

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff interview and record review, the facility did not ensure court-ordered documents for guardianship and protective placement were obtained and/or on file for 1 resident (R) (R14) of 14 sampled residents.</p> <p>R14 had a court-ordered guardian. The facility did not have court documents for determination of permanent guardianship on file. In addition, the facility did not ensure court-ordered protective placement was completed for R14.</p> <p>Findings include:</p> <p>WI State Statute Chapter 55.03(4). The law requires a court-ordered protective placement for any resident admitted to a nursing home who has a legal guardian and whose nursing home stay exceeds ninety days.</p> <p>WI State Statute Chapter 54 indicates Standby guardian means an individual designated by the court under s. 54.52 (2) whose appointment as guardian becomes effective immediately upon the death, resignation, or court's removal of the initially appointed guardian, or if the initially appointed guardian is temporarily or permanently unable, unavailable, or unwilling to fulfill his or her duties. Chapter 54.52(2) states upon assuming office, the standby guardian shall so notify the court. Upon notification, the court shall issue new letters of guardianship that specify that the standby guardianship is permanent or that specify the time period for a limited standby guardianship.</p> <p>From 6/24/24 through 6/26/24, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] with diagnoses including cerebral palsy and mild cognitive impairment. R14's Minimum Data Set (MDS) assessment, dated 2/8/24, indicated R14 had severe cognitive impairment. R14 medical record indicated R14 had a court-appointed guardian.</p> <p>R14's medical record contained a court document indicating determination and order for standby guardian, termination of guardian of the estate, and protective placement with an unintelligible date. The document indicated the reason for guardianship with need for protective placement in a nursing home; however, the document did not specify the name of the facility or the date of protective placement or indicate when R14's protective placement was last reviewed. The name of R14's guardian was listed on the document with the words is new legal guardian as of Sept. 1997 handwritten on the document. The facility was not able to provide documents that indicated permanent guardianship was in place for R14 or an annual protective placement order.</p> <p>(continued on next page)</p>

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: 525685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 11:02 AM, Surveyor interviewed Social Services Director (SSD)-C and Nursing Home Administrator (NHA)-A. SSD-C confirmed the facility did not have documentation on annual review for protective placement or documentation on permanent guardianship. The facility was not able to provide additional documentation to show the facility filed for protective placement when R14 was admitted to the facility.</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff interview and record review, the facility did not ensure 3 residents (R) (R7, R12 and R23) of 3 residents reviewed for hospitalization received a transfer notice that included the date of the transfer, the reason for the transfer, the location of the transfer, and appeal rights. In addition, the facility did not inform the State Long-Term Care Ombudsman for 2 (R7 and R23) of 3 residents reviewed for transfer/discharge.</p> <p>R7 was transferred to the hospital on 2/24/24. R7 was not provided with a written transfer notice. In addition, the Ombudsman was not notified of R7's transfer.</p> <p>R12 was transferred to the hospital on 11/13/23, 1/1/24, and 2/27/24. R12 was not provided with written transfer notices.</p> <p>R23 was transferred to the hospital on 6/11/24. R23 was not provided with a written transfer notice. In addition, the Ombudsman was not notified of R23's transfer.</p> <p>Findings include:</p> <p>The facility's Transfer and Discharge (including Against Medical Advice (AMA)) policy, with a revision date of 7/15/22, states that it is the policy of the facility to permit each resident to remain in the facility, and not to transfer or discharge the resident from the facility except as initiated by the resident, necessary for the health and safety of residents or other individuals are endangered, or as otherwise permitted by law. In the event of emergency transfers/discharges, the facility will notify the resident and/or resident representative, and complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents the resident's status, diagnosis, allergies, reasons for transfer/discharge, contact information for practitioner, current medications, treatments, pertinent medical information, special risks, care plan goals, isolation precautions, and any other documentation, as applicable, to ensure a safe and effective transition of care. In addition, the Social Services Director (SSD) or designee shall provide notice of the transfer to a representative of the State Long-Term Care Ombudsman via a monthly list.