STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525333	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Health Care Center	121 Hospital Dr Watertown, WI 53098

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not report 1 of 4 incidents to the State Survey Agency timely. R4 reported that R2 came in to R4's room on 4/8/24 and R2 touched R4 on the buttock and pulled his pants down. R4 reported this to facility staff on 4/8/24. The facility failed to report non-consensual sexual touching to state agency timely as the facility reported to state agency on 4/10/24. Evidenced by: The facility policy, Abuse, Neglect, And Exploitation, dated 10/01/22, states, in part; .Sexual Abuse is non-consensual sexual contact of any type with a resident .1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies .within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . R2 was admitted to the facility on [DATE] with diagnoses that includes, dementia with other behavioral disturbance, cognitive communication, and unsteadiness on feet. R2's most recent Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) of 99 indicating R2 is severely cognitively impaired. R2 has an activated power of attorney. R2's Comprehensive Care Plan states, in part; .may get confused/agitated or get nervous and anxious: in new surroundings, when left alone .presents as confused, but agreeable/positive typically. Does get agitated and curse but is redirect-able. Has made statements indicating aggression/aggression towards self, but out of context and res immediately moves on. Conversation is non-linear. Date: 1/19/24 .Approach me from the front and address me by name. Call me by name or touch/hold my hand. That makes me feel secure. If I don't like what I'm doing, let me choose something else. If I'm upset, please re-direct the conversation or task. Involve me in tasks that make me feel useful. Please avoid things that make me more anxious. Date: 1/19/24 Sometimes demonstrate sexually inappropriate behaviors exhibited by disrobing in public, disrobing in other resident's room, inappropriate touching, sexual comments, thinking another resident is his girlfriend, making comments saying, Oh your no fun Date: 4/9/24 .I will interact with others appropriately during social and care situations. Date: 4/9/24 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observed R2 on 4/22/24 at 2:30PM in the common living room area. Surveyor observed R2 watching T.V., appropriately dressed, and smiling. R2 showed Surveyor the living room area and was talking about the T.V. R2 was unable to form complete sentences. Surveyor observed R2's bedroom on opposite unit from R4's bedroom. R2's interactions with Surveyor were appropriate and Surveyor observed multiple staff in line of sight of R2. R4 was admitted to the facility on [DATE] with a diagnoses that includes, anxiety disorder, depression, respiratory failure, heart failure, and chronic pain syndrome. R4's most recent MDS, dated [DATE], indicates a BIMS of 15 indicating R4 is cognitively intact. R4 is her own person. R4's Comprehensive Care Plan states, in part; My safety is at risk and there is a potential for abuse due to: R4 being in a safe place for another resident that has sexual comments, buying this other resident snacks and food, allowing this other resident to come into her room to talk. R4 states she feels bad for this resident and likes that this other resident comes to her to talk. Date: 4/9/24. I will be kept safe and free from abuse through my next review .Educate R4 to stay away from resident R2. Education provided to R4 to not buy things for resident. Education provided to not allow this other resident into room. If resident wants to talk in the common areas where staff are present. Inform staff if feeling unsafe. Please keep others out of my room that don't belong there. Date: 4/9/24 . On 4/22/24 at 2:40 PM, R4 indicated she expected that someone from state would want to discuss incident from 4/8/24. R4 indicated R4 feels fine and stated, To be honest, I don't want you (Surveyor) here. R4 indicated R4 has zero concerns with the situation with R2. R4 indicated R2 came into R4's bedroom on 4/8/24 and touched her buttock and pulled his pants down. R4 indicated R4 does not feel scared or fearful. R4 indicated she feels bad for R2 because R2 has dementia and is lonely. R4 indicated she would talk to and help out R2. R4 indicated her bedroom was moved and that the facility encouraged R4 to talk to R4's psych NP (Nurse Practitioner). R4 has no concerns with the follow up from the incident and feels safe at the facility. Surveyor reviewed facility self-report and investigation. Facility self-report states, in part; . Is date and time when occurred known? Yes. Date occurred .4/8/24. Time occurred 07:30PM. Is occurred date and time estimated? Yes. Date discovered 4/10/24. Briefly describe the incident .- 4/8/24 PM shift: Writer was informed R4 was laying on her stomach in her bed video chatting with her kids and R2 came into R4 room and touched her on the buttock and then proceeded to pull his pants down. R4 was able to redirect R2 out of her room .4/8/24 AIT (Administrator in Training) went to speak with R4 who states to AIT she knows he (R2) is confused; she does not feel hurt, sexually assaulted, or have any physical and emotional pain. Facility put R2 on 15-minute watch. R4 was offered a new room off the same unit as R2 . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24 at 3:05 PM, SW J (Social Worker) indicated she is aware of the incident between R2 and R4. SW J indicated she has had several conversations with R4 regarding the incident and completed a trauma assessment. SW J indicated she asked R4 how she was feeling and if she felt safe at the facility. SW J indicated SW J left early on 4/8/24 and the incident was reported to her later in the day on 4/9/24. SW J indicated SW J started her part of the process on 4/9/24. SW J indicated R4 told her she felt safe and feels bad for R2 because R2 has dementia. SW J indicated R4 talked about past trauma regarding R4's father. SW J indicated R4 told SW J that she would like to talk to the psych NP and that the psych NP was in the building on 4/10/24. R4 shared with NP additional information on 4/10/24 which resulted in the facility to believe an investigation needed to be started at that time. The facility submitted the self-report to the state agency on 4/10/24, after they received additional information from the psych NP. On 4/22/24 at 3:10 PM, DON B (Director of Nursing) indicated a self-report was not sent to state agency because an investigation was not started on 4/8/24. DON