residents Affected - Few	- Dental consult as needed - Monitor for difficulty chewing/swallowing - Notify physician if oral intake declines During an interview on 11/9/21 at 12:53 P.M., Hospice Nurse #2 told Unit Manager #1 and the surveyor she had just seen Resident #6 and, because he/she had lost nine pounds, his/her dentures needed to be fixed as they did not fit properly due to weight loss and that four teeth on the upper set were broken. She further said the upper denture was just sitting in there and adhesive would not create the proper fit. Hospice Nurse #2 said she documented her recommendations on the Hospice Communication Sheet for the attending physician a month ago, but it had not been addressed. During an interview on 11/9/21 at 12:53 P.M., Unit Manager #1 said the hospice recommendation from Hospice Nurse #2 was not in Resident #6's medical record and was not sure what happened to it. She further said there was no signed consent in the medical record for dentistry, but should have been done upon admission. Unit Manager #1 said Resident #6 could sign for him/herself, and did not know why it had not been not done yet. On 11/9/21 at 1:09 P.M., the surveyor observed Resident #6 sitting upright in his/her electric wheelchair. His/her upper denture was loose and hanging down from his/her gums. Resident #6 moved it up and down with his/her tongue. Broken/missing teeth were observed on the upper left denture. During an interview on 11/9/21 at 1:10 P.M., Unit Manager #1 said she found the hospice recommendation, written 35 days earlier, in a folder behind the nurses' station, but it was not reviewed or addressed by the attending physician. Unit Manager #1 said a better system was needed for communication with the attending physician. During an interview on 11/10/21 at 8:39 A.M., Nurse #5 said she knew Resident #6's dentures were loose, but did not know they were broken. She further said Hospice Nurse #2 told her the last time she had been there that Resident #6's dentures needed to be replaced. Nurse #5 said she did not refer Resident #6 for dental services because she was waiting for the attending physician to look at the request. On 11/15/21 at 8:12 A.M., the surveyor observed, while Resident #6 was smiling, broken/missing teeth on the left upper denture. Resident #6 shook his/her head yes when the surveyor asked him/her if the dentures were causing him/her pain while eating. During an interview on 11/15/21 at 8:47 A.M., Resident #6 used his/her iPad to communicate with the surveyor and typed that his/her dentures broke after he/she dropped them almost a year ago at the facility. During an interview on 11/15/21 at 9:23 A.M., Certified Nursing Assistant (CNA) #16 said she knew Resident #6's dentures were broken about two weeks ago and told the nurse, but the nurse already knew. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Actual harm Residents Affected - Few	On 11/16/21 at 10:08 A.M., the surveyor observed CNA #18 clean and insert Resident #6's dentures with adhesive. The surveyor observed four missing teeth on Resident #6's upper denture, three on his/her left and one on his/her right. CNA #18 said she had been working at the facility for eight months, and the dentures had been like that since that time. She further said she told a nurse who was no longer working at the facility and a CNA who told her she already knew. During an interview on 11/15/21 at 1:00 P.M., the Director of Nurses (DON) said there should have been better communication between the facility and hospice regarding Resident #6's dentures, but there was not. She further said the attending physician should have been notified by means other than by just placing the recommendation in a folder. The DON said an investigation into how the dentures were broken was not done, per facility policy, but should have been. During an interview on 11/15/21 at 4:30 P.M., the DON said the dental signed consent should have been obtained upon admission, but was not. She further said Resident #6 should have received prompt dental services when his/her dentures were first identified as being loose or broken, but did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations and interviews the facility failed to provide food that was palatable and at a safe and appetizing temperature. Findings include: On 11/5/21 at 10:21 A.M., the surveyor observed Certified Nursing Assistant (CNA) #11 bringing a resident breakfast. The CNA said the resident needed assistance with eating and the staff had just noticed the resident had not been given his/her breakfast meal. On 11/5/21 at 12:34 P.M., the surveyor observed the lunch meal truck arrive on the [NAME] unit. There were three staff members observed to be passing the lunch meals and the last meal was provided to a resident at 2:05 P.M., one and a half hours after it arrived on the unit. A test tray was sent on the [NAME] unit meal cart on 11/12/21. The surveyor observed the first meal truck (an enclosed, insulated cart) arrive on the [NAME] unit at 12:33 P. M. The second meal cart (an open cart, holding six meal trays) arrived on the unit at 12:37 P.M. At 12:46 P.M., the surveyor observed the CNAs adding utensils to the meal trays on the meal carts and pouring resident drinks. During an interview on 11/12/21 at 12:46 P.M., CNA #5 said the staff on the [NAME] unit were responsible for putting items on the trays including utensils, salt and pepper, butter, creamers and beverages. The first lunch tray was passed at 12:47 P.M., 14 minutes after it arrived on the unit. The surveyor observed two CNAs passing meal trays to 31 residents. The nurse on the medication cart was observed to be distributing medications while the meals were being passed. The last tray was taken from the meal truck at 1:34 P.M., one hour and one minute after it arrived on the unit. A surveyor and the regional Food Service Director obtained temperatures of the food on the test tray. - the chicken parmesan was 105 degrees Fahrenheit (F) and was cool to taste - the pureed chicken parmesan was 90 degrees F and was cool to taste -the broccoli was 90 degrees F and was cold to taste - the pureed mixed vegetable was 100 degrees F and cool to taste (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the mashed potatoes were 105 degrees F and tepid to taste During an interview on 11/12/21 at 1:40 P.M., the Regional Food Service Director said passing meal trays to residents should not have taken an hour and the meal truck and meal cart would not be able to hold the temperature of the food for that amount of time. She said the temperatures observed of the test tray were