</p> <p>1. From 6/24/24 through 6/26/24 Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, generalized hypertension, and mild cognitive impairment. R7'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 R7 had moderate cognitive impairment. R7 was R7's healthcare decision maker.</p> <p>On 2/24/24, R7 was transferred to the hospital following a fall with injury and admitted with diagnoses including right frontal subdural hematoma and type II odontoid fracture. R7 returned to the facility on [DATE].</p> <p>R7's medical record did not indicate a written transfer notice was provided to R7 or R7's emergency contact.</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. From 6/24/24 through 6/26/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness on one side of the body) affecting the right dominant side, conversion disorder with motor symptom or deficit, and history of venous thrombosis and embolism. R12's MDS assessment, dated 1/15/24, had a BIMS score of 15 out of 15 which indicated R12 had intact cognition. R12 was R12's health care decision maker.</p> <p>On 11/13/23, R12 was sent to the hospital following a change in condition and admitted with a diagnosis of loss of sensation to bilateral lower extremities. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate a written transfer notice was provided to R12 or R12's emergency contact.</p> <p>On 1/1/24, R12 was transferred to the hospital following a change in condition and admitted for a possible stroke. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate a written transfer notice was provided to R12 or R12's emergency contact.</p> <p>On 2/27/24, R12 was transferred to the hospital for pre-planned medical testing. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate a written transfer notice was provided to R12 or R12's emergency contact.</p> <p>3. On 6/25/24, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder, history of urinary tract infections (UTIs), diabetes, and anxiety disorder. R23's MDS assessment, dated 5/29/24, had a BIMS score of 15 of 15 which indicated R23 had intact cognition. R23 was R23's healthcare decision maker.</p> <p>R23 was transferred to the hospital on 6/11/24 with stroke-like symptoms. R23's medical record did not indicate a written transfer notice was provided to R23 or R23's emergency contact. In addition, the State Long-Term Care Ombudsman was not notified of R23's transfer.</p> <p>On 6/25/24 at 2:44 PM, Surveyor interview Nursing Home Administrator (NHA)-A who confirmed transfer notices were not completed. NHA-A stated for emergent transfers, the nurse is responsible for completing the notice of transfer/discharge, at least verbally, and if the resident is not capable, the nurse should call the resident's emergency contact or representative. NHA-A stated the Social Worker is responsible for following up with the resident and/or their representative on the next business day.</p> <p>On 6/26/24 at 11:02 AM, Surveyor interview Social Service Director (SSD)-C who acknowledged residents should be notified of transfers. SSD-C stated when SSD-C is not in the facility, it is the responsibility of the nurse to issue the transfer/discharge notice. SSD-C stated if SSD-C is in the facility, the notice is provided by SSD-C. SSD-C acknowledged SSD-C has not been completing transfer/discharge notices. SSD-C also confirmed SSD-C has not been submitting monthly transfer/discharge notification to the State Long-Term Care Ombudsman.</p> <p>(continued on next page)</p>

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 10:00 AM, NHA-A confirmed the facility has not been notifying the State Long-Term Care Ombudsman of transfers and discharges.</p>

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff interview and record review, the facility did not ensure 3 residents (R) (R7, R12 and R23) of 3 residents reviewed for hospitalization received the proper bed hold notice when transferred to the hospital.</p> <p>R7 was transferred to the hospital on 2/24/24. The facility did not provide R7 with a bed hold notification.</p> <p>R12 was transferred to the hospital on 11/13/23, 1/1/24 and 2/27/24. The facility did not provide R12 with a bed hold notifications.</p> <p>R23 was transferred to the hospital on 6/11/24. The facility did not provide R23 with a bed hold notification</p> <p>Findings include:</p> <p>The facility's Transfer and Discharge (including Against Medical Advice (AMA)) policy, with a revision date of 7/15/22, states it is the policy of the facility to permit each resident to remain in the facility, and not to transfer or discharge the resident from the facility except as initiated by the resident, necessary for the health and safety of residents or other individuals are endangered, or as otherwise permitted by law. The facility will provide a notice of the facility's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours after the transfer.