

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038</p> <p>Based on interview and record review, the facility failed to protect a resident's right to be free from verbal/mental abuse by a Certified Nursing Assistant (CNA). This affected 1 of 4 residents (R1) reviewed for abuse.</p> <p>R1 had a verbal altercation with CNA C (Certified Nursing Assistant) which led CNA C to become angry and persevere on the altercation. CNA C then wrote a letter to R1 telling him that she was going to kill him.</p> <p>The facility's failure to keep residents safe from verbal/mental abuse created a finding of Immediate Jeopardy that began on 5/26/24. The Administrator was informed of Immediate Jeopardy on 6/11/24 at 1:26 PM. The immediate jeopardy was removed and corrected on 5/27/24. This is being cited as past noncompliance.</p> <p>Evidenced by:</p> <p>The facility's policy titled Abuse, Neglect, and Exploitation dated 10/1/22, states in part 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. Definitions: .Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .</p> <p>R1 was admitted to the facility on [DATE] with diagnoses that include encephalopathy (a broad term for any brain disease that alters the brain function or structure), type 2 diabetes mellitus, hallucinations, and congestive heart failure (CHF; a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). R1's most recent Minimum Data Set (MDS) dated [DATE] states that R1 had a Brief Interview of Mental Status (BIMS) of 10 out of 15 indicating that R1 has moderate cognitive impairment. R1's MDS also indicates that R1 is dependent on staff for transfers, toileting, and dressing. R1 is wheelchair bound.</p> <p>On 5/26/24, R1 had a verbal altercation with CNA C. R1 had yelled at CNA C for not closing his door. This led to CNA C becoming quite upset and repeatedly telling her co-workers about the incident.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525333
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/27/24, R1 found a note in his room that stated: [R1] don't f***ing swear at me about closing the door and if you ever yell and swear at me again I will f***ing kill you due to man like you who is mental retard due to causing drama for no reason and don't take order from man like you. I don't like you and I hope you drop dead someday. {sic}</p> <p>R1 showed the note to a CNA, who reported the note to the Licensed Practical Nurse (LPN), who then gave the note to the Director of Nursing (DON).</p> <p>On 5/27/24, the facility began an investigation. Witness statements are as follows:</p> <p>CNA D writes in part, On Sunday, May 26th, a CNA, [CNA C] approached me, very upset, stating that R1 cussed her out for not shutting his door. These are things that were said to me by CNA C throughout remainder of out PM (evening) shift. CNA C repeatedly (emphasis intended) told me the story. She said that he has ruined her happiness of the day and that she doesn't deserve it because she didn't do anything wrong. She repeatedly told me how angry she was, literally over and over. She said, no one will talk to me like that and that as long as she doesn't hit or shoot anyone, she will be ok. She said she was going to stand up for herself .I tried de-escalating her thoughts numerous times. I told her that I get cussed at sometimes too, and that it happens to everyone. She did not want to hear any of that. I could sense the anger was brewing .I said that we cannot allow ourselves to become reactive to behaviors. She then went back and literally repeated the entire story .Upon clock out time, downstairs by the time clock, CNA C was still carrying on about how R1 had ruined her night, the whole story, literally all over again .The nurse and I discussed her behaviors, and I clocked out and went to my car.</p> <p>Statement from LPN E was obtained by DON B via a telephone call is as follows, On Sunday night 5/6/24 CNA C got very angry and upset about R1 being mean and swearing at her. CNA C asked LPN E if she doesn't hit or swear at other residents, was there anything else she shouldn't do. LPN E told CNA C even the tone of voice can be a problem and not okay. CNA C got upset with LPN E. CNA C then went to CNA D and was talking about how R1 was swearing at her.</p> <p>Statement from CNA F states, On 5/26/24 when picking up supper trays, CNA C came to the nurse's station stating she didn't understand why R1 swore at her. He never swore at me before. He was swearing because I didn't close his door. She continued on about him swearing at her and was telling other staff member how he was swearing at her. She was still talking about when I left my shift at 8 PM.</p> <p>It is important to note that Surveyor called and left messages for CNA D and LPN E and has not received return calls.</p> <p>Statement from CNA G states in part, .I was walking through the hallway and resident called me over to help him and turn off the A/C (air conditioner), while I was leaving the room, he asked me who the manager was of this place and told me that someone hates me here he was in his wheelchair and pulled out the note from his dresser. So, I asked the [sic] from across the hall to help me and I handed her the note.