not adequate for meal intake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41107 Based on observation, document review, and interview, the facility failed to ensure the dishmachine operated at required temperatures to ensure all dishes, utensils, and cookware were properly cleaned in order to prevent illness. Findings include: On 11/4/21 at 9:15 A.M., the surveyor observed the dishmachine in use. The following temperatures were observed with Dietary Staff #2: -Wash temperature: 152 degrees Fahrenheit (F) -Rinse: 168 degrees F Review of the October 2021 temperature log for the dishmachine, indicated wash and rinse temperatures which fell below the required temperatures, and that the manager had been notified. Several temperatures had not been logged, but for the ones that had, 19 wash temperatures were below the required 160 degrees, and 40 rinse temperatures were below the required 180 temperature. During an interview on 11/4/21 at 9:15 A.M., Dietary Staff #2 said the dishmachine wash temperature should be 160 degrees F, and the rinse should be 180 degrees F. She further said the rinse is usually between 172 and 180 degrees F. She said she thought the facility was looking into getting a new dishmachine since they had been having problems with the temperatures. She also said the staff was supposed to consistently record the dishmachine temperatures, but they had not. During an observation and interview on 11/4/21 at 9:35 A.M., the Food Service Director (FSD) said there had been issues with the outer thermometers on the dishmachine, so they used a portable thermometer sometimes. The FSD put a portable thermometer through the dishmachine twice. She said the temperature reading on the portable thermometer was 156.6 degrees F after it went through the dishmachine, which would be the rinse temperature. She also said the only way to get the wash temp is via the external thermometer, which was 152 degrees F. She said the wash temperature should be 160 degrees F, but it was not, and the rinse temperature should be 180 degrees, but it was not. She said the dishmachine was not holding the proper temperatures. The FSD said the staff had notified her of the low temperatures, and she passed the information along. She further said, she thought the facility was getting a new dishmachine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 36542 Based on observations and interviews, the facility failed to ensure it was administered in a manner that enables it to use resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include: During the recertification survey conducted from 11/4/21 through 11/16/21, the survey team observed concerns with insufficient staff, resulting in residents with weight loss not having weights monitored, residents not having meal intake monitored, residents with tracheostomies not being monitored, residents with pressure areas not being evaluated, and residents not getting out of bed. During an interview on 11/4/21 at 4:30 P.M., the scheduler said there had been a lack of staffing in the facility for at least two months. She said she had been working with one staffing agency. She said she contacted additional agencies this week and last week, but had not contacted them prior. She said when she contacted the agencies they were unable to provide staffing due to lack of payment from the facility ownership to the agencies. She provided a list of 13 staffing agencies that were contacted over the past two weeks, despite a staffing shortage for months. During an interview on 11/12/21 at 11:06 A.M., the scheduler said she had been doing her best to work with facility staff on covering open shifts and felt lack of wages and bonuses contributed to not picking up shifts. She said she had been receiving two staff members from one staffing agency and felt the facility was not provided more due to not paying at a competitive rate. She said the facility had not been able to obtain staffing from other agencies due to non-payment. She said the Administrator was aware of this. During an interview on 11/16/21 at 1:50 P.M., the Administrator said she was aware that staffing agencies were unable to send staff to the facility due to outstanding bills and the facility was not operating at their designated staffing ratios identified in their facility assessment. She said the operating company/ownership handled all accounts payable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on review of the facility assessment and interview, the facility failed to review and update the assessment, as necessary, to indicate the changes in staff and necessary resources to competently carry out the facility's goals. Finding include: Review of the facility assessment tool, dated January 15, 2021, included but was not limited to the following: - Facility acuity: - Facility does not provide isolation or quarantine for active infectious disease. - Resources needed to provide competent support and care for our resident population every day and during emergencies: - Staffing Plan: A continual process, with ongoing recruitment activities including: advertising, sign on bonus program, nurse aide training, tuition reimbursement. -Nursing: - [NAME] Unit: 0.5 Unit Manager, 1 Nurse (all three shifts), 4 Certified Nursing Assistants (CNAs) (first and second shift), and 1 CNA overnight - Mayflower: 1 Unit Manager, 2 Nurses (all three shifts), 6 CNAs (first and second shift), and 2 CNAs overnight - Hopkins: 0.5 Unit Manager, 1 Nurse (all three shifts), 3 CNAs (first and second shift), and 2 CNAs overnight - [NAME]: 0.5 Unit Manager, 1 Nurse (all three shifts), 5 CNAs (first and second shift), and 2 CNAs overnight - [NAME]: 0.5 Unit Manager, 1 Nurse (all three shifts), 3 CNAs (first and second shift) and 2 CNAs overnight - Staff training education and competencies: -Staff development coordinator has current documentation of training's and competencies for staff. Observations throughout the entirety of the survey by all surveyors indicated the staffing pattern was not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/16/21 at 3:11 P.M., the Administrator reviewed the facility assessment with the surveyor and said the information indicating the facility did not provide quarantine for residents was incorrect and that they should have planned for that when formulating the document. She said the staffing pattern included the floating of other disciplined staff to assist the nursing staffing, but the pattern was wrong and she could not say when the last time the documented required staffing ratios were met for nursing. She further said the competencies had not