STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009719	A. BUILDING: _____ B. WING _____	C 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF PLYMOUTH	112 S RIVER RD PLYMOUTH, WI 53073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/11/2026 with additional information gathered through 05/13/2026, Surveyors conducted a complaint investigation at Kindred Hearts of Plymouth. As a result, 3 of 3 complaints were substantiated and 7 deficiencies were identified. Census: 12	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, Administrator F did not supervise the daily operation of the Community Based Residential Facility (CBRF) to ensure that personnel, finance, and physical plant needs were satisfied. Findings include: On 05/11/2026, Surveyors conducted 3 complaint investigations at Kindredhearts Plymouth.	N 214		

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

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N 214	Continued From page 1 On 05/11/2026 at 11:30 AM, Surveyors met with Director B. Surveyors interviewed Director B regarding concerns identified. Director B stated s/he has been at the facility for about 4 years. Director B stated the facility had good compliance prior to Administrator F taking over. Director B stated Administrator F does not come to the facility and that s/he resides out of the state of Wisconsin. Director B stated s/he contacts the office for Administrator F and the director of operations is not good with follow-through. Director B confirmed the grass needed to be cut, but the company that does the grass cutting/maintenance will not come to the facility as they have not been paid, same scenario as the previous grass company they used. Director B confirmed Resident 2 has had problems with the ACH (automated clearing house) payments. Director B shared bank printouts s/he received from Resident 2's financial person. Resident 2's monthly payment was automatically taken out every month until December 2025. On 12/30/2025, the company withdrew the following: - December 2025 and January 2026's payment on 12/30/2025 - February 2026 payment on 01/21/2026 - March 2026 payment on 01/29/2026 - (note on message "not sure why it was pulled SO early" from Resident 2's financial person) - April 2026 payment on 02/19/2026 and returned insufficient funds on 02/24/2026 - April 2026 payment on 03/05/2026 and returned insufficient funds on 03/10/2026 (note on message "They are paid in pull [sic] through March.") Director B confirmed Resident 2's guardian stopped the ACH payment and stated s/he would	N 214		

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N 214	Continued From page 2	N 214		

send a check going forward. Resident 2 was charged 2 insufficient fund charges. Director B was unable to provide documentation that Resident 2 was refunded for the insufficient fund charges. Director B provided a copy of the ACH agreement dated 05/28/2025. The agreement provided the bank, routing number, account number and Resident 2's name, with the monthly transaction amount to be withdrawn.

Surveyors identified the following concerns:

Environment:
- The provider did not ensure a safe, clean, comfortable and homelike environment was provided.
- The provider did not ensure grass and landscaping was maintained.
- The provider did not ensure bathrooms and shower/tubs were functional.

Resident Care:
- The provider did not ensure an adequate supply of food was provided to residents.
- The provider did not ensure a weekly menu was posted and followed.

On 05/11/2026 at 2:00 PM, Surveyors interviewed Director B. Director B acknowledged the issues with Administrator F and stated Licensee D had informed him/her there was a new management company starting on 05/12/2026. Director B stated a volunteer brought food in so the residents had food to eat. S/he also reported the volunteer will also cook and help in the kitchen when they are short staffed. Director B acknowledged staff are not always paid when they should be and that Administrator F's company hasn't reimbursed the staff/volunteer for items they purchased for the residents.

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N 214	Continued From page 3 The administrator did not supervise the daily operation of the CBRF to ensure that personnel, finance and physical plant needs were satisfied.	N 214		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff interviews, the provider did not ensure 12 of 12 resident's medications were securely stored. Findings include: The provider is licensed to provide services for up to 15 residents who may be advanced age and/or have irreversible dementia/Alzheimer's. The census at the time of Surveyors onsite visit to the facility was 12. On 05/11/2026 at 11:30 AM, Surveyors entered the facility and observed 1 medication cart sitting in the dining room area near the kitchen. The medication cart was unlocked and there were no staff near the cart. Surveyors observed Caregiver A in the kitchen preparing a lunch meal. Surveyor opened the medication cart and observed resident scheduled and as needed prescription medications. At 12:00 PM and 2:20 PM, Surveyor observed visitors in the dining room area and an unlocked medication cart. At 12:15 PM, Surveyors observed residents	N 419		