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Statement from LPN H states in part, [CNA] alerted writer that R1 had a letter in his room that was threatening resident. Writer went to resident's room and reported the letter to DON B immediately. Writer asked resident when he noticed the letter, resident stated after lunch, but it could have been before lunch. Resident stated the letter was in his chair on top of clothes next to his sink .Writer asked resident if there was any staff who he may have yelled at, or any staff who seemed upset, resident stated no, I yell at everyone to close my door and they always leave it open. Resident asked if there is any staff he does not get along with, resident stated no. Resident asked if there is any staff he does not like? Resident stated no. Resident stated, Surprisingly this weekend no one's been an issue. Resident asked if he feels scared for his safety. Resident stated No, I wish they would come see me, I have lived in scarier places in my life.</p> <p>It should be noted that R1 has a BIMS of 10, an activated healthcare power of attorney, and a diagnosis including encephalopathy. R1's response to the threatening letter is incongruent to how a reasonable person would respond to receiving a letter in their home that threatens to kill them and humiliates them, especially if the individual were dependent on others to provide daily care for them. A reasonable person would have extreme fear, anxiety, and feel humiliated by the threat and derogatory language used in the letter.</p> <p>Statement from CNA C on 5/27/24 states:</p> <ol style="list-style-type: none"> 1. Not in my computer 2. Walked in hallway and went to his room to check on him and he was okay in bed. I turn around and I saw the letter on the chair and that's when I touched the paper, when I did however glance a little bit to know the first sentence was, I got scared and walk away from his room. 3. Later on, the PM shift is when other staff saw the letter on the chair and took it with them, to the nurse station to figure out who did the typing the letter about [R1] death wish. I did touch it again to see the whole story about the letter, but they saw it first in the nurse station first before I touch it again. 4. I never did type and print the letter. {sic} <p>On 5/28/24, NHA A (Nursing Home Administrator) called the local police department. PO I (Police Officer) responded to the call. PO I's report states that he spoke with NHA A who suspected that CNA C wrote the letter, but at this time was unable to prove it and that CNA C quit when she was being questioned about leaving the note. PO I spoke with R1 who stated that he did not want a complaint and did not feel scared. R1 just wanted the information documented. NHA A reported that CNA C would not be hired back at the facility and currently lives in [city name].</p> <p>On 5/29/24, NHA A requested that CNA C bring in her personal laptop so they could search it for any indication that she wrote the letter. CNA C complied and brought the computer to the facility. The Administrative Assistant looked through the computer and it appeared that it had been dry erased. Per the facility's investigation summary, the Administrative Assistant spoke with CNA C again, and eventually CNA C confessed to writing the letter. CNA C reported to the facility administration that she was having mental health issues.</p> <p>Statement from CNA C on 5/29/24 states:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>+ Went to library in [city name] for typing the letter to make the point to him about him yelling at me about closing door and I got carry away with it and I'm very, very sorry about the whole situation about the incident.</p> <p>+ I don't hate him, and we never argue either. His did yell at me by accident due to him having bad day.</p> <p>+ I will never do that ever again. This is only incident that I dealt with only.</p> <p>+ I wish nothing would happen to him at all. I'm so glad he is safe and sound. I don't think he is mean person. {sic}</p> <p>On 6/10/24 at 9:59 AM, Surveyor interviewed R1. Surveyor asked R1 about the letter he received, R1 reported that the letter said, I want to kill you and You should die. Surveyor asked R1 what he did once he found the letter, R1 stated that he gave it to someone in charge. R1 also reported to Surveyor that the police came and asked him some questions. Surveyor asked R1 how receiving the letter made him feel, R1 stated, I didn't give a s**t. I was a little worried because I'm in a wheelchair, if they wanted to kill me, they probably could. R1 reported to Surveyor that he feels safe and is not fearful of staff.</p> <p>On 6/10/24 at 1:28 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if CNA C was terminated, NHA A stated that CNA C was suspended and required to seek treatment for her mental health issues prior to returning to work.