</p> <p>1. From 6/24/24 through 6/26/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure and mild cognitive impairment. R7'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 R7 had moderately impaired cognition. R7 was R7's healthcare decision maker.</p> <p>On 2/24/24, R7 was transferred to the hospital following a fall with injury and admitted with diagnoses including right frontal subdural hematoma and type II odontoid fracture. R7 returned to the facility on [DATE].</p> <p>R7's medical record did not indicate R7 or R7's representative were provided with a bed hold notification.</p> <p>2. From 6/24/24 through 6/26/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness on one side of the body) affecting the right dominant side and conversion disorder with motor symptom or deficit. R12's MDS assessment, dated 1/15/24, had a BIMS score of 15 out of 15 which indicate R12 had intact cognition. R12 was R12's healthcare decision maker.</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/23, R12 was transferred to the hospital following a change in condition and admitted with a diagnosis of loss of sensation to bilateral lower extremities. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate R12 or R12's representative were provided a bed hold notification.</p> <p>On 1/1/24, R12 was transferred to the hospital following a change in condition and admitted for a possible stroke. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate R12 or R12's representative were provided a bed hold notification.</p> <p>On 2/27/24, R12 was transferred to the hospital for pre-planned medical testing. R12 returned to the facility on [DATE].</p> <p>R12's medical record did not indicate R12 or R12's representative were provided a bed hold notification.</p> <p>3. On 6/25/24, Surveyor reviewed R23's medical record. R23 was admitted to facility on 2/2/24 with diagnoses including neurogenic bladder, history of urinary tract infections (UTIs), diabetes, and anxiety disorder. R23's MDS assessment, dated 5/29/24, had a BIMS score of 15 of 15 which indicated R23 had intact cognition. R23 was R23's healthcare decision maker.</p> <p>R23 was transferred to the hospital on 6/11/24 with stroke-like symptoms. R23's medical record did not indicate R23 or R23's representative were provided a bed hold notification.</p> <p>On 6/25/24 at 2:44 PM, Surveyor interview Nursing Home Administrator (NHA)-A who confirmed bed hold notices were not provided. NHA-A stated for emergent transfers, the nurse should provide a bed hold notice, at least verbally, and if the resident is not capable, the nurse should call the resident's emergency contact or representative. NHA-A stated the Social Worker is responsible for following up with the resident or their representative on the next business day.</p> <p>On 6/26/24 at 11:02 AM, Surveyor interview Social Service Director (SSD)-C who acknowledged residents should be provided the option for a bed hold. SSD-C stated when SSD-C is not in the facility, it is the responsibility of the nurse to provide a bed hold notice. SSD-C stated if SSD-C is in the facility, SSD-C provides the bed hold notice. SSD-C acknowledged SSD-C has not been completing bed hold notices.</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff interview and record review, the facility did not ensure the state mental health authority was promptly notified following a significant change in mental illness for 1 resident (R) (R12) of 6 sampled residents.</p> <p>R12 was admitted to the facility on [DATE] with a diagnosed mental illness (MI) with corresponding medication. The facility did not submit R12's Preadmission Screen and Resident Review (PASRR) Level I for a Level II Screen following R12's acute psychiatric hospital stay from 10/25/23 through 10/30/23.</p> <p>Findings include:</p> <p>According to Centers for Medicare and Medicaid Services' (CMS), Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual, dated October 2023, if a significant change in status (SCSA) occurs for an individual known or suspected to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act .The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed .Referral should be made as soon as the criteria indicating such are evident - the facility should not wait until the SCSA is complete.</p> <p>In addition, a referral for Level II Resident Review Evaluations is required for individuals previously identified by PASRR to have mental illness, intellectual disability/developmental disability, or a related condition in the following circumstances: note: .A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis) .A resident transferred, admitted , or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.