been completed as required and documented for the specialty care this year and could not provide any competencies after June 2020. She said she was aware that it was over the 12 month mark, but the facility had not had a staff development coordinator consistently. She said she did make sure the facility assessment was completed annually, but they did not use it or otherwise update it when significant changes occurred within the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 27189 Based on record review and staff interview, the facility failed to maintain medical records that are complete, accurate, and systemically organized within accepted professional standards of practice for one Resident (#85), out of a total sample of 30 residents. Specifically, the facility failed to ensure Resident #85 had a current physician's order to receive Psychiatric consultant services. Findings include: Resident #85 was admitted to the facility March 2021 with diagnoses including adjustment disorder and depression. Record review indicated the Resident was seen by the Psychiatric consultant initially on 4/23/21 and seven times thereafter with the most current consult on 10/22/21. Further record review indicated there was no physician's order to receive these services. During interview on 11/16/21 at 12:18 P.M., the Director of Nursing and Unit Manager #2 said that there should have been a physician's order in place for the services and there was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 42742 Based on observation, interview, and record review, the facility failed to ensure staff communicated and coordinated hospice care with the attending physician as needed to ensure the needs for one Resident (#6), out of a total sample of 30 residents, were addressed and met. Resident #6 was admitted to the facility with diagnoses including aphasia (loss of ability to understand or express speech) and left hemiparesis (paralysis on one side of the body) following cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 10/15/21, indicated Resident #6 received hospice care. Review of the Hospice Nursing Facility Services Agreement, dated August 2013, included but was not limited to the following: - Professional Standards. Facility shall ensure that all facility services are provided competently and efficiently. - General. Hospice and facility shall communicate with one another regularly and as needed .for each hospice patient .and documenting such communication in its respective clinical records to ensure the needs of hospice patients are met 24 hours per day. Review of the facility Hospice Care Plan, initiated 1/21/20, indicated Resident #6 was admitted to hospice related to cerebrovascular accident (CVA) resulting from brain and lung cancer. Interventions included the following: - Coordinate Resident's daily care with Hospice and/or palliative care givers During an interview on 11/9/21 at 12:53 P.M., Hospice Nurse #2 told Unit Manager #1 and the surveyor she had just seen Resident #6 and, because he/she had lost nine pounds, his/her dentures needed to be fixed as they did not fit properly due to weight loss and four teeth on the upper set were broken. She further said the upper denture was just sitting in there and adhesive would not create the proper fit. Hospice Nurse #2 said she documented this same recommendation on the Hospice Communication Sheet a month ago, on 10/5/21, for the attending physician, but it was not addressed. During an interview on 11/9/21 at 12:53 P.M., Unit Manager #1 said the recommendation from Hospice Nurse #2 was not in Resident #6's medical record and was not sure what happened to it. On 11/9/21 at 1:09 P.M., the surveyor observed Resident #6 sitting upright in his/her electric wheelchair. His/her upper denture was loose and hanging down from his/her gums. Resident #6 moved it up and down with his/her tongue. Broken/missing teeth were observed on the left upper denture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/9/21 at 1:10 P.M., Unit Manager #1 said she found the Hospice Recommendations, written 35 days earlier, in a folder behind the nurses' station, but said it was not reviewed or addressed by the attending physician. Unit Manager #1 said a better system was needed for communication with the attending physician and hospice. During an interview on 11/10/21 at 8:39 A.M., Nurse #5 said she knew Resident #6's dentures were loose, but did not know they were broken. She further said Hospice Nurse #2 told her the last time she had been there that Resident #6's dentures needed to be replaced. Nurse #5 said she did not refer him/her for dental services because she was waiting for the attending physician to look at the request. On 11/16/21 at 10:08 A.M., the surveyor observed CNA #18 clean and insert Resident #6's dentures with adhesive. The surveyor observed four missing teeth on Resident #6's upper denture, three on his/her left and one on his/her right. During an interview on 11/15/21 at 1:00 P.M., the Director of Nurses said there should have been better communication between the facility and hospice regarding Resident #6's dentures, but there was not. She further said the attending physician should have been notified by means other than just placing the recommendation in a folder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27189 Based on observation, policy review, and staff interview, the facility failed to ensure that staff implemented infection prevention and control practices and policies. Specifically, the facility (1) Failed to utilize appropriate Personal Protective Equipment (PPE) and perform hand hygiene when entering and exiting the rooms of quarantine residents and when providing high contact care to quarantine residents; (2) Failed to ensure staff knew the COVID-19 status of residents and utilized appropriate infection control precaution signs; (3) Failed to ensure a COVID-19 positive residents maintained quarantined, sanitized communal items utilized by residents who were COVID-19 positive and performed hand hygiene following use of communal items thereby increasing the potential for transmission of COVID-19 within the facility; (4) Failed to ensure that infection control practices were followed as per facility policy/protocols while performing a treatment/dressing change to the Resident's pressure ulcer; and (5) Failed to ensure oxygen tubing that had been observed on the floor was removed and changed. Findings include: 1. During an interview on 11/4/21 at 9:10 A.M., Consultant Staff #3 said the facility follows the more stringent guidance that comes out from either the Centers for Disease Control and Prevention (CDC), Centers for Medicaid and Medicare Services, and Department of Public Health (DPH) guidance for COVID-19 and follows guidance from the epidemiologist that is assigned to their facility. She further said it was a recommendation from the epidemiologist to place all Residents on quarantine. During an interview on 11/4/21 at 9:12 A.M., the Administrator and Consultant Staff #3 said the expectation is that staff wear N95s and face shields/eye protection at all times and full PPE when entering the quarantine rooms. They said the staff are rapid tested (BinaxNOW performed) every day before their shift. The first case of the facility's current outbreak was 10/12/21, and the first positive case of this outbreak was a resident. