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	08/20/2025

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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(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. Based on observation, staff interview, and record review, the facility did not ensure kitchen equipment was monitored appropriately to ensure food safety. This practice had the potential to affect all 17 residents residing in the facility.The dishwasher did not meet the minimum wash and rinse temperatures to prevent the spread of foodborne illness. In addition, staff did not document internal surface temperatures.Staff did not consistently complete documentation logs for parts per million (PPM) of the sanitizing solution.Findings include:On 8/18/25 at 9:58 AM, Surveyor interviewed Dietary Manager (DM)-G and Regional Manager (RM)-H who indicated the facility follows the Federal and State Food Codes (whichever is stricter).Mechanical Warewashing:The 2022 Food and Drug Administration (FDA) Food Code documents at 8-103.12 (C) To maintain and provide to the regulatory authority or the department upon request records specified under section 1-106.12 that demonstrate that the following is routinely employed: (1) Procedures for monitoring the critical control points, (2) Monitoring of the critical control points.The 2022 FDA Food Code documents at Chapter 4-501.15 Warewashing Machines, Manufacturers, Operating Instructions: To ensure properly cleaned and sanitized equipment and utensils, warewashing machines must be operated properly. The manufacturer affixes a data plate to the machine providing vital, detailed instructions about the proper operation of the machine including wash, rinse, and sanitizing cycle times and temperatures which must be achieved.The 2022 FDA Food Code documents at Chapter 2-103.11 Person in Charge: The person in charge shall ensure that: (L) Employees are properly sanitizing multi-use equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, chemical concentration, pH, temperature, and exposure time for chemical sanitizing.The facility's Warewashing policy indicates all dish machine water temperatures will be maintained in accordance with manufacturer's recommendations for high temperature machines .Temperature and/or sanitizer concentration logs will be completed, as appropriate.On 8/20/25 at 9:09 AM, Surveyor completed a follow-up tour of the kitchen and noted staff were already in the process of washing dishes. Surveyor interviewed DM-G who stated the facility uses a hot water sanitizing machine. DM-G indicated the minimum wash temperature is between 150-160 degrees Fahrenheit (F) and the minimum rinse temperature is 180 degrees F. DM-G stated staff monitor and document temperatures prior to washing dishes 3 times per day. DM-G stated staff monitor the internal surface temperature with a fixed thermometer that is run through the machine prior to washing. DM-G stated the temperature should be above 160 degrees F. DM-G showed Surveyor the thermometer which was just run through the dish machine and read 164.3 degrees F. Surveyor observed the manufacturer's data plate attached to the underside of the dish machine. DM-G was not aware of the data plate. The data plate indicated a minimum wash temperature of 160 degrees F and a minimum rinse temperature of 180 degrees F. Surveyor observed Dietary Aide (DA)-I complete dishwashing. During the observation, Surveyor noted a rinse temperature of 176 degrees F on the machine's external thermometer. Surveyor noted DA-I did not monitor to ensure the minimum temperature was reached and did not rewash the dishware. On 8/20/25, Surveyor reviewed the facility's dish machine logs. The log template indicated temperatures are documented 3 times per day. (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the logs for May 2025 through August 2025 and noted the following:~ In May 2025, the minimum rinse temperature was not reached in 35 of 93 occurrences. ~ In June 2025, the minimum rinse temperature was not reached in 16 of 90 occurrences.~ In July 2025, the minimum rinse temperature was not reached in 37 of 93 occurrences.~ In August 2025, the minimum wash temperature was not reached in 12 of 58 occurrences.Surveyor noted the facility's dish machine logs included documented PPM monitoring, but did not include internal surface temperature monitoring.On 8/20/25 at 11:34 AM, Surveyor interviewed DM-G who was not aware the dish machine log did not include an area to document internal surface temperatures. DM-G confirmed staff should be documenting internal surface temperatures for the dish machine. Sanitizing Solution PPM:The 2022 FDA Food Code documents at 8-103.12 (C) Maintain and provide to the regulatory authority or the department upon request records specified under section 1-106.12 that demonstrate that the following is routinely employed: (1) Procedures for monitoring the critical control points, (2) Monitoring of the critical control points.The 2022 FDA Food Code at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.On 8/20/25, Surveyor reviewed the facility's sanitizer bucket logs which indicated staff should test and document PPM of the sanitizing solution a minimum of every 4 hours or more often if necessary. Surveyor reviewed the May 2025 log and noted testing of the PPM of the sanitizing solution was not documented on 27 of 124 occasions.On 8/20/25 at 11:34 AM, Surveyor interviewed DM-G who confirmed staff should consistently test and document PPM of the sanitizing solution in the sanitizer buckets.