STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Health Services	916 E Clifford St Plymouth, WI 53073

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 - Minimal harm or potential for 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. 47248 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 Resident (R) (R5) of 2 sampled residents received appropriate care and services to prevent urinary tract infections (UTIs). Staff did not ensure R5 was provided catheter care in a manner that decreased the risk of infection. Findings include: The facility's Catheter Care policy, revised 3/15/23, indicates: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use .Privacy/dignity bags will be available and catheter drainage bags should be covered or shielded at all times while in use . On 8/26/24, Surveyor reviewed R5's medical record. R5 had diagnoses including type 2 diabetes with chronic kidney disease, retention of urine, and benign prostatic hyperplasia (BPH) with lower urinary tract symptoms. R5's Minimum Data Set (MDS) assessment, dated 6/11/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderately impaired cognition. On 8/26/24 at 8:25 AM, Surveyor observed R5 in R5's room and noted R5's catheter drainage bag was uncovered and attached to the bottom of R5's wheelchair. R5's catheter tubing and drainage bag were in contact with the floor. A dignity bag was hung on the bottom of the other side of R5's wheelchair. On 8/26/24 at 10:21 AM, Surveyor observed R5 in R5's room and noted R5's catheter bag was uncovered and attached to the bottom of R5's wheelchair. R5's catheter tubing and drainage bag were in contact with the floor. A dignity bag was hung on the bottom of the other side of R5's wheelchair. Surveyor interviewed R5 who stated nursing staff assist with catheter care which was completed earlier that morning. R5 stated R5's catheter bag was hung underneath R5's wheelchair and R5 could not see the bag and tubing. R5 stated R5 relied on nursing staff to ensure catheter care was performed without complications. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525685	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Health Services	916 E Clifford St Plymouth, WI 53073

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 1:20 PM, Surveyor observed R5 in R5's room and noted R5's catheter bag was uncovered and attached to the bottoms of R5's wheelchair. R5's catheter tubing and drainage bag were in contact with the floor. A dignity bag was hung on the bottom of the other side of R5's wheelchair. On 8/26/24 at 1:22 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who was unsure of the facility's policy regarding covering catheter bags. ADON-C stated catheter bags should be hung below the level of the bladder and catheter bags and tubing should not be on the floor. During the interview, ADON-C and Surveyor went to R5's room. ADON-C confirmed R5's catheter bag was uncovered and the bag and tubing were in contact with the floor. ADON-C stated catheter bags and tubing should be kept off the floor for infection prevention and confirmed the facility's catheter care process was not followed.