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Interim Infection Prevention and Control Recommendations for Health Care Personnel During the Coronavirus 2019 Pandemic, updated September 10, 2021, indicated healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection, and also patients who have met criteria for 14 day quarantine and should be isolated, that HCP follow recommendations for proper use of personal protective equipment (PPE) including gowns, face masks, eye protection and gloves. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Personal Protective Equipment dated 9/24/21 included but is not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	HCP who enters the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). For residents requiring transmission-based precautions and placed in quarantine for suspected COVID-19, the CDC recommendation for gown use is to put on a clean isolation gown upon entry into patient room or care area. Change the gown if soiled. Remove and discard the gown into a dedicated waste or linen container before leaving the patient room. Review of the quarantine precaution sign indicated everyone must clean hands when entering and exiting, wear a gown, mask-N95-face mask acceptable if N95 not available., eye protection and gloves. It indicated to keep door closed (when performing an aerosol-generating procedures). LOBBY On 11/9/21 at 8:00 A.M., the surveyor observed a staff member enter the building with a surgical mask in place; the staff member doffed (removed) the mask and attempted to obtain another mask from the box on the reception desk which she discovered was empty. The staff member proceeded to walk around the lobby area without a mask for approximately 7 seconds before exiting the lobby. The staff member obtained another surgical mask, donned (put on) it, and then re-entered the building. The staff member who was at the reception desk did not intervene and either replace the empty box or immediately ask the staff member to leave the area. On 11/10/21 from 6:45 A.M. to 7:50 A.M., the surveyor observed that the Receptionist had donned a surgical mask and never changed into an N95. The facility wants everyone who enters the building to remove their surgical mask and don an N95, unless proceeding directly to the lower level where there are no Resident care areas. Just beyond the double doors in the lobby are the patient care areas, Mayflower North and South. During an interview on 11/10/21 at 10:00 A.M., the Administrator and the Director of Nursing were told of the surveyors' observations of the Receptionist, and they stated that she should have been wearing an N95. MAYFLOWER SOUTH During an observation with interview on 11/4/21 at 9:57 A.M., the surveyor observed the unit to have numerous resident rooms with conflicting signs outside the door, some indicating residents on quarantine and other indicating COVID case in facility in last 14 days. Nurse #1 said the signs are confusing to the staff and the staff wear N-95 masks, and eye protection everywhere and gowns when entering any room with a quarantine sign. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/21 at 10:21 A.M., the surveyor observed CNA #1 don a gown outside of a resident's room. There were two signs outside the door of the room the first indicated it pertained to the resident in the A bed and said PPE to be used for facility with active COVID-19 cases in the last 14 days. It indicated a gown is to be worn for direct resident care activities. The second sign indicated it pertained to the residents in the B and C beds and indicated quarantine and indicated the PPE to be used included a gown be donned prior to entering the room. The surveyor observed Regional Staff Development Coordinator (SDC) stop CNA #1 from donning the gown and heard her say, You don't need a gown to go in there and give the resident in A bed water, only the residents in beds B and C are quarantined. CNA #1 removed the gown, entered the room, provided the resident in bed A with a cup and left the room performing hand hygiene (HH). During an interview on 11/4/21 at 12:48 A.M., Regional Infection Prevention Nurse (IPN) and Regional SDC were asked about the sign use outside of the residents' rooms and required PPE for rooms with multiple signs. Regional IPN said the expectation is that any staff entering a room with a quarantine sign would don PPE in alignment with quarantine PPE usage which includes a gown upon crossing the threshold of the room. Regional IPN said the signs are confusing for staff. Both the Regional IPN and Regional SDC agreed that if any room had a quarantine sign outside of the door staff should don an N-95, eye protection, gown, and gloves due to having the quarantine resident in the room which makes the whole room a quarantined room. Regional SDC said she redirected CNA #1 incorrectly and CNA #1 should've donned a gown prior to entering the resident room on the Mayflower South Unit. Neither could provide any guidance as to why they implemented this process/procedure but agreed that the quarantine resident makes the whole room quarantine. MAYFLOWER NORTH A. On 11/4/21 at 11:12 A.M., the surveyor observed Nurse #13 enter a quarantine room on the Mayflower North Unit carrying two beverages in Styrofoam cups wearing goggles and a N95 facemask which was not covering her nose. She was not wearing a gown or gloves. She exited the room to get straws then reentered wearing only her goggles and N95 facemask below her nose. An isolation droplet/contact precautions sign was posted directly outside the resident's room indicating full personal protective equipment (PPE) was required upon entering the room consisting of a gown, N95 face mask, gloves, and goggles. During an interview on 11:13 A.M., Nurse #13 said she should have worn full PPE prior to entering the quarantine room but did