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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure each resident receives care, consistent with professional standards of practice (SOP) to prevent pressure injuries (PI) and each resident with PIs receives necessary treatment and services, consistent with professional SOP, to promote healing, prevent infection, and prevent new injuries from developing in 1 of 4 sampled residents (R1). R1 admitted with no pressure injuries and was identified to be at risk for PI development. R1 developed an unstageable pressure injury. The facility failed to put aggressive measures in place to promote healing, prevent infection, and to prevent new PI from developing. Evidenced by: Facility policy, titled Pressure Injury Prevention Guide, dated 2016, includes: . it is the policy of the facility to implement evidence based interventions for all residents who are assessed at risk or who have a pressure injury present . individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment . interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used, and for tasks the frequency for performing them . prevention devices will be utilized in accordance with manufacturer recommendations . interventions will be documented in the care plan and communicated to all relevant staff . compliance with interventions will be documented in the medical record . the effectiveness of interventions will be monitored through ongoing assessment of the resident . Repositioning: reposition all residents at risk of, or with existing pressure injuries, . every two hours, using both side lying and back positions . Reposition one in bed and out of bed . Pressure Relieving Devices: the standard mattress for all facility beds are pressure redistribution mattresses with high specification reactive foam . provide alternative support services as needed . (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

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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	R1 admitted to the facility on [DATE] with diagnoses including chronic kidney disease stage 3, muscle wasting and atrophy, muscle weakness, asthma, arthritis, chronic congestive heart failure, and unsteady on feet. R1's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 9/6/24, indicates R1's cognition is intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. His MDS also indicates R1 requires substantial/maximal assistance to meet his needs in the following areas: toileting hygiene, rolling left to right, lower body dressing, putting on/taking off footwear, sitting to lying, and lying to sitting. R1's MDS indicates he is totally dependent on the assistance of staff to meet his needs in the following areas: bed to chair transfer, toilet transfer, and tub/shower transfer. On 10/17/24 at 10:21 AM, RR D (Resident Representative) voiced concerns to Surveyor regarding R1 developing a PI and the facility staff not responding timely to assist R1's need for repositioning/turning, staff leaving R1 in soiled briefs for long periods of time, and R1 not being offered an air mattress. R1's Braden Scale, dated 7/30/24, indicates R1 is at moderate risk for PI development with a score of 14. R1's Comprehensive Care Plan, initiated 7/30/24, includes: Focus- 7/30/24 Potential For Skin Integrity as evidenced by Braden Scale for Predicting PI Risk: High Risk for PI . Goal- initiated 7/30/24, target date 11/16/24 Resident's skin will remain intact . Interventions/Tasks- 7/30/24 educate resident/representative about proper skin care to prevent breakdown . educate resident/representative about proper usage of pressure reducing devices . educate resident/representative on the importance of keeping skin clean and moisturized . evaluate skin integrity, monitor nutritional status, perform objective PI risk tool such as Braden . provide skin care per facility guidelines and as needed . R1's Braden Scale, dated 8/6/24, indicates R1 is at moderate risk for PI development with a score of 16. Of note despite R1 being at risk for PI the facility did not implement aggressive measures to prevent PI development. R1's Skin Assessment, dated 8/13/24, includes: left inguinal region redness noted . right inguinal region redness noted . R1's Nurse Notes, dated 8/18/24, include: Nursing observation, evaluation, and recommendations are: during morning cares resident was found to have an open area to coccyx approximately 1.2 cm (centimeters) x 0.3 cm open area to coccyx area . No bleeding. No drainage noted. No odor noted. No signs and symptoms of infection this time . Area cleaned with soap/water. Zinc applied and covered with foam dressing. Resident encouraged to offload weight when possible. Wound nurse C informed of new concern. Primary Care Provider notified and responded with the following feedback: notify wound nurse C and continue current wound treatment. R1's Braden Scare, dated 8/20/24, indicates R1 is at risk for PI development with a score of 17. R1's Specialty Physician Wound Evaluation and Management Summary, dated 8/20/24, includes: Patient present with a wound on his coccyx. At the request of the referring provider . a thorough wound care assessment and evaluation was performed today . (continued on next page)