B indicated on 4/8/24 they immediately talked with R4 after learning about the incident, implemented 15-minute checks for R2, and offered R4 to move rooms. DON B indicated R4 told facility she was not scared, did not view what occurred as sexual assault, and declined to change rooms. DON B indicated R4 talked with psych NP on 4/10/24 and shared that she did feel sexually assaulted and has PTSD (Post-Traumatic Stress Disorder) from past relationships. Psych NP shared this information with the facility, and the facility started an investigation and sent state agency self-report. On 4/23/24 at 9:35AM, ANHA C (Assistant Nursing Home Administrator) indicated he talked with R4 on 4/8/24 right after R4 reported the incident to facility staff. ANHA C indicated he asked R4 if she felt safe, was experiencing trauma from incident, if she had been physically/emotionally/mentally harmed by the incident, and R4 indicated she was not. R4 indicated she is friends with R2. ANHA C indicated R4 did not view the incident as sexual assault, therefore, a report to the state agency was not submitted. The facility did implement 15-minute checks and offer R4 to move rooms on 4/8/24. The psych NP shared additional concerns that R4 shared with NP on 4/10/24, and the agency sent in report to state agency at that time. ANHA C indicated the facility followed the Resident-to-Resident Altercation flow chart. Surveyor and ANHA C reviewed SOM (State Operations Manual) Examples of Sexual Contact Flow chart. Examples of Sexual Contact Flow chart, states, in part; .Required to Report .Unwanted touching of the breasts or perineal area . Surveyor asked if it was unwanted touching and ANHA C indicated it was unwanted. ANHA C indicated R4 did not view the incident as sexual assault and when it was reported R4 felt it was sexual assault the facility started investigation and reported it to state agency. The facility failed to report an allegation of non-consensual sexual touching to the state agency within the appropriate time frame.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on interview and record review, the facility did not ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed (R1). R1 has known self-injurious behavior and the facility did not ensure measures were in place to protect him from further accidents and self-injurious behavior. Findings include R1 was admitted to the facility on [DATE] and has diagnoses that include anxiety, depression and quadriplegia. R1's most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 14, indicating R1 is cognitively intact. R1 was discharged from a local hospital to the facility. His discharge diagnoses include Polysubstance abuse, history of cocaine abuse and marijuana use. R1's care plan states, Focus: .has been intoxicated from alcohol and cannabis during stay here .has tested positive for Fentanyl (Narcotic) and THC (Tetrahydrocannabinol/Marijuana) on a drug screen .Interventions: Attempt interventions before my behaviors begin . AODA (Alcohol Other Drug Abuse) background/history of substance use/abuse and is aware of AODA risks. The facility documented the following progress notes for R1: *11/15/23 at 7:45 AM: History of polysubstance abuse *11/16/23 at 3:50 AM: Resident stated that he was on oxycodone and tramadol while in the hospital and would like it back because he is going through withdrawals. *11/2423 at 2:56 PM: Cocaine abuse, in remission. Past history of cocaine use disorder. *12/28/23 at 1:37 PM: Resident had another ER (emergency room) visit on 12/27 related to hyperglycemia and intoxication On 1/10/24, the facility conducted a drug screen on R1, which came back positive for THC and fentanyl. On 1/22/24, R1 tested positive for THC (results returned 1/26/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/13/24, R1 was found unresponsive in his room. The facility conducted vitals, administered Narcan and sent R1 to the Emergency Department (ED). R1 returned to the facility the same day. Documentation from the ED indicates R1 tested positive for THC, Fentanyl and Cocaine. The facility conducted an investigation that included interviews of staff, which revealed that R1 had been seen in the parking lot with his brother and later the brother was observed in R1's room inside the facility. No staff or residents observed any drug use or illicit materials. The facility also interviewed R1 who stated that his brother gave him a pill. The facility contacted local law enforcement and put a no trespassing order in place for R1's brother on 4/15/24 and stated he was not allowed on the facility property. The facility provided documentation to Surveyors that they had educated facility management on the no trespassing order, but the documentation did not include non-management staff. Additionally, as of 4/15/24, all R1's visitations were to be supervised by staff. It should be noted that R1 did not sign out of the building on 4/13/24 and R1's brother did not sign into the facility as a visitor, according to facility records. Surveyor's interviewed various staff members on 4/23/24 and revealed the following: *CNA E (Certified Nursing Assistant), CNA H, CNA I, and RN F (Registered Nurse) stated there were no resident visitors that were not allowed in the building. *RC D (Receptionist), who sits near the front door, stated all R1's visits needed to be supervised, but stated she was unaware of any resident visitors that were not allowed in the building or on grounds. *LPN G (Licensed Practical Nurse) stated she was aware that R1's brother was not to visit but did not know what he looked like. On 4/23/24 at 11:10 AM, ANHA C (Assistant Nursing Home Administrator) stated that property included the facility's parking lot. ANHA C stated that all facility management staff were educated on the no trespassing order on R1's brother and that the front desk is staffed Monday through Friday from 8:00 AM to 8:00 PM and on the weekends from 9:00 AM to 5:00 PM. After this time the doors are locked. When asked how the facility would keep R1 from potentially passing drugs in the parking lot as he did on 4/13/24, ANHA C stated he was unsure. The facility was aware the R1 has a history of drug abuse prior to admission to the facility and, while under their care, has tested positive for alcohol and drugs multiple times, engaging in self-injurious behavior. When the facility became aware R1's brother was on the property providing R1 with drugs, the facility put measures into place to try and prevent further visits from R1's brother but did not educate, alert, and notify all staff of R1 required this supervised measure to prevent further drug use.