not. She further said she should have worn her N95 facemask above her nose but did not. On 11/8/21 at 8:05 A.M., the surveyor observed Nurse #5 wearing her goggles on top of her head in the hallway at her medication cart. Nurse #7 arrived at the unit nurses' station without wearing eye protection (goggles or face shield). During an interview on 11/8/21 at 8:05 A.M., Nurse #5 and Nurse #7 said they should have been wearing eye protection on the unit but were not. On 11/15/21 at 7:00 A.M., the surveyor observed Nurse #14 at the nurses' station wearing her personal eyeglasses. She was not wearing eye protection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/5/21 at 7:00 A.M., Nurse #14 said she was not wearing eye protection because her goggles kept falling off her face every time she bent over. She further said she should have asked for an alternative form of eye protection but did not. B. On 11/15/21 at 8:23 A.M., the surveyor observed a soiled pair of men's underwear and jeans resting on the floor, not bagged, in front of the soiled utility room in the hallway of the Mayflower North Unit. Four staff members walked up and down the hall during breakfast meal service and did not pick up the soiled clothing. During an interview on 11/15/21 at 8:51 A.M., the surveyor observed the Minimum Data Set (MDS) nurse bag the clothing and carry it into the soiled utility room, 28 minutes after it was initially observed by the surveyor and said they should not have been left on the floor in the hallway. C. On 11/15/21 at 2:27 P.M., the surveyor observed a used BinaxNOW swab specimen resting on top of the medical chart tower. The swab was dated 11/14/21. During an interview on 11/15/21 at 2:27, Nurse #15 said it should not have been there. During an interview on 11/15/21 at 3:11 P.M., the DON said the BinaxNOW swab should have been thrown away immediately after use and the soiled resident's laundry should not have been left on the floor in the hallway of the unit. She further said eye protection was required on all units and personal eyeglasses were not an acceptable form of eye protection. [NAME] Unit: On 11/16/21 at 7:00 A.M., the surveyor observed CNA #15 at the [NAME] Unit nurses' station without wearing a facemask or eye protection. He was wearing only his personal eyeglasses. During an interview on 11/16/21 at 7:00 A.M., CNA #15 said a N95 facemask and eye protection was required on the unit, and he should have been wearing them, but was not. During an interview on 11/4/21 at 7:50 A.M., the Administrator said full PPE was required, including an N95 facemask, for all direct care and prior to entering a quarantine room. 2. [NAME] UNIT On 11/4/21 at 8:30 A.M. the surveyors were provided a list of residents who were currently COVID-19 positive, the residents resided on the [NAME] and Hopkins unit. Both units were identified to have COVID-19 residents and COVID-19 recovered residents (COVID-19 positive in the previous three months). A. During an interview on 11/4/21 at 9:31 A.M., Nurse #7, who was assigned to the [NAME] unit, said she did not know which residents on the unit were currently positive for COVID-19 and she did not have a list to indicate which residents currently had COVID-19. She said she had been following the signs on the rooms to determine which residents were on precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/21 at 9:36 A.M., the surveyor observed conflicting precaution signs posted on rooms 205, 210 and 211. One pink sign indicated there were isolation precautions (droplet/contact) and staff was to wear a gown, an N95 respirator, eye protection and gloves when entering the room and a white sign which indicated general PPE (personal protective equipment) for a facility with COVID-19 cases in the last 14 days and to wear a mask, eye protection and gloves and to wear a gown during high contact care. During an interview on 11/4/21 at 11:09 A.M., Certified Nursing Assistant (CNA) #6 said she did not know which residents on the unit were positive for COVID-19 and did not feel the facility had been following infection control protocols for COVID-19 positive residents. During an interview on 11/4/21 at 12:18 P.M., the Infection Control Preventionist said she had not posted the precaution signs on the resident rooms, and it was the regional Staff Development Coordinator who determined two signs would be used for rooms where one resident was COVID-19 positive and the other was COVID-19 recovered. She said the white sign indicated to staff that they could enter a room with a COVID-19 positive resident to see the resident who was recovered, without donning a gown and gloves. During an interview on 11/5/21 at 8:15 A.M., Nurse #10 said she did not know which residents on the unit were COVID-19 positive and she did not have a list. B. On 11/4/21 at 9:20 A.M., the surveyor approached the room of Resident #9 which had a white transmission precaution sign, indicating there had been COVID-19 positive residents in the facility within 14 days and to wear a gown and gloves while providing direct care. The surveyor entered the room of Resident #9 wearing only an N95 mask and a face shield (no gown or gloves), following the directions on the precaution sign posted on the room. During an interview on 11/4/21 at 9:24 A.M., Resident #9 asked if the surveyor knew he/she was on quarantine related to COVID-19. The surveyor checked the COVID-19 positive list provided by the Infection Control Preventionist, identified the Resident was COVID-19 positive and left the resident room. On 11/4/21 at 9:28 A.M., the surveyor observed CNA #10 enter the room of Resident #9 wearing only an N95 mask and eye protection. During an interview on 11/4/21 at 9:30 A.M., CNA #9 said she did not know if Resident #9 was currently COVID-19 positive and was following the precaution signs on the resident rooms. During an interview on 11/4/21 at 10:58 A.M., Nurse #7 said she had obtained a list of residents on the unit who were COVID-19 positive. At 11:00 A.M. the surveyor observed the general PPE precaution sign still posted on the room of Resident #9, there was no isolation precaution sign to notify staff to don full PPE prior to entering the room. 3A. Resident #102 was on the list of COVID-19 positive residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/21 at 11:34 A.M., the surveyor observed Resident #102 walk out of his/her room at the end of the hall, walk all the way down the hall, say hello to Nurse #7 and enter the unit day room. Resident #102 was observed to enter the unit kitchenette and get ice from the ice cooler and use the communal ice scoop to