</p> <p>Between 6/24/24 and 6/26/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] from another Skilled Nursing Facility (SNF) with diagnoses including hemiplegia (weakness on one side of the body) affecting the right dominant side, borderline personality disorder, obsessive-compulsive disorder (OCD), unspecified mood (affective) disorder, major depressive disorder, suicidal ideation, and conversion disorder with motor symptom or deficit. R12's Minimum Data Set (MDS) assessment, dated 1/15/24, had a BIMS score of 15 out of 15 which indicated R12 had intact cognition. R12 was R12's healthcare decision maker.</p> <p>R12's physician orders included:</p> <p>~ Adderall ER10 MG (milligrams) once per day for OCD</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ Lithium Carbonate ER 450 MG give 0.5 tablet in the evening for unspecified mood (affective) disorder, major depressive disorder, suicidal ideations, and borderline personality disorder.</p> <p>R12's PASRR Level I Screen, dated 7/24/23, indicated R12 had a serious MI with corresponding medication of lithium carbonate and that R12 displayed symptoms of a major MI which indicated the need for a Level II Screen. R12's medical record did not indicate a Level II Screen was completed.</p> <p>On 10/25/23, R12 was admitted to a psychiatric hospital for acute inpatient behavioral health due to suicidal threats. R12 returned to the facility on [DATE] with medication changes.</p> <p>On 6/24/24 at 11:02 AM, Surveyor interviewed Social Service Director (SSD)-C and Nursing Home Administrator (NHA)-A. SSD-C verified a PASRR Level II Screen was not completed for R12. SSD-C acknowledged a Level II Screen should have been completed following R12's original admission to the facility and after R12's acute inpatient psychiatric hospital stay.</p>

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff interview and record review, the facility did not monitor for adverse reactions or side effects of high risk medications for 1 resident (R) (R3) of 5 residents reviewed for unnecessary medications.</p> <p>R3 was prescribed anti-convulsant medications for seizures. R3 did not have a care plan that addressed seizures or contained monitoring interventions for adverse reactions and side effects of the anti-convulsant medication.</p> <p>Findings include:</p> <p>The facility did not provide a policy related to non-psychotropic high-risk medications.</p> <p>Between 6/24/24 and 6/26/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with a diagnosis of epilepsy. R3's Minimum Data Set (MDS) assessment, dated 6/20/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R3 had severely impaired cognition.</p> <p>R3's medical record indicated R3 was prescribed the following anti-convulsant medications since admission on 3/15/24.</p> <p>~ Gabapentin 300 mg (milligrams) by mouth three times a day for neuropathy</p> <p>~ Levetiracetam 500 mg by mouth one time a day for seizures</p> <p>~ Primidone oral tablet (Primidone) 100 mg by mouth three times a day for seizures</p> <p>R3's medical record did not contain a care plan that indicated R3 had seizures and did not contain monitoring interventions for seizures or adverse reactions and side effects of the anti-convulsant medications.</p> <p>On 6/26/24 at 8:48 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified there were no monitoring interventions in place for R3's anti-convulsant medication or seizures. NHA-A confirmed monitoring interventions should have been in place.</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on observation, staff interview, and record review, the facility did not ensure meal preferences were followed for 2 residents (R21 and R8) of 16 sampled residents.</p> <p>R21 stated the facility often lost R21's meal ticket which had R21's preferences for lunch on 6/24/24. During an observation of lunch service on 6/24/24, R21 did not receive R21's documented preferences.</p> <p>R8's care plan indicated R8 was legally blind and contained an intervention that staff should explain what was on R8's plate and where the food was located. The intervention was not consistently followed.</p> <p>Findings include:</p> <p>Between 6/24/24 and 6/25/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder. R21's Minimum Data Set (MDS) assessment, dated 6/7/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R21 had intact cognition. R21 had an order for a regular diet.</p> <p>During lunch service in the dining room on 6/24/24 at 12:56 PM, Dietary Manager (DM)-D stated DM-D did not have a meal ticket for R21 and provided R21 with regular menu items including Salisbury steak, mashed potatoes, and buttered corn.