

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 11/14/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228</p> <p>Based on observation, interview, and record review, the facility did not ensure that self-administration of medications was determined to be clinically appropriate for 1 of 1 supplemental residents (R1) investigated for self administration of medication.</p> <p>Surveyor observed R1 to have medication at bedside. R1 did not have a self-administration of medication assessment completed.</p> <p>Evidenced by:</p> <p>The facility policy, entitled, Resident Self Administration Medication, dated 3/1/20, states, in part: .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; . g. The resident's ability to ensure that medication is stored safely and securely.7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.</p> <p>Example 1</p> <p>R1 admitted to the facility on [DATE] with diagnoses which include, in part: heart failure, unspecified; chronic pain syndrome; and anxiety disorder.</p> <p>R1's MDS (Minimum Data Set) dated 10/22/24, indicates BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 is cognitively intact.</p> <p>R1's Self-Administration of Medication assessment, dated 11/5/24 4:50PM, states, in part: 1. Capable of storing medications in a secure location-marked Fully capable.5. Capable of administering eye drops/ointments-marked Fully capable.12. Capable of administering nasal sprays or drops-marked N/A (Not Applicable).</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
---	-------	-----------

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 11/14/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/5/24 at 3:35 PM, RN O (Registered Nurse) stated that R1 self administers eye drop, Restasis. Surveyor observed multiple single dose vials of Restasis on R1's bedside table.</p> <p>On 11/6/24 at 8:40 AM, Surveyor observed Fluticasone nasal spray, Afrin nasal spray, Restasis eye drops, and artificial tears on bedside table while observing medication administration task with LPN N (licensed practical nurse). Surveyor asked R1 if facility staff had spoken with R1 about self-administration of medication and safe medication storage. R1 stated no. LPN N stated that medications for self-administration needed to be locked when in a resident room.</p> <p>On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that residents are allowed to self-administer medications if they have the appropriate assessment and are deemed safe. DON B indicated that the assessment needs to be done prior to the resident self-administering medications. DON B indicated that self-administered medications kept in a resident's room are to be stored in a locked drawer or a lock box.</p> <p>(Important to note the Self-Administration of Medication assessment for R1 was dated/timed after observation of medication at bedside and RN stating that R1 self administers. Medications were observed sitting on over the bed table at resident's bedside. There was no lock box for medication storage.)</p>

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 11/14/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882</p> <p>Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 2 of 20 residents (R76 and R10) reviewed for MDS accuracy.</p> <p>R76's MDS assessment indicated that R76 discharged due to being deceased while R76 discharged home to the community.</p> <p>R10's Minimum Data Set (MDS) assessment did not indicate R10 had a gradual dose reduction (GDR) on her [DATE] MDS.</p> <p>Evidenced by:</p> <p>Example 1</p> <p>R76 admitted to the facility on [DATE] after a fall at home. She had the following diagnoses severe sepsis secondary to a urinary tract infection from e. coli bacteria.</p> <p>R76's admission assessment, signed [DATE], indicates R76 admitted to the facility for a short-term rehab stay.</p> <p>R76's discharge summary, dated [DATE], includes Patient will be discharged home. She will be provided a 30-day supply of medications. Patient to follow up with primary care provider within 2 weeks and follow up with nephrology. Patient is understanding and agreeable .</p> <p>R76's MDS, with ARD (Assessment Reference Date) of [DATE], indicates R76 discharged from the skilled nursing facility, her return was not anticipated, and this was an unplanned discharge due to deceased status.</p> <p>(It is important to note R76 discharged to the community, but her MDS indicates R76 is deceased .)</p> <p>On [DATE] at 8:49 AM DON B (Director of Nursing) and Corporate RN C (Registered Nurse) indicated R76 discharged home to the community. Surveyor, DON B, and Corporate RN C reviewed R76's MDS section A. DON B stated, We should not have marked deceased . We will have to do an addendum. We will re-educate the staff who filled this section out.</p> <p>On [DATE] at 9:01 AM MDS Coordinator NN indicated the facility staff who completed this section should not have marked deceased and an addendum needs to be made.</p> <p>49436</p> <p>Example 2</p> <p>R10 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, dementia with psychotic disturbance, and anxiety disorder.</p> <p>(continued on next page)</p>