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, staff interview, and record review, the facility did not ensure garbage and refuse were properly disposed of in outside garbage receptacles. This practice had the potential to affect all 17 residents residing in the facility.On 8/18/25, the lid on an outside refuse dumpster was open and the rear sliding door on another dumpster was ajar with exposed food pulled out. In addition, insects, including wasps and/or bees, were observed inside and outside the dumpster near the exposed food.Findings include:On 8/18/25 at 9:58 AM, Surveyor interviewed Dietary Manager (DM)-G and Regional Manager (RM)-H who indicated the facility follows the Federal and State Food Codes (whichever is stricter).The facility's Dispose of Garbage and Refuse policy, dated August 2017, indicates all garbage and refuse will be collected and disposed of in a safe and efficient manner .The Dining Services Director coordinates with the Director of Maintenance to ensure the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris .The Dining Services Director will ensure that appropriate lids are provided for all containers.The Wisconsin Food Code documents at Chapter 5-501.13, Receptacles: Except as specified in (B) of this section, receptacles and waste handling units for refuse, recyclables, and returnables and for use with materials containing food residue shall be durable, cleanable, insect- and rodent-resistant, leakproof, and nonabsorbent.The Wisconsin Food Code documents at Chapter 5-501.15, Outside Receptacles: (A) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for refuse and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.On 8/18/25 at 9:39 AM, Surveyor conducted an initial tour of the kitchen with Dietary Aide (DA)-I. During the tour, Surveyor and DA-I observed two outside dumpsters located by the receiving dock doors. One dumpster had an open lid with exposed refuse. The other dumpster had a rear sliding door that was ajar. Surveyor observed several garbage bags inside the dumpster that were open with exposed food. Surveyor also observed a bag that contained sliced bread outside the dumpster on the receiving dock ledge behind the open door. Surveyor and DA-I noted several slices of bread were removed from the bag and on the cement with bees and/or wasps hovering over the exposed food and inside the dumpster.On 8/18/25 at 9:58 AM, Surveyor interviewed DM-G who verified dumpster lids and doors should be securely shut.On 8/19/25 at 12:08 PM, Surveyor interviewed RM-H who stated DM-G cleaned the dumpsters and removed all exposed food.On 8/20/25 at 11:34 AM, Surveyor interviewed DM-G who stated DM-G thoroughly cleaned the dumpster area. DM-G stated the rear door to the dumpster was broken but DM-G and another staff got it closed and called the disposal company.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on staff interview and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect all 17 residents residing in the facility.The facility did not track employee call ins due to illness and did not monitor signs and symptoms of illness or return to work dates. The facility's Infection Surveillance policy, dated 3/8/23, indicates: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Infection surveillance refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection related data .10. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza, or gastrointestinal infection outbreaks. From 8/18/25 to 8/20/25, Surveyor reviewed the facility's infection surveillance program which did not include tracking employee call ins due to illness or monitoring signs and symptoms of illness and return to work dates. Surveyor requested resident and staff line lists for January 2025 to the present. The facility provided resident line lists, including data related to infections as well as tracking and trending information. The facility did not provide documentation of employee illnesses or employee call ins due to illness for January 2025 to the present. Surveyor noted the facility had a COVID-19 positive staff in April of 2025 and a COVID-19 positive staff and resident on 8/20/25. On 8/18/25 at 11:40 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility does not keep track of employee call ins due to illness. DON-B indicated DON-B was told employees do not have to give a reason why they called in so the call in is documented on a slip without a reason. On 8/20/25 at 10:11 AM and 10:58 AM, Surveyor interviewed [NAME] President of Success (VPS)-C who indicated the facility does not have a policy or procedure for employee call ins due to illness and does not monitor employees' signs and symptoms of illness or return to work dates.