</p> <p>On 6/24/24 at 1:04 PM, Surveyor followed up with R21 who stated R21 did not choose corn, but received corn with lunch. R21 stated R21 frequently crossed off items on the meal ticket ahead of time for items R21 did not want. R21 stated R21 crossed off corn because corn upsets R21's stomach and chose a salad instead. Surveyor observed a plate in front of R21. Surveyor noted all the the food was eaten except the corn. When Surveyor asked if R21 received the items that R21 requested on the meal ticket, R21 stated R21 did not have a meal ticket with the meal. R21 stated R21's meal ticket is often missing and R21 does not receive what R21 orders.</p> <p>Between 6/24/24 and 6/25/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] with a diagnosis of unqualified visual loss, both eyes. R8's MDS assessment, dated 4/4/24, had a BIMS score of 12 out of 15 which indicated R8 had moderately impaired cognition.</p> <p>R8's medical record contained a nutrition care plan related to poor vision, type 2 diabetes, chronic diarrhea related to bowel resection due to colon cancer, history of weight loss, and impaired skin integrity. An intervention, dated 1/6/23, stated to explain food placement.</p> <p>During lunch service on 6/25/24 at 12:39 PM, Surveyor observed [NAME] (CK)-E plate food for R8 and state CK-E did not have a meal ticket for R8. Surveyor observed CK-E cut up and plate the correct food for R8. CK-E then passed R8's plate to Dietary Aid (DA)-H who provided R8 with the plate. DA-H set R8's plate down and walked away. Surveyor did not observe DA-H explain what was on R8's plate or where the food was located on the plate.</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24, Surveyor requested a copy of R8's meal ticket. On 6/26/24, staff provided a copy of R8's meal ticket which indicated R8 was prescribed a consistent carbohydrate diet with large protein portions. Instructions indicated to cut up R8's food. Surveyor noted the meal ticket did not indicate R8 was legally blind or contain an instruction to explain the placement of food to R8.</p> <p>On 6/25/24 at 2:00 PM, Surveyor interviewed R8 who stated R8 could not see well. R8 confirmed staff did not tell R8 what food was on R8's plate or the location of the food on the plate when staff set the plate down at lunch. R8 stated some staff explain the food placement but some do not. R8 stated it is important to R8 for staff to explain what is on R8's plate because R8 does not like the green stuff and does not want to get a mouthful of something R8 does not like.</p> <p>On 6/24/24, Surveyor interviewed DM-D who verified meal tickets get lost and stated DM-D was trying to devise a better system. DM-D stated DM-D prints a batch of meal tickets at a time and residents/staff go through the tickets and circle their preferences. DM-D stated DM-D installed a holder on the side of the refrigerator in the dining room with tickets stapled or clipped together but confirmed there were still issues with lost meal tickets. When asked about residents' preferences, DM-D confirmed residents should receive their preferences and ordered diets.</p> <p>On 6/26/24, Surveyor interviewed Nursing Home Administrator (NHA)-A who acknowledged dietary staff might not know specific approaches on a resident's care plan since dietary staff generally see meal tickets and not care plans.</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 26 residents residing in the facility.</p> <p>Staff did not perform proper hand hygiene prior to donning gloves, while passing silverware, prior to touching ready to eat food, and while doing dishes.</p> <p>Staff did not wear a beard net while plating food.</p> <p>The handwashing sink in the nourishment room on a resident unit was not in clean condition and appeared to be used for things other than handwashing.</p> <p>Kitchen equipment, refrigerators, an ice machine, and dishes were not stored clean, in a down facing position, covered appropriately, and/or stored 6 inches off the floor.</p> <p>Food items in unit refrigerators were not labeled or dated and/or were expired.</p> <p>Findings include:</p> <p>On [DATE] at 10:16 AM, Surveyor began an initial kitchen tour of the kitchen with Dietary Manager (DM)-D who stated the facility follows the Federal and State food codes (whichever is stricter).</p> <p>Hand Hygiene:</p> <p>The Wisconsin Food Code documents at Chapter 2 Personal Cleanliness at ,d+[DATE].14 titled When to Wash: Food employees shall clean their hands and exposed portions of their arms as specified under , d+[DATE].12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms .(E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (H) Before putting on gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.</p> <p>The Wisconsin Food Code documents at Chapter ,d+[DATE].11: (B) Knives, forks, and spoons that are not pre-wrapped shall be presented so that only the handles are touched by employees.