add ice to his/her personal re-usable cup. Neither the nurse nor the CNA at the nurses' station intervened regarding the Resident being out of his/her room or using communal items. On 11/4/21 at 4:50 P.M., the surveyor observed Rehabilitation Staff #2 exit the room of Resident #102 with a therapeutic band and inflated balloon. The staff was observed to place both items on the nurses' station desk. During an interview, at this time, the rehabilitation staff member said she had not cleaned the items after using the items with a COVID-19 positive resident, then inquired if she was supposed to. On 11/5/21 at 10:26 A.M., the surveyor observed Resident #102 come down the hallway from his/her room. The Resident approached CNA #5 and requested ice and water. The Resident handed his/her re-usable water bottle to CNA #5. CNA #5 was observed to go to the kitchenette and put ice in the re-usable water bottle with a disposable cup, fill the cup with water and hand it back to the Resident. The CNA was not observed to perform hand hygiene prior to going to another resident room and donning a gown and gloves and entering the room. B. Resident #21 was on the list of COVID-19 positive residents. On 11/5/21 at 9:36 A.M., the surveyor observed Resident #21 seated in front of the nurses' station, wearing an N95 mask and using the nurses' station telephone. The Resident was observed to hang up the telephone and go to his/her room. The surveyor did not observe staff sanitize the telephone following use. On 11/5/21 at 12:12 P.M., the surveyor observed Resident #21 seated in a chair near the nurses' station. The Resident was provided a drink with a straw and starts drinking it in the hallway. On 11/05/21 at 12:47 P.M., the surveyor observed Resident #21 seated in front of the nurses' station, wearing a surgical mask and using the nurses' station telephone. The Resident was observed to hang up the telephone and the phone rang. Nurse #7 was observed to answer the phone, without sanitizing it. When she hung up the phone, she approached the medication cart and picked up a thermometer. The nurse was not observed to use hand sanitizer after handling the telephone which had been used by a Resident #21 (positive for COVID-19) and prior to touching a thermometer. 4. Review of the policy titled: clean dressing change, dated: 7/2017 indicated the following: -establish a clean field -gather supplies and place on clean field -remove old dressing, remove gloves, and sanitize hands prior to applying clean gloves (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/16/21 at 2:02 P.M., the surveyor, with the Resident #29's permission, observed Nurse #11 perform a wound dressing change. Nurse #11 donned her gown and brought the treatment cart of supplies into the Resident's room and parked it at the end of the Resident's bed. The nurse then donned clean gloves removed the old dressing from Resident #29 and then donned a second pair of gloves over the first pair; she did not change her gloves or perform HH in between steps as required. She proceeded to open the treatment cart with her contaminated gloved hands opening the third drawer and retrieving the dressing supplies she needed. She then used clean scissors to cut the primary dressing to the required size for the wound, doff both pairs of her dirty gloves, perform HH and donned a clean pair of gloves. She cleansed the area, doffed her gloves, performed HH and donned a new pair of gloves then applied the primary and secondary dressing to the Resident's wound. She gathered her trash and placed it in a garbage bag, doffed her gloves, performed HH. During an interview on 11/16/21 at 2:08 P.M., immediately following the observation, Nurse #11 said she always brings the treatment cart into the room because if she forgets something she doesn't want to have to doff her gown because it is too time consuming. She said she did not believe she had breached infection control protocols. During an interview on 11/16/21 at 2:27 P.M., Director of nurses (DON) was made aware of the treatment observations and said the treatment cart should not enter a resident's room and it is a breach of infection control protocol. She said the nurse entering the treatment cart with 2 pairs of dirty gloves on was also a breach of infection control and created a potential issue. She said the expectation is that a clean field be set up separate from a dirty area and the procedure follows the policy and standard for dressing changes. She said Nurse #11 did not complete the dressing change per standard or expectation using good infection control practices. 5. HOPKINS During an interview with observation on 11/08/21 at 8:06 A.M., the surveyor entered Resident #85's room and observed the oxygen tubing on the floor, and not in use by the Resident. The surveyor observed a piece of tape on the oxygen tubing dated 9/19. Resident #85 said that he/she only uses the oxygen at night. On 11/9/21 at 10:15 A.M. and 1:00 P.M., the surveyor observed the oxygen tubing on the floor. During an interview on 11/10/21 at 11:43 A.M., the DON said she also was aware of the oxygen tubing on the floor, and said that this was a breach in infection control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 27189 Based on record review, policy review, and interview, the facility failed to ensure the criteria for the initiation of antibiotics, per the facility's Antibiotic Stewardship Policy and infection control requirements, was followed. Findings include: Review of the facility's policy titled Antibiotic Stewardship, dated July 2017, included but not limited to the following: It is the policy of this facility to treat only symptomatic infections meeting criteria, and to promote antibiotic stewardship to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use. The facility will establish an Antibiotic stewardship team dedicated to improving anatomic use. The core members of the team will include but not be limited to the Medical Director, Pharmacy Consultant, Director of Nurses and Infection Preventionist (IP). Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infections with antibiotic resistive organisms. They also can lead to an increase in the development of antibiotic resistance within the facility and burden of excess cost to the resistant, the facility and community (CDC-Core Elements of Antibiotic Stewardship for Nursing Homes). Record review indicated: COVID-19 Protocol: -Hydroxychloroquine 200 milligrams (mg) by mouth daily for ten days -Azithromycin (antibiotic) 500 mg by mouth daily for ten days -Aspirin 81 mg by mouth daily for ten days The above Protocol was initiated for 57 residents. During an interview on 11/09/21 at 4:55 P.M., the surveyors met with the IP to discuss the infection control policies and practices, which included the Antibiotic Stewardship Program. The IP said that she follows the Antibiotic Stewardship program/policy and that she follows the specific criteria to monitor for appropriate antibiotic use. She further said the Medical Director can, at times, be resistant to the Antibiotic Steward ship protocols. The IP had also brought forward the use of the Azithromycin in regards to starting an antibiotic for a virus to the Medical Director's attention, but the Medical Director started the protocol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/10/21 at 1:37 P.M. with the surveyors and the Director of Nursing (DON), the Medical Director was asked about the clinical rationale for the initiation of an antibiotic which was included in the above protocol, as it goes against the core principals of the Antibiotic stewardship policy/protocol; and COVID-19 is a virus and antibiotics are not effective in treating a virus. The Medical Director said the problem here is that he believes we are dealing with a ghost (COVID-19), and that it is a man-made virus. The Medical Director said that he uses the same protocol the government used but he had changed it to be administered over 10 days and not the exact protocol the government started. On 11/10/21 at 1:37 P.M., the Medical Director said that he did agree with the surveyor that it is not in line with the Antibiotic Stewardship Policy/protocol and that an antibiotic is not effective in treating a virus. He then said that this is the protocol the government used and that the surveyor would have to ask the government about the protocol. Review of the website FDA.gov indicated the FDA cautions against use of Hydroxychloroquine or Chloroquine for COVID-19 and removed the emergency use authorization on 6/15/20. The FDA also recommends antibiotic therapy for patients who have COVID-19 and develop a bacterial infection such as pneumonia. There was no documented evidence of residents having pneumonia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 27189 Based on observation, interview, and policy/protocol review, the facility failed to ensure staff performed the BinexNOW COVID-19 Ag Card test (rapid testing) correctly. Findings include: The BinexNOW COVID-19 Ag Card is a type of test called an antigen test. Antigen tests are designed to detect proteins from the virus that causes COVID-19 in respiratory specimens, for example nasal swabs. This is considered a form of rapid testing as the results are displayed in 15 minutes. Review of the BinexNOW COVID-19 Ag Product insert (revised August 2020) and the BinexNOW COVID-19 Ag Card (revised August 2020) instructions for completing the test included but was not limited to the following: Precautions: Wear appropriate personal protection equipment (PPE) and gloves when running each test and handling patient specimens. Change gloves between handling of specimens suspected of COVID-19. Nasal Swab: To collect a nasal swab sample, carefully insert the swab into the nostril exhibiting the most visible drainage or the nostril that is most congested, if drainage is not visible. Using gentle rotation, push the swab until resistance is met (less than one inch into the nostril). Rotate the swab five times or more against the nasal wall then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril. Test procedure Open the test card just prior to use, lay it flat and perform assay as follows. (The test card must be flat when performing testing, do not perform testing with the test card in any other position). Hold extraction Reagent bottle vertically, hovering 1/2 inch above the TOP HOLE, slowly add SIX DROPS to the TOP HOLE of the swab well. DO NOT touch the card with the dropper tip while dispensing reaction. Insert sample into BOTTOM HOLE and firmly push upwards so that the swab tip is visible in the TOP HOLE. Rotate (twirl) swab shaft three times CLOCKWISE (to the right). Do not remove swab. Note: False negative results can occur if the sample swab is not rotated (twirled) prior to closing the card. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Peel off adhesive liner from the right edge of the test card. Close and securely seal the card. Read results in the window 15 minutes after closing the card. In order to ensure proper performance, it is important to read the results promptly at 15 minutes, and not before. Results should not be read after 30 minutes. Note: When reading test results, tilt the card to reduce glare on the result window, if necessary. Invalid results are as follows: If no lines are seen; If just the Sample Line is seen; The Blue Control line remains blue. On 11/09/21 at 6:50 A.M., the surveyor entered the facility. There were 12 staff members in the lobby and many were not within six feet of one another. There was no staff member at the reception desk ensuring staff did not enter the facility until they performed the self test. At this time, Physical Plant Assistant (PPA) #1, got off the elevator and entered into the lobby and observed the surveyor in the lobby. PPA #1 told the surveyor that he had not been assigned to the reception desk, however he began to monitor the process. He was asked by the surveyor if there is no one assigned to the desk, who's responsibility is it to ensure staff is performing the testing today and he said no one. The surveyor observed numerous BinexNOW cards on the table in the area that the testing is performed. Review of the facility's process is as follows: -Staff member enters the building -The staff member assigned to the desk ensures that a temperature is taken and the staff sign in -The staff member proceeds to the area where the BinexNOW is performed. -The process on how to perform the BinexNOW is posted on the patrician wall (instructions are in English and Portuguese). -The first line of the procedure indicates to don/put on gloves. -All the supplies are located in the testing area. -The BinexNOW supplies are on one table and the cards are to be placed on a separate table after the process is complete. -The staff member performs the BinexNOW independently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The staff member places the completed test with their name and the time the test was performed on the other table in the area. -The staff then waits for the results in the lobby (15 minute). On 11/09/21 at 7:35 A.M., the surveyor went to the lobby to observe the process of the staff self swabbing and performing the BinexNOW