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N 419	Continued From page 4 eating lunch in the dining room and an unlocked medication cart. At 2:55 PM, Surveyors interviewed Director B who acknowledged the medication cart was unlocked and stated, "You caught us on a bad day." At 3:35 PM, Surveyors observed an unlocked medication cart and the medication keys hanging freely from the locking mechanism. The provider did not ensure resident's medications were securely stored.	N 419		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make the weekly menus available to residents or document deviations on the menu. Findings include: On 05/08/2026, the Department received a complaint alleging the menu was not posted in the common area or otherwise made available to residents.	N 450		

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N 450	Continued From page 5 On 05/11/2026 at 11:30 AM, Surveyors entered the facility and observed pork chops, mashed potatoes and carrots being prepared. Surveyors requested a copy of the menu from Caregiver A. Caregiver A pointed to a pack of paper hanging on the exterior of the refrigerator. Surveyor reviewed the documents and did not observe a weekly menu. Caregiver A acknowledged there was no weekly menu posted and when asked what was being served for dinner, s/he stated, "I'll figure it out after lunch." S/he discussed that many of the meals are based on what ingredients they have available at the time. On 05/11/2026 at 12:15 PM, Surveyors interviewed Director B who confirmed they do not have a weekly menu posted. S/he stated they have 2 food menus, one prepared by a dietitian and the other prepared by the facility. Director B reported, "A lot of residents don't like the dietician menu, so we provide alternatives and make our own menu." S/he also stated, "Supper is on the fly. It's usually something small like soup, salad or a sandwich." Director B discussed they place a grocery order twice per month on the 8th and 18th, but they often run low on "the basics" a week before they are scheduled to order again. S/he stated, "A volunteer spent $200 on groceries last week. We wouldn't have had enough to get us through." Director B reported, "I have to send the grocery bill order amount to [Management Company C] for approval prior to placing the order and I have a hard time getting a hold of them." Director B reported staff have also purchased food items on their own for residents and have not been reimbursed by Management Company C. On 05/11/2026 at 2:21 PM, Surveyors interviewed	N 450		

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N 450	Continued From page 6 Licensee D. Licensee D acknowledged s/he had used Venmo to send money to Director B the week prior, so s/he could purchase food for the residents. The provider did not make the weekly menus available to residents or document deviations on the menu.	N 450		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were adequately safeguarded against unauthorized access or use when electronic records were stored on 2 unsecured laptops in the dining room. Findings include: The provider is licensed to provide services for up to 15 residents who may be advanced age and/or have irreversible dementia/Alzheimer's. The census at the time of Surveyors onsite visit to the facility was 12. On 05/11/2026 at 11:30 AM, Surveyors entered the facility and observed a medication cart and desk area in the dining room. There was one laptop on top of the medication cart and another one sitting on the desk. Both laptops containing resident electronic records were open and accessible to anyone in the facility. There was a document titled "Items that require immediate attention" on both laptop screens and identified 3	N 479		

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N 479	Continued From page 7 shift tasks "Accountability for task completion; Accountability for MAR [medication administration record] completion; and Check laundry." There was an additional task identifying Resident 1 and his/her room number with instructions to "Check call light placement - Ensure call light is within reach." At 12:00 PM and 2:20 PM, Surveyor observed visitors in the dining room area and 2 unsecured laptops. At 12:15 PM, Surveyors observed residents eating lunch in the dining room and unsecured laptops. On 05/11/2026 at 2:55 PM, Surveyors interviewed Director B who acknowledged the laptops containing resident electronic records were not secured. S/he stated, "You caught us on a bad day." The provider did not ensure resident records were adequately safeguarded.	N 479		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was	N 481		

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N 481	Continued From page 8	N 481		

clean, safe, comfortable, well maintained or homelike.

Findings include:

On 05/08/2026, the Department received a complaint alleging concerns with the facility needing repairs.