</p> <p>The Wisconsin Food Code documents at Chapter ,d+[DATE].14 Wiping Cloths, Use Limitation: (A) Cloths in-use for wiping food spills from tableware and carry-out containers that occur as food is being served shall be: (1) Maintained dry; and (2) Used for no other purpose. (B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S ,d+[DATE].114; and (2) Laundered daily as specified under ,d+[DATE].11 (D).</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's General Food Preparation and Handling policy, with a review date of [DATE], indicates: 5. Equipment: F. Tongs or other serving utensils will be used to serve breads or other items to avoid bare hand contact with food.</p> <p>The facility's Bare Hand Contact with Food and Use of Plastic Gloves policy, with a review date of [DATE], indicates: .1. Staff will use good hygienic practices and techniques with access to proper hand washing facilities (available soap, hot water, and disposable towels). Antimicrobial or antiseptic gel is not used in place of proper hand washing techniques. 3. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single-use gloves shall be used for only one task, used for one purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning work with food) and after removing single-use gloves. 6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hand must be watched. 7. Wash hands after removing gloves.</p> <p>The facility's Hand Washing-Food and Nutrition Services policy, with a review date of [DATE], indicates: Hands and exposed portions of arms should be washed immediately before engaging in food preparation: .f. After handling soiled equipment or utensils, Before donning disposable gloves for working with food and after gloves are removed. 4. Hand washing procedures will be posted by each hand-washing sink. 5. Food preparation and/or pot sinks will not be used for handwashing.</p> <p>During lunch service on [DATE] at 12:23 PM, Surveyor observed [NAME] (CK)-F don a pair of gloves prior to food service. CK-F did not wash hands prior to donning gloves.</p> <p>On [DATE] at 12:24 PM, Surveyor observed Dietary Aid (DA)-H approach the silverware tray. DA-H picked up a stack of forks, spoons, knives, and napkins. DA-H then passed out silverware in the dining room. DA-H walked from resident to resident, placed a napkin next to each resident and placed a knife, fork, and spoon in front of each resident. Surveyor observed DA-H touch the tips of the knives with DA-H's bare hands during the process. DA-H did not wash hands prior to touching clean silverware and napkins.</p> <p>On [DATE] at 12:25 PM, Surveyor observed CK-F take pre-service meal temperatures. Surveyor observed CK-F remove gloves, record the temperature, don gloves, and check the next temperatures. CK-F did not wash hands prior to donning gloves.</p> <p>On [DATE] at 12:31 PM, Surveyor observed CK-F don gloves to begin meal service. Surveyor observed CK-F touch scoops and food covers on the steam table while plating food for a resident. CK-F did not wash hands prior to donning gloves for meal service.</p> <p>On [DATE] at 10:22 AM, Surveyor observed Dietary Aid (DA)-G wash dishes. Surveyor observed DA-G spray and rinse dirty dishes with gloved hands, place the dishes in a rack, and push the rack through the dishmachine. DA-G then removed gloves and rinsed DA-G's hands with the wand used to rinse dirty dishes. DA-G then walked to the clean side of the dish area, pulled a clean rack out of the dishmachine, and touched clean bowls in a bin with DA-G's unwashed hands. When Surveyor stopped DA-G and informed DA-G that Surveyor did not observe DA-G wash hands prior to touching clean dishes, DA-G confirmed DA-G did not wash DA-G's hands.</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 1:03 PM, Surveyor interviewed Regional Dietary Manager (RDM)-K and informed RDM-K of Surveyor's observations during meal service. RDM-K confirmed staff should perform hand hygiene prior to donning gloves, should touch silverware by the handles, and should use a tong for ready-to-eat food during meal service.</p> <p>On [DATE] at 10:25 PM, Surveyor interviewed DM-D who confirmed DA-G should have washed hands prior to touching clean dishes.</p> <p>Beard Net:</p> <p>The State of Wisconsin Food Code documents at ,d+[DATE].11: Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.</p> <p>During lunch service on [DATE] at 12:23 PM, Surveyor observed CK-F put food in the steam table, obtain food temperatures, and plate two residents' meals behind the service area in the dining room. CK-F did not wear a beard net during the observation.</p> <p>On [DATE] at 2:42 PM, Surveyor interviewed DM-D who verified CK-F should have worn a beard net.