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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Systems: Genitourinary- intermittent incontinence . Support surfaces: bed- group 1 . chair: pressure reduction cushion . Feet: pillow, non-skid socks . Exam: Orientation- oriented to person, oriented to place . Mood and affect- calm, appropriate, content . Focused Wound Exam: unstageable DTI (Deep Tissue Injury) . Etiology- pressure . Duration- greater than 3 days . Objective- healing/maintain healing . Wound size- 1.5 cm x 0.3 cm x 0.2 cm . Surface area- 0.45 cm squared . Exudate- light sero-sanguinous . Recommendations-off-load wound, reposition per facility protocol, group 2 mattress, upgrade offloading chair cushion . Evaluation by wound care specialist within 7 days with further intervention as indicated . R1's Grievance, dated 8/25/24, includes: R1's wife was upset that her husband had his call light on for 45 minutes and he ended up having an accident within that time. R1's Grievance, dated 8/26/24, includes: R1's wife was upset that call light was on for 45 minutes, then while investigating wife had an issue with call light wait time on 8/26/24 . R1's Weekly Skin Impairment and Wound Evaluation, dated 8/27/24, includes: unstageable DTI to the coccyx . wound identified 8/18/24 . pressure ulcer . unstageable: full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed . Visible tissue : 100 percent slough tissue present . Drainage: moderate amount of serosanguineous . Odor present: No . Measurement: 1.5 cm x 0.3 cm x 0.2 cm . Any signs of potential infection: No . Wound/Skin Impairment is unchanged . R1's Specialty Physician Wound Evaluation and Management Summary, dated 9/3/24, includes: Patient present with a wound on his coccyx. At the request of the referring provider . a thorough wound care assessment and evaluation was performed today . Review of the Systems: Genitourinary- intermittent incontinence . Support surfaces: bed- group 1 . chair: pressure reduction cushion . Feet: pillow, non-skid socks . Exam: Orientation- oriented to person, place, time, and situation . Mood and affect- calm, content. Cooperative . Focused Wound Exam: stage 3 pressure wound coccyx full thickness . Etiology- pressure . Duration- greater than 17 days . Objective- healing/maintain healing . Wound size- 1.0 cm x 0.3 cm x 0.2 cm . Surface area- 0.30 cm squared . Exudate- moderate sero-sanguinous . Recommendations-off-load wound, reposition per facility protocol, group 2 mattress, upgrade offloading chair cushion . Evaluation by wound care specialist within 7 days with further intervention as indicated . (It is important to note the recommendations made on 8/20/24 for a group 2 mattress and to upgrade offloading chair cushion. It is also important to note the physician's observation this visit, 9/3/24, of R1 having a group 1 mattress and a pressure reduction cushion and again the recommendations of a group 2 mattress and to upgrade R1's offloading chair cushion.) (continued on next page)

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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 at 10:21 AM, during an interview, RR D (Resident Representative) indicated R1 was left for long periods of time without assistance in changing positions or with incontinence care after an incontinent episode. RR D indicated the police department has been called due to R1 not being able to get help or reach his call light to signal help. RR D indicated R1 was on the same mattress throughout his stay, even after a PI was discovered. R1's Comprehensive Care Plan, dated 10/17/24, initiated 7/30/24, includes: Focus- 7/30/24 Potential For Skin Integrity as evidenced by Braden Scale for Predicting PI Risk: High Risk for PI . Goal- initiated 7/30/24, target date 11/16/24 Resident's skin will remain intact . Interventions/Tasks- 7/30/24 educate resident/representative about proper skin care to prevent breakdown . educate resident/representative e about proper usage of pressure reducing devices . educate resident/representative on the importance of keeping skin clean and moisturized . evaluate skin integrity, monitor nutritional status, perform objective PI risk tool such as Braden . provide skin care per facility guidelines and as needed . (It is important to note the facility did not update R1's comprehensive care plan to reflect R1's open wound and aggressive measures/interventions to be implemented when R1 was found to have an unstageable PI.) On 10/17/24 at 1:30 PM, during an interview, Med Tech E indicated she recalls providing care to R1 but does not recall if the facility changed his mattress throughout his stay. Med Tech E indicated when a resident develops a PI, the care plan should be updated with new interventions and goals to promote healing, such as repositioning the resident more often. On 10/17/24 at 1:32 PM, RN F (Registered Nurse) indicated R1 spent a lot of time in his chair and not so much time in his bed. RN F indicated R1 needed the assistance of two staff for transfers and bed mobility. RN F indicated she did not recall if R1's mattress was changed during his stay. RN F indicated R1's care plan should have been updated when the PI was noted to include a new goal and interventions to promote healing and prevent infection. On 10/17/24 at 1:41 PM, during an interview, RR G indicated she was in to visit R1 daily. RR G indicated staff would be aware of R1 having had an incontinence episode but would not assist him. RR G indicated R1 requires 2 staff to transfer and many times there were not 2 staff available to assist. RR G recalled a time R1 had his call light on, due to an incontinence episode, for 45 minutes. When staff came in, they de-activated the call light and left the room to retrieve another staff member. R1 waited 10 minutes and put his call light on again. This time one staff came in with his meal tray and told him to eat and then the staff would assist him with incontinence care. RR G indicated R1 was left in a dirty brief for over an hour and expected to eat his meal with a dirty brief on. RR G indicated R1's mattress was a foam mattress and was not an air mattress and this is the mattress R1 had throughout his stay. On 10/17/24 at 1:45 PM, during an interview, R1 stated, I was given a bed when I got there and that is the one I had until I left. R1 indicated many times he called for assistance with toileting needs or repositioning needs and was left to wait for long periods of time. R1 indicated he was left in soiled briefs for long periods of time also. (continued on next page)

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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 at 2:00 PM, DON B (Director of Nursing) indicated when staff became aware of R1's PI, his care plan should have been updated. DON B indicated she would like to see turning and repositioning frequency on care plan, air mattress added, and chair cushion updated with dates. DON B indicated R1's skin integrity care plan was created on 7/30/24 and was not updated through his stay. DON B and Surveyor reviewed R1's Physician Wound Evaluation, noting the mattress recommendations on 8/20/24 and on 9/3/24. DON B indicated usually the wound care nurse, the maintenance man, or office support changes out the mattress, but she can't recall if R1's was ever changed from the original foam mattress. DON B and Surveyor reviewed facility policy regarding PI prevention and care. DON B indicated staff should record in resident's medical record the type of devices that are being used and staff are to follow physician recommendations when it comes to devices or interventions.