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored and labeled appropriately in 1 of 1 medication cart and 1 of 1 medication storage room. This practice had the potential to affect more than 4 of the 17 residents residing in the facility.The medication cart contained resident medications with no use-by or open dates.R10's eye drops were not labeled with R10's name or instructions for use.On 8/19/25, a medication cart was left unlocked and unattended.Findings include:The facility's Medication Administration General Guidelines policy, dated1/25, indicates: .During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse .The cart must be clearly visible to the personnel administrating the medications when unlocked.During medication pass on 8/19/25 from 5:32 AM to 8:38 AM, Surveyor noted the medication cart contained the following medications with no open or use-by dates:~ A NovoLog flex pen injector 100 unit/milliliter (ml) for R10. ~ A bottle of dorzolamide hydrochloride/timolol maleate 2%/0.5% ophthalmic solution for R10. ~ A bottle of cyclosporine ophthalmic emulsion 0.05% for R10. ~ A bottle of brimonidine tartrate ophthalmic solution 0.15% for R10. ~ A bottle of prednisolone acetate ophthalmic suspension 1% for R10.On 8/19/25 at 8:45 AM, Surveyor interviewed Registered Nurse (RN)-M who verified R10's eye drops were not labeled with open dates.On 8/19/25 at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who verified insulins and eye drops should be labeled with open dates.2. On 8/19/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including diabetes, methicillin sensitive Staphylococcus aureus (MSSA), glaucoma, and legal blindness.R10's medical record contained an order for Cosopt ophthalmic solution 2-0.5% (dorzolamide HCL-timolol maleate), instill 3 drops in right eye once daily for glaucoma.On 8/19/25 at 8:38 AM, Surveyor observed RN-M prepare to administer dorzolamide hydrochloride/timolol maleate 2%/0.5% ophthalmic solution to R10 when Surveyor noted there was not a label on the eye drop bottle or the storage bag that indicated R10's name, an open date, or instructions for use.On 8/19/25 at 8:45 AM, Surveyor interviewed RN-M who verified R10's eye drops and storage bag did not contain a label or resident identifier.3. On 8/19/25 at 5:18 AM, Surveyor noted a medication cart was unlocked and unattended in front of the nurses' station.On 8/19/25 at 5:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-O who verified the medication cart should not be unlocked when unattended.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement written policies and procedures that prohibit and prevent abuse for 2 of 8 staff reviewed for caregiver background checks.The facility did not ensure a thorough caregiver background check was completed for Licensed Practical Nurse (LPN)-E and Certified Nursing Assistant (CNA)-F.Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/2022, indicates: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .I. Screening - A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff .Background checks, including re-checks, will be completed consistent with applicable state laws and regulations. Responsibility of performance of compliance checks on contracted temporary staff will be established via contractual agreement. 2. Screenings may be conducted by the facility itself, a third-party agency .3. The facility will maintain documentation of proof that the screening occurred.On 8/19/25, Surveyor reviewed background check information for 8 facility staff, including LPN-E and CNA-F.LPN-E's hire date by corporate was listed as 10/30/24. LPN-E transferred to the facility on 6/22/25. LPN-E's Background Information Disclosure (BID) form was dated 6/23/25. LPN-E's Department of Justice (DOJ) criminal background check letter and Integrated Background Information System (IBIS) letters were both dated 8/18/25 (after the survey team entered the facility).CNA-F's hire date was listed as 1/2/2025. CNA-F's BID form was dated 8/23/23 which was prior to CNA-F's eighteenth birthday. The facility did not complete a new BID form after CNA-F turned eighteen on 7/5/25 and did not obtain DOJ or IBIS letters.On 8/19/25 at 10:44 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated background checks should be completed prior to staff starting at the facility. On 8/19/25 at 12:20 PM, Surveyor interviewed Business Office Manager (BOM)-D who indicated the facility's system changed approximately two weeks prior. BOM-D indicated recruiters from corporate used to complete the hiring process and background checks. BOM-D confirmed LPN-E did not have a DOJ or IBIS letter on file and a thorough background check was not completed prior to 8/18/25. BOM-D indicated CNA-F was under eighteen when hired and confirmed CNA-F worked in the facility between 7/5/25 and 8/18/25. BOM-D indicated CNA-F should have completed a new BID form after CNA-F turned eighteen.