STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.** Based on interviews and records reviewed, for two of three sampled residents (Residents #2 and #3) the Facility failed to ensure residents were free from physical abuse, when on 9/2/20 they failed to prevent Resident #1 from slapping, grabbing and trying to choke Resident #2 and on 9/8/20 while Resident #1 was supposed to be on one to one supervision by a staff member, he/she was left unobserved long enough to wrap his/her hands around Resident #3's neck. Findings include: Resident #1's most recent Minimum Data Set (MDS) Assessment, dated as completed 8/21/20, indicated that his/her cognitive patterns were severely impaired and he/she had a Guardian. Resident #1's care plan concern related to behavioral symptoms, dated as initiated 11/23/19, indicated one of his/her goals included that Resident #1 would not harm him/herself or others. Care plan interventions included staff to address Resident #1's wandering by walking with or redirecting Resident #1 and to intervene as needed to protect the rights and safety of others. Resident #2's most recent MDS Assessment, dated as completed 6/26/20, indicated that his/her cognitive patterns were severely impaired. During an interview on 9/14/20 at 4:00 P.M., Resident #2 said that Resident #1 asked him/her for the face mask he/she had in his/her hands. Resident #2 said that when he/she told Resident #1 that he/she could not have the face mask, Resident #1 slapped him/her in the head and choked him/her. During an interview on 9/14/20 at 2:50 P.M., the Occupational Therapy Assistant said that around 5:30 P.M. on 9/2/20, Resident #1 hit Resident #2 on the forehead and grabbed Resident #2's jaw and squeezed it really hard. During an interview on 9/23/20 at 12:41 PM, Certified Nurse Aide (CNA) #1 said that on 9/2/20 around 5:30 P.M., she saw Resident #1 standing beside Resident #2 with his/her hands around Resident #2's throat or neck. During an interview on 9/24/20 at 3:10 PM, CNA #5 said that on 9/2/20 around 5:30 P.M., she saw Resident #1 standing beside Resident #2 with his/her hands grabbing Resident #2's face. During an interview on 9/21/20 at 4:07 PM, Nurse #1 said that on 9/2/20 around 5:30 P.M., she heard commotion in the dining room and when she responded, CNA #1 and CNA #5 were separating Resident #1 and Resident #2. Nurse #1 said that CNA #1 and CNA #5 told her that Resident #1 tried to choke Resident #2 and grabbed Resident #2's face. During an interview on 9/14/20 at 4:15 P.M., the Director of Nurses said that Resident #1 was sent to the emergency department for an evaluation on 9/2/20 and when he/she returned, he/she was placed on one to one supervision. Resident #1's care plan concern for behaviors included an update on 9/3/20 which indicated that he/she would receive one to one supervision by staff members. Resident #3's MDS Assessment indicated his/her cognitive patterns were severely impaired. Resident #3 was not interviewed by the Surveyor due to Resident #3's cognitive impairment. CNA #1 said that on 9/8/20 during the 3:00 P.M. to 11:00 P.M. shift, she was assigned to provide Resident #1's one to one supervision. CNA #1 said that around 6:00 P.M. she and Resident #1 were seated at a table together in the dining room. CNA #1 said that although she and Resident #1 were alone at the table, residents were seated at other tables in the dining room. CNA #1 said that when the meal trucks were parked in the doorway to the dining room, she stood and walked across the dining room to retrieve Resident #1's meal tray. CNA #1 said while retrieving the tray, she heard yelling and when she turned around, she saw Resident #1 standing next to Resident #3 with his/her hands wrapped around Resident #3's neck. CNA #1 said that she and another CNA separated Resident #1 from Resident #3. In an email dated 9/23/20, the Administrator wrote that the Maintenance Director measured the distance from the dining room table where CNA #1 left Resident #1 to the meal trucks to be 9.5 to 10 feet. The Director of Nurses said Resident #1 was sent to the hospital emergency department on 9/8/20 for evaluation. Although Resident's #2 and #3 were cognitively impaired and unable to communicate physical and mental harm, a reasonable person would experience physical pain and mental anguish when choked and slapped by another resident.

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

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