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47248 Based on observation, staff and resident interview, and record review, the facility did not ensure 3 Residents (R) (R1, R2, and R5) of 5 sampled residents received the necessary care and services to prevent dehydration. The facility did not provide consistent hydration for R1, R2, and R5. Findings include: The facility's Hydration policy, dated 7/26/22, indicates: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health .4. b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: .i. Offer the resident a variety of fluids during and between meals . 1. On 8/26/24, Surveyor reviewed R1's medical record. R1 had diagnoses including type 2 diabetes, severe constipation due to opioid use with current complications involving impaction, history of pressure and diabetic wounds with recent amputation of partial toe, and gout. R1's Minimum Data Set (MDS) assessment, dated 8/8/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. On 8/26/24 at 8:16 AM, Surveyor interviewed R1 who stated the water cup on R1's bedside table was from two days ago. R1 stated nursing staff do not provide water unless R1 asks. R1 stated R1 asks for water but it is not provided at times. R1 stated R1 had a care conference approximately one month ago and brought the concern to administration's attention. R1 stated R1 brought up the concern again at a follow-up care conference approximately one week prior. R1 stated it upset R1 that water was not provided and R1 frequently did not receive water when R1 asked. R1 stated R1 was concerned for residents who did not have the ability to ask and wondered how they were being hydrated. 2. On 8/26/24, Surveyor reviewed R2's medical record. R2 had diagnoses including fracture of the left tibia and hemiplegia (weakness on one side of the body). R2's MDS assessment, dated 7/23/24, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. On 8/26/24 at 10:17 AM, Surveyor interviewed R2 who stated the water cup on R2's bedside table was from last night. R2 stated R2 has to ask staff if R2 wants water. R2 stated R2 resided in other facilities were staff provided water throughout the day which staff did not do at this facility. 3. On 8/26/24, Surveyor reviewed R5's medical record. R5 had diagnoses including type 2 diabetes with chronic kidney disease, diabetic polyneuropathy, retention of urine, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, and gout. R5's MDS assessment, dated 6/11/24, had a BIMS score of 11 out of 15 which indicated R5 had moderately impaired cognition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 10:21 AM, Surveyor interviewed R5 who stated the cup on R5's bedside table (which contained under 100 cc (cubic centimeters) of water) was from yesterday. R5 stated staff do not offer water or ensure water cups are filled and R5 has to staff if R5 wants water. R5 stated R5 asked staff for water that morning but had yet to receive it. R5 stated R5 was unsure what residents could who not ask received for hydration which bothered R5. On 8/26/24 at 11:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who stated CNA-F often did not have enough time to complete a water pass and provide hydration to residents. CNA-F stated water was provided per residents' request and confirmed staff were expected to complete a water pass each shift. On 8/26/24 at 11:38 AM, Surveyor interviewed CNA-D who stated staff were expected to complete a water pass once per shift and as needed. CNA-D stated water passes weren't completed at times due to staffing. CNA-D stated residents who asked for water were provided water and residents who were unable to ask received water at meals and during medication administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff and resident interview and record review, the facility did not ensure accurate administration of medication for 1 Resident (R) (R1) of 5 sampled residents. R1 did not consistently receive scheduled medications timely as ordered by R1's physician. Findings include: The facility's Medication Administration policy, dated 1/2024, indicates: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices . Medications are administered within 60 minutes of the scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center . On 8/26/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, anxiety disorder, and history of urinary tract infections (UTIs). R1's Minimum Data Set (MDS) assessment, dated 5/29/24, stated R1's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R1 had intact cognition. R1's medical record indicated R1 was responsible for R1's healthcare decisions. On 8/26/24 at 8:15 AM, Surveyor interviewed R1 who stated R1 often received R1's scheduled medications late. On 8/26/24, Surveyor reviewed R1's medical record which contained the following physician orders: ~ Cefadroxil (used to treat infection) oral capsule 500 mg (milligrams) give 1 capsule by mouth every morning and at bedtime (start date 8/8/24, end date 8/14/24). ~ Gabapentin (used to treat nerve pain) capsule 300 mg give 1 capsule by mouth three times a day. ~ Hydroxyzine HCl (hydrochloride) (used to treat anxiety) oral tablet 50 mg give 50 mg by mouth three times a day. ~ Insulin lispro (used to treat high blood sugar) (1 unit dial) subcutaneous solution pen injector 100 unit/ml (milliliter) Inject 10 units subcutaneously with meals .Give with sliding scale. ~ Insulin lispro (1 unit dial) subcutaneous solution pen injector 100 unit/ml inject as per sliding scale: if 0-100 = -2 (If less then 100 subtract 2 units); 150-199 = 2; 200-249 = 4; 250-299 = 6; 300-350 = 8, subcutaneously three times a day .hold if not eating. ~ Blood glucose monitoring before meals and at bedtime. Call Medical Doctor (MD) if blood glucose level is less than 100 or greater than 350. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 12:34 PM, Surveyor interviewed [NAME] President of Success (VPS)-E via phone. VPS-E stated the facility had liberalized medication pass times for most scheduled medications. VPS-E stated AM on the Medication Administration Record (MAR) meant a timeframe for medication pass of 6:00 AM to 10:00 AM; Noon meant a timeframe of 10:00 AM to 2:00 PM; PM meant a timeframe of 2:00 PM to 6:00 PM; and HS meant a timeframe of 6:00 PM to 10:00 PM. On 8/26/24, Surveyor reviewed R1's August 2024 MAR which indicated R1's cefadroxil was scheduled for AM and HS; R1's gabapentin was scheduled for AM, noon, and HS; R1's hydroxyzine was scheduled for AM, noon, and HS; R1's base dose of insulin lispro was scheduled for 8:00 AM, 12:00 PM and 5:00 PM; R1's sliding scale insulin was scheduled for AM, noon, and HS; and R1's blood sugar monitoring was scheduled for 7:30 AM, 11:30 AM, 5:00 PM, and 8:00 PM. On 8/26/24 at 1:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding meal times. NHA-A stated the facility's meal times were 8:30 AM for breakfast, 12:30 PM for lunch, and 5:30 PM for dinner. On 8/26/24, Surveyor reviewed a Medication Admin Audit Report which contained the medications R1 received from 8/9/24 through 8/26/24 and indicated the following: ~ On 8/9/24, R1's 8:00 AM dose of insulin lispro (to be given with meals as ordered) was administered at 9:56 AM; R1's AM dose of sliding scale insulin was administered at 9:57 AM; R1's blood sugar (to be obtained before meals as ordered) was obtained at 9:55 AM. ~ On 8/9/24, R1's 12:00 PM dose of insulin lispro was administered at 1:17 PM. ~ On 8/9/24, R1's noon dose of sliding scale insulin and blood sugar level was administered/obtained at 1:18 PM. ~ On 8/10/24, R1's 8:00 AM dose of insulin lispro was administered at 9:57 AM (to be given with sliding scale insulin as ordered); R1's AM dose of sliding scale insulin was administered at 10:44 AM from R1's 7:30 AM blood sugar level which was obtained at 8:57 AM. ~ On 8/10/24, R1's AM doses of cefadroxil, gabapentin, and hydroxyzine were administered at 10:47 AM. ~ On 8/10/24, R1's 12:00 PM dose of insulin lispro was administered at 1:28 PM; R1's noon dose of sliding scale insulin was administered at 3:04 PM from R1's 11:00 AM blood sugar level which was obtained at 1:28 PM. ~ On 8/10/24, R1's HS doses of gabapentin and hydroxyzine were administered at 10:17 PM. ~ On 8/11/24, R1's 12:00 PM dose of insulin lispro was administered at 2:00 PM; R1's noon dose of sliding scale insulin was administered at 2:01 PM from R1's 11:00 AM blood sugar level which was obtained at 2:00 PM. ~ On 8/12/24, R1's AM doses of gabapentin and hydroxyzine were administered at 10:42 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 8/12/24, R1's AM dose of sliding scale insulin was administered at 11:15 AM from R1's 7:30 AM blood sugar level which was obtained at 9:03 AM. ~ On 8/24/24, R1's 12:00 PM dose of insulin lispro was administered at 2:27 PM; R1's noon dose of sliding scale insulin was administered at 2:28 PM from R1's 11:00 AM blood sugar level which was obtained at 2:23 PM. ~ On 8/24/24, R1's noon doses of gabapentin and hydroxyzine were administered at 2:24 PM. On 8/26/24 at 1:47 PM, Surveyor interviewed VPS-E via phone. VPS-E verified R1's insulin should have been given with meals as ordered. VPS-E also verified the medications listed above were administered late based on the documentation.