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Preadmission Screen and Resident Review (PASRR) was submitted for additional screening after a new antipsychotic medication was prescribed for 1 resident (R) (R12) of 5 sampled residents.On 8/27/24, R12 was prescribed Seroquel (an antipsychotic medication) for mood and behavior. The facility did not update R12's Level I PASRR Screen and did not submit for another Level II evaluation when R12 was prescribed a new medication.Findings include:From 8/18/25 to 8/20/25, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including malignant carcinoid tumor of the small intestine, anxiety disorder, depression, and labile mood. R12's Minimum Data Set (MDS) assessment, dated 8/7/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R12 had intact cognition. R12 had a Guardian who was responsible for R12's healthcare decisions. R12's PASRR Level I Screen was updated on 8/22/24 due to R12's change of condition and sent to the state designated authority for a PASRR Level II evaluation. The Level II Screen was completed on 8/23/24 and included R12's mental illness diagnoses of depression, anxiety, and labile mood and medications, including Zoloft (an antidepressant medication), Xanax (a sedative medication) and Depakote (an anticonvulsant medication).On 8/27/24, R12 was prescribed Seroquel for mood and behavior. R12's medical record did not include an updated PASRR Level I or Level II Screen.On 8/20/25 at 11:49 AM, Surveyor interviewed Social Worker (SW)-P who was responsible for completing PASRR Level I Screens and submitting them for Level II evaluation. SW-P stated SW-P completes resident reviews every 3 months to verify any changes. SW-P stated staff also notify SW-P if there is a change in condition or a new medication or diagnosis. SW-P confirmed R12's PASRR Level I Screen should have been updated to include the new order for Seroquel and submitted for a Level II evaluation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During medication administration observations, 2 errors occurred during 26 opportunities which resulted in an 7.69% medication error rate that affected 2 residents (R) (R7 and R16) of 4 residents observed during medication administration. On 8/19/25, R7 was administered the wrong cough medication.On 8/19/25, R16's scheduled 6:00 AM medication was administered at 7:36 AM.Findings include:The facility's Medication Administration General Guidelines policy, dated1/25, indicates: Prior to medication administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR); Medications are administered in accordance with written orders of the prescriber; Medications are administered within 60 minutes of scheduled time .1. On 8/19/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including diabetes, congestive heart failure, chronic kidney disease, and dysphagia.R7's medical record contained an order (dated 7/28/25) for guaifenesin-dextromethorphan (DM) liquid 100-10 mg/5ml, give 5 ml by mouth every 6 hours as needed for cough. On 8/19/25 at 6:43 AM, Surveyor observed Registered Nurse (RN)-M prepare and administer 5 milliliters (ml) of dextromethorphan hydrobromide 20 milligrams (mg)/guaifenesin 200 mg/phenylephrine hydrochloride 10 mg liquid (a combination medication used as a cough suppressant, an expectorant to help loosen mucous in the airways, and a nasal decongestant) from the facility's house stock. Surveyor noted the stock medication administered by RN-M was not in accordance with R7's order. On 8/19/25 at 3:28 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the wrong medication was administered to R7.2. On 8/19/25, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including multiplesclerosis (MS), anxiety, and depression.On 8/19/25 at 7:31 AM, Surveyor observed RN-M prepare and administer a 0.5 mg alprazolam extended release (ER) oral tablet to R16. The medication card label stated to give every 12 hours at 0600 (6:00 AM) and 1800 (6:00 PM). Surveyor reviewed R16's MAR which contained an order for alprazolam ER oral tablet extended release 24 hour 0.5 mg, give 1 tablet two times daily for anxiety 0600 and 1800.On 8/19/25 at 7:36 AM, Surveyor interviewed DON-B who verified R16's alprazolam 0.5 mg tablet that was scheduled for 6:00 AM was administered late.