test. The surveyor observed three staff members as follows: Staff Member #1 performed the self test correctly and sat down to wait for the results. She told the surveyor that she self times and has another person, usually the person who is at the desk, verify the results. Staff Member #2 performed the testing incorrectly, as she did not perform the nasal swab correctly. Staff Member #3 performed all the steps correctly except when it was time to insert the nasal swab into the card, she inserted the Q-tip into the card from the top hole and not the bottom hole and closed the card. She went to sit down to await results. At 7:55 A.M. the Administrator entered the building and the surveyor made her aware of the incorrect BinexNOW test performed by Staff member #3. During an interview on 11/9/21 at 7:55 A.M., Staff Member #1 was still in the lobby and the surveyor asked her how she was in-serviced on the correct procedure. She said that she was at the facility one weekend and asked a nurse on duty who gave her instructions and that she had never been inserviced on the process. During an interview on 11/9/21 at 7:57 A.M., the surveyor then asked the Physical Plant Assistant #1 about the process, who is usually assigned to the desk to oversee the process and he stated he did not know who was supposed to be there today He further stated that he was put at the desk today because no one was scheduled. He said that today he just made sure to take everyone's temperature and that all he did because he is not aware of being responsible for anything further because he usually is not at the desk During an interview on 11/09/21 at 4:55 P.M., the Infection Preventionist (IP) said that the Epidemiologist assigned to the facility had directed them to Binex all staff when they enter the building, prior to the start of their shift due to the outbreak (106 COVID-19 positive residents and 28 COVID-19 positive staff) in the facility. The IP said whoever is sitting at the reception desk is responsible for overseeing the process. The IP further said that there should not be numerous staff in the lobby, which the surveyor indicated to her, was observed this morning. The IP said that once the results are ready, the staff member then shows the Binex card to the person at the desk for verification of the results. The IP was aware that the process was not followed this morning and she had not been made aware that there was no staff available or scheduled at the front desk for oversight of the process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She said that that a second staff member is required to verify the results and typically whoever is overseeing the process at the desk verifies the results. The IP was asked about the 11:00 P.M. to 7:00 A.M. shift and said there is no one assigned to oversee the process on that shift. She said that the 11:00 P.M. to 7:00 A.M. shift staff swab themselves and they should have a nurse present to verify the result but does not have any documentation that the results are verified by someone else. At this time, the surveyors made her aware of the observations made by the surveyors of the staff not following the proper procedure to perform the self testing and that there was a concern with the process. The IP said that the staff have all been trained but staff are obviously not performing the self testing correctly. On 11/10/21 at 6:45 A.M., the surveyor observed the following: Receptionist #1 was at the front desk. She had a surgical mask donned (put on). The surveyor asked what her responsibilities were when she was assigned to the front desk. She said that she takes everyone's temperature, ensures that the screening forms are completed and that staff sign in and records the testing results. Receptionist #1 said that she ensures the staff are distanced from each other and that only six staff members are present in the lobby at one time. On 11/10/21 from 6:45 A.M. - 7:45 A.M., the surveyor observed staff members entering the building and observed the following: Staff Members #1 through #7 performed the self testing incorrectly. Staff Member #8 performed the self testing correctly, performing all the necessary steps. Staff Member #9 through #22 performed the self testing incorrectly. The following is what was observed by the surveyor: -Not all staff donned gloves at the start of the process. -Not all staff performed the nasal swabbing correctly. -Not all staff ensured that the testing card laid flat, some even held the folded test card in their hands while placing the drops in the top hole. -Not adding six drops to the top hole (three to ten drops had been observed being added to the top hole and some staff added the drops to the bottom hole). -Not all staff twisted the nasal swab three times after inserting the swab into the testing card. The surveyor observed 22 staff members performing the BinexNOW self testing from 6:45 A.M. through 7:45 A.M. (one hour) and only 1 out of 22 staff members performed the process correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/10/21 at 10:00 A.M., the Administrator and the Director of Nursing (DON) were made aware of the surveyors observations of the staff performing the BinexNOW testing this morning and that only 1 out of 22 staff members performed the self-testing correctly. The surveyor asked for the in-servicing that the staff had received prior to the initiation of this process. The surveyor also asked what type of mask the Receptionist is supposed to have donned, and they said that the expectation was that she would have on an N95 mask. During an interview on 11/10/21 at 12:00 P.M., the Regional Staff Development Coordinator and the Regional IP said the in-servicing had not been completed, but should have been. This resulted in the facility failing to ensure that all staff performing the BinexNOW COVID-19 Ag Card test (rapid testing) were performing the test correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	11/16/2021

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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 36542 Based on interview, review of personnel files and training documentation, the facility failed to ensure three out of five sampled employees were provided with training on dementia management in accordance with State and Federal requirements. Findings include: Review of five employee records failed to include information regarding dementia management training for employees. On 11/16/21 at 4:45 P.M., the Administrator said she was unable to locate documentation regarding dementia management training for Nurse #3, Nurse #7 and Nurse #11.