</p> <p>On 6/10/24 at 3:36 PM, Surveyor interviewed PO I. Surveyor asked PO I about his investigation regarding the letter that R1 had received, PO I stated that he came to the facility and spoke with R1 and NHA A and at that point there was no proof that CNA C had written the letter, therefore there was nothing else he could do. Surveyor asked PO I what R1's response was to the letter, PO I stated that R1 reported that he was not scared, was not in fear, and was not intimidated by the letter. PO I reported that NHA A updated him that CNA C had confessed to writing the letter, but neither R1 nor the facility wanted to press charges. Surveyor asked PO I if a threat, like the one R1 had received, would be criminal in nature, PO I stated, with a victim, yes it would be.</p> <p>On 6/13/24 at 1:05 PM, Surveyor interviewed LPN H. Surveyor asked LPN H to recall the day she was made aware of the letter, LPN H stated that she was at the nurse's station and a CNA asked her if she had heard about the letter. LPN H stated that she had not and accompanied the CNA to R1's room, read the letter, and then immediately called DON B. LPN H stated that she questioned R1 about the note, if he felt safe, and if he knew where the note came from. Surveyor asked LPN H what time she was made aware of the note, LPN H stated that it was around 8:00 PM. Surveyor asked LPN H if she had worked with CNA C in the past, LPN H stated yes. Surveyor asked LPN H if CNA C had displayed behaviors in the past, LPN H stated never, and she was shocked when she found out that CNA C had written the letter.</p> <p>R1 is dependent on staff for all care. R1 received a letter threatening to kill him and used derogatory language toward R1. A reasonable person would have extreme fear and anxiety if they received a letter in their home stating a subject wanted to kill them and would be humiliated with the use of derogatory language.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's failure to prevent and protect residents from verbal/mental abuse created a reasonable likelihood for serious harm to occur and a finding of Immediate Jeopardy. The facility removed and corrected the immediate jeopardy on 5/27/24 when it completed the following:</p> <ol style="list-style-type: none"> 1. Initiated immediate investigation. 2. Trauma assessment completed for R1 3. PHQ9 (Depression screening) assessment for R1. 4. Completed a new BIMS for R1. 5. Abuse Policy education to all staff. 6. R1's care plan was updated. 7. Placed R1 on 15-minute checks. 8. R1 was placed on the 24- hour board to monitor psychosocial well-being. 9. Interviewed residents and staff regarding abuse. 10. Complete skin checks on residents who were not able to be interviewed. 11. Suspended alleged employee. 12. Education to all staff to immediately notify management if they have a concern regarding staff burnout.

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038</p> <p>Based on interview and record review, the facility did not ensure that all alleged violations involving abuse are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials for 1 of 4 sampled residents (R1) reviewed for abuse.</p> <p>R1 received a life-threatening letter from a facility Certified Nursing Assistant (CNA), the facility failed to report the incident to the State Agency (SA)</p> <p>This is evidenced by:</p> <p>The facility's policy titled Abuse, Neglect, and Exploitation dated 10/1/22, states in part .Definitions: .Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .VII .1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in 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 .</p> <p>R1 was admitted to the facility on [DATE] with diagnoses that include encephalopathy (a broad term for any brain disease that alters the brain function or structure), type 2 diabetes mellitus, hallucinations, and congestive heart failure (CHF; a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). R1's most recent Minimum Data Set (MDS), dated [DATE], states that R1 had a Brief Interview of Mental Status (BIMS) of 10 out of 15 indicating that R1 has moderate cognitive impairment. R1's MDS also indicates that R1 is dependent on staff for transfers, toileting, and dressing. R1 is wheelchair bound.</p> <p>On 5/26/24, R1 had a verbal altercation with CNA C (Certified Nursing Assistant). R1 had yelled at CNA C for not closing his door. This led to CNA C becoming quite upset and repeatedly telling her co-workers about the incident.</p> <p>On 5/27/24, R1 found a note in his room stating, [R1] don't f***ing swear at me about closing the door and if you ever yell and swear at me again I will f***ing kill you due to man like you who is mental retard due to causing drama for no reason and don't take order from man like you. I don't like you and I hope you drop dead someday. {sic}</p> <p>On 5/27/24, the facility started an investigation. The facility interviewed residents and staff, called the police, but did not report the incident to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/24 at 1:28 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if he reported this incident to the State Agency, NHA A stated no, because the resident didn't feel abused and felt safe. NHA A reported that he used the algorithm to determine whether to report or not. Surveyor requested to see the algorithm used. NHA A provided the algorithm for Resident-to-Resident abuse.</p> <p>The facility never reported verbal/mental abuse to the State Agency.</p>		