</p> <p>Handwashing Sink:</p> <p>The Wisconsin State Food Code documents at ,d+[DATE].11 Using a Handwashing Sink: (A) A handwashing sink shall be maintained so that it is accessible at all times for employees use. (B) A handwashing sink may not be used for purposes other than handwashing.</p> <p>The Wisconsin State Food Code documents at ,d+[DATE].14 Handwashing Signage: A sign or poster that notifies food employees to wash their hands shall be provided at all handwashing sinks used by food employees and shall be clearly visible to food employees.</p> <p>The Wisconsin State Food Code documents at ,d+[DATE].11 (Equipment) Good Repair and Proper Adjustment: (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE].</p> <p>On [DATE] at 2:05 PM, Surveyor inspected the nourishment room located across from the dining room on a resident unit. Surveyor noted the room contained a single sink with a bottle of dish soap and a bottle of cleanser between the wall and the sink. In addition, the upper right corner of the sink contained a sponge with brown edges, the top of the faucet contained a dry, crusted, brown-stained maroon rag, and one of drains contained chunks of food. Surveyor observed splatter around the sink and behind the wall. Surveyor opened the cabinet underneath the sink and noted the bottom of the cabinet had fallen out and contained crumbling fiberboard with dark/brown areas that appeared to be mold/mildew.</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] 2:42 PM, Surveyor interviewed DM-D who stated the sink in the nourishment room was the sink kitchen staff needed to use for handwashing during meal service. DM-D stated the nourishment room sink was the only handwashing sink on the unit for kitchen staff. DM-D stated both housekeeping and kitchen staff cleaned the nourishment room. DM-D was unsure why there was dish soap, a dirty rag, and a sponge on/around the sink. DM-D confirmed the sink did not contain signage that indicated the sink was for handwashing. DM-D was also not aware of the condition of the cabinet underneath the sink.</p> <p>Cleanliness/Covering of Kitchen Equipment:</p> <p>The Wisconsin State Food Code documents at ,d+[DATE].11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles: (A) Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (3) At least 15 cm (6 inches) above the floor and (2) Covered or inverted.</p> <p>The facility's General Food Preparation and Handling policy, with a review date of [DATE], indicates: 5. Equipment: A. All food service equipment should be cleaned, sanitized, air dried, and reassembled after each use. D. Flatware will be stored in such a manner to encourage contact with handles only. E. Staff will handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces that food or drink will come in contact with.</p> <p>During the initial kitchen tour on [DATE], Surveyor observed an uncovered meat slicer on the counter that contained dried food. DM-D stated the meat slicer had not been used that day. DM-D stated DM-D would clean and cover the meat slicer.</p> <p>On [DATE] at 2:01 PM, Surveyor observed an uncovered three shelf utility cart in the dining room behind the kitchen service area that contained various dishes staff used to plate food during meal service. Surveyor observed a large plastic bag next to the cart that looked as if it was used to cover dishes on the cart. Surveyor noted the cart contained plates on the top shelf that faced up and bowls that were not inverted on two other shelves.</p> <p>On [DATE] at 1:57 PM, Surveyor observed a full size refrigerator in the dining room. The bottom of the refrigerator contained a dried pink and yellow substance. Surveyor also observed colored splatter behind juice containers on the second shelf. In addition, Surveyor observed dried pink splatter on the third shelf and cracks with what appeared to be a black substance at the bottom of the refrigerator.</p> <p>On [DATE] at 2:05 PM, Surveyor observed an ice machine in the nourishment room that contained drips on the inside and outside. Surveyor observed a coffee maker directly above the ice machine. Surveyor also observed a mini refrigerator/freezer in the nourishment room that contained dried brown splatter. In addition, a box of single-service decaf Folgers coffee packets was sitting on the floor.</p> <p>On [DATE] at 2:42 PM, Surveyor interviewed DM-D who confirmed food items should be stored 6 inches off the floor. DM-D also confirmed the refrigerators in the dining room and the nourishment room should be cleaned and stated the refrigerators are cleaned by housekeeping and kitchen staff. DM-D also verified the coffee splatter on the ice machine.