On 05/11/2026 at 2:05 PM, Surveyors toured the facility accompanied by Director B and observed the following:

Hallways:
- 4 of 4 large rectangular ceiling vents in 2 of 2 hallways were covered in layers of dust
- A ceiling light cover near the laundry room was loose and contained dead insects

Shared shower room (near room 8):
- The toilet leaks water and is not usable
- The walk-in shower had a ceramic tile covering a hole in the floor and covered in soap scum that was dark in color
- There was a black-like substance resembling mold outside of the bottom of the shower near the wall

North Public Restroom:
- A ceiling vent was covered in dust
- The rubber seal on the door of the whirlpool-type tub is not secure and leaks water

Vacant Room 4:
- A ceiling vent was covered in dust
- 1 of 2 windowpanes was secured with tape and the other was unable to be closed/locked

Sunroom
- A green/gray colored recliner chair was missing

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N 481	Continued From page 9 the bottom leg rest exposing metal brackets Exit door (near room 5 and 6): - The bottom of the exit door was missing a piece of weatherstripping approximately 6 to 7 inches in length Dining room: - There were gaps in between pieces of the brown vinyl flooring Lawn: - The grass surrounding the facility was overgrown On 05/11/2026 at 2:55 PM, Surveyors interviewed Director B who acknowledged Surveyors concerns. Director B stated staff assist with cleaning duties and maintenance through Management Company C will come when they have a list of things to fix. Director B confirmed the toilet was not working and the water being turned off, the walk-in tub leaked and was unusable, and the repairs to the walk-in shower were a temporary fix. Director B stated the window in Room 4 fell out during a wind storm and maintenance put the window in using tape. Director B confirmed the grass needed to be cut, but the last 2 companies they used will not come to perform the grass cutting/landscaping as they were not paid. The provider did not ensure a living environment that was clean, safe, comfortable, well maintained or homelike. Cross Reference: N0608 DHS 83.55(1)(a) One Toilet, Sink and Bath or Shower	N 481		

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N 608	Continued From page 10	N 608		
N 608	83.55(1)(a) One toilet, sink, and bath or shower The CBRF shall provide at least one toilet, one sink and one bath or shower for every 10 residents and other occupants or fraction thereof. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a bathing or shower area for every 10 residents in the facility. The facility had 2 bathing rooms; however, only one was usable for 12 residents. The other bathing area was unusable due to a leak. Findings include: On 05/08/2026, the Department received a complaint alleging concerns with resident bathing areas. The provider is licensed to provide services for up to 15 residents who may be advanced age and/or have irreversible dementia/Alzheimer's. On 05/11/2026 at 2:05 PM, Surveyors toured the facility's bathing areas accompanied by Director B. Surveyors observed the first shower room across from Room 8. There was an "Out of Order" sign posted on the outside of the door. Surveyors observed a white walk-in shower with a dark gray colored ceramic square floor tile secured with white caulk on the bottom of the floor. The tile was raised and was not level to the shower floor. Director B stated staff were using a shower chair to move a resident and the wheel of the shower chair put a hole in the floor of the shower. Director B stated maintenance came and placed a tile over the hole and used caulk to keep it in place. Director B confirmed the out of	N 608		

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N 608	Continued From page 11 order sign was for the toilet that was leaking and the water to the toilet was turned off. Surveyors also observed the "North Public Bathroom" bathing room near the dining room that included a whirlpool-type tub and no shower. The rubber seal on the tub door was hanging off the door and was no longer secured. Director B acknowledged they use the toilet, but they cannot use the walk-in tub. Director B confirmed all 12 residents are utilizing the walk-in shower. The provider did not provide a bathing or shower area for every 10 residents in the facility. Cross Reference: N0481 DHS 83.43(1) Environment Safe, Clean and Comfortable	N 608		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exit passageways were provided with emergency egress lighting with a stand-by-power source for 1 of 1 emergency egress lighting units between rooms 5 and 6 in a common hallway. Findings include: On 05/11/2026 at approximately 2:05 PM, Surveyors toured the facility with Director B. Surveyor tested the egress lighting between Rooms 5 and 6 and it did not work. Director B acknowledged s/he was aware the emergency	N 666		

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N 666	Continued From page 12 lighting unit was not working, as the fire department had been there and identified the concern. Director B stated s/he submitted a request to [Management Company C] at the beginning of April but has not received a response and no authorization to have the emergency light fixed. The provider did not ensure all emergency egress lighting units were in working order.	N 666		