</p> <p>Labeling, Dating, and Expired Food Items:</p> <p>(continued on next page)</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Wisconsin Food Code documents at ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under paragraph ,d+[DATE].12, and except as specified in paragraph (E), (F), and (H) of this section, refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. Commercially processed food open and hold cold (B) Except as specified in paragraph (E)-(H) of this section, refrigerated, ready to eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in paragraph (A) of this section and; (1) The day the original container is opened in the food establishment shall be counted as day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p> <p>On [DATE] at 2:01 PM, Surveyor observed the dining room refrigerator and noted three unlabeled and undated fruit plates covered in plastic wrap. The refrigerator also contained two covered and unlabeled resident meals.</p> <p>On [DATE] at 2:42 PM, Surveyor interviewed DM-D who confirmed the fruit plates should be labeled and stated one of the meal trays was left from lunch because the resident was at an appointment. DM-D confirmed the lunch trays were not labeled.</p> <p>On [DATE] at 2:23 PM, Surveyor reviewed the items in the nourishment room refrigerator with Certified Nursing Assistant (CNA)-I. Surveyor also observed the following:</p> <p>~ One Ziploc bag labeled 209 which contained what appeared to be deli ham. The bag was not labeled with the contents, was not dated, and did not contain an expiration date. CNA-I confirmed the bag was not labeled and also stated the packaging looked puffy and full of air. CNA-I threw bag in the garbage.</p> <p>~ One 24 ounce (oz) container of Great Value Lowfat Cottage Cheese with an expiration date of ,d+[DATE] and labeled M. D. CNA-I confirmed the cottage cheese was expired and stated when staff have time they check the refrigerator for expired and outdated items.</p> <p>~ Three 4 oz containers of HC Plus 100% Prune Juice. Two containers did not contain written or manufacturer's expiration dates. The third container was dated [DATE]. CNA-I was not sure how long the prune juice was for and stated licensed staff handle prune juice.</p> <p>On [DATE] at 2:42 PM, Surveyor interviewed DM-D who verified the items in the refrigerator should be dated and disposed of when expired.</p>		

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 06/26/2024
NAME OF PROVIDER OR SUPPLIER Plymouth Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>32768</p> <p>Based on observation, staff interview, and record review, the facility did not maintain an infection control program designed to prevent the development and transmission of disease and infection during the provision of care for 1 resident (R) (R23) of 2 sampled residents.</p> <p>CNA (Certified Nursing Assistant)-I did not appropriately change gloves during the provision of care for R23.</p> <p>Findings include:</p> <p>The facility's Hand Hygiene Policy, dated 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>On 6/26/24, Surveyor reviewed R23's medical record. R23 was admitted to facility on 2/2/24 with diagnoses including neurogenic bladder, history of urinary tract infections (UTIs), and diabetes. R23's Minimum Data Set (MDS) assessment, dated 5/29/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R23 had intact cognition. The MDS also indicated R23 required extensive assistance with bed mobility, transfers, and hygiene.</p> <p>On 6/26/24 at 10:51 AM, Surveyor observed CNA-I and CNA-J provide peri and catheter care for R23. CNA-I and CNA-J washed hands and donned gloves. CNA-I then placed clean wash cloths on the bedside table and touched multiple items in the bathroom, including the faucet. CNA-J pulled down R23's brief in preparation for peri and catheter care. CNA-I wiped R23's peri area from front to back with a soapy cloth. CNA-I then folded the cloth and wiped again. CNA-I rinsed R23's peri area from front to back with a clean cloth and dried R23's peri area with a towel. CNA-J then wiped R23's Foley catheter tubing from the top of the tubing down to the drainage bag with a clean cloth. CNA-I dried R23's Foley tubing with the same towel used during peri-care. CNA-I and CNA-J then rolled R23 on the left side. With the same gloved hands, CNA-I wiped R23's buttocks from front to back with a clean cloth. CNA-I then rinsed R23's buttocks from front to back. With the same gloved hands, CNA-I dried R23's buttocks with a towel. CNA-I continued with cares and touched R23's side and clean brief and assisted R23 onto R23's back to apply the brief. During the process, CNA-I touched multiple areas on R23 and R23's bed. CNA-I then touched multiple surfaces in R23's bathroom and placed the soiled wash cloths in a bag. CNA-I tied the bag and set the bag on the floor. CNA-I then removed gloves and washed hands.</p> <p>On 6/26/24 at 10:21 AM, Surveyor interviewed CNA-I who verified CNA-I did not change gloves during the provision of care for R23. CNA-I verified CNA-I received hand hygiene education at the facility but forgot when CNA-I provided care for R23.</p>		