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 11/14/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R10's quarterly MDS (Minimum Data Set) dated [DATE], question section N0450 B: Has a gradual dose reduction been attempted is marked NO, indicating a GDR (Gradual Dose Reduction) has not been attempted. Section N0450 C: Date of last attempted GDR: was not answered.</p> <p>On [DATE], R10's Risperdal oral tablet 0.5 mg was reduced from four times a day to three times a day.</p> <p>R10's physician orders dated [DATE] include Risperdal oral tablet 0.5mg three times a day.</p> <p>On [DATE] at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding the MDS process. DON B indicated the facility follows the Resident Assessment Instrument (RAI) Manual for completing the MDS. DON B indicated the [DATE] quarterly MDS should have been completed correctly to include R10's GDR that was completed on [DATE].</p>

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 11/14/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents (R) received adequate supervision to prevent accidents for 2 of 2 sampled residents (R57 and R56) and 3 supplemental residents (R36, R63, and R35) reviewed for the charging of their electric wheelchairs.</p> <p>R57's electric wheelchair was plugged in and charging in his room.</p> <p>R35's electric wheelchair was in her room along with her charging cord for her electric wheelchair.</p> <p>Surveyor observed R56's power wheelchair charger plugged into the wall in room.</p> <p>Surveyor observed R36's power wheelchair charger plugged into the wall in room.</p> <p>Surveyor observed R63's power wheelchair charger plugged into the wall in room.</p> <p>This is evidenced by:</p> <p>The facility policy Electric Wheelchair Policy, implements 3/8/20, states, in part: Due to the potential for fire or explosion, all electric wheelchairs will be recharged in an area which is not used by the residents for sleeping and which has no oxygen in the vicinity.</p> <p>Example 1</p> <p>On 11/5/24 at 11:34 AM, Surveyor observed R57's electric wheelchair plugged in and charging in his room.</p> <p>Example 2</p> <p>On 11/5/24 at 3:14 PM, Surveyor observed R35's electric wheelchair in her room. The electric wheelchair charging cord was plugged into the wall in her room, although the cord was not plugged into the wheelchair.</p> <p>On 11/4/24 at 2:11 PM, Surveyor interviewed CNA K (Certified Nursing Assistant) about where the facility charges the residents electric wheelchairs. CNA K stated staff charge the residents' electric wheelchairs in their rooms. CNA K stated she was uncertain if the electric wheelchairs should be charged in the residents' rooms or not.</p> <p>On 11/4/24 at 2:15 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) about where the facility charges the residents electric wheelchairs. LPN F stated the facility charges the electric wheelchairs in the residents' rooms.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/4/24 at 2:16 PM, Surveyor interviewed DON B (Director of Nursing) about where the facility charges the residents electric wheelchairs. DON B indicated the electric wheelchairs should be charged in the big room by the shower room on the north wing. DON B indicated they should not be charged in the resident's room because of the batteries.</p> <p>38882</p> <p>Example 3</p> <p>R36 admitted to the facility on [DATE] with Multiple Sclerosis. R36 utilizes a power wheelchair for mobility.</p> <p>On 11/4/24 at 2:00 PM Surveyor observed R36's power wheelchair charging unit to be plugged into an outlet in his bedroom. During an interview COTA HH (Certified Occupational Therapy Assistant) indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms.</p> <p>On 11/4/24 at 2:02 PM R36 stated, They charge it in my room, pointing out the charger unit connected to the outlet in his room.</p> <p>On 11/4/24 at 2:12 PM CNA II (Certified Nursing Assistant) indicated the facility charges all of the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them.</p> <p>On 11/4/24 2:16 PM DON B (Director of Nursing) indicated power wheelchairs should not be charging in resident rooms.</p> <p>On 11/4/24 at 2:24 PM INHA D (Interim Nursing Home Administrator) indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door.</p> <p>Example 4</p> <p>R56 admitted to the facility on [DATE]. R56 utilizes a power wheelchair for mobility.</p> <p>On 11/4/24 at 2:00 PM during an interview COTA HH indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms.</p> <p>On 11/04/24 at 2:04 PM R56 stated, They charge it in the bathroom. Surveyor observed R56's power wheelchair charging system to be connected to an outlet in R56's bathroom.</p> <p>On 11/4/24 at 2:12 PM CNA II indicated the facility charges all the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them.</p> <p>On 11/4/24 02:16 PM DON B indicated power wheelchairs should not be charging in resident rooms.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/4/24 at 2:24 PM INHA D indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door.</p> <p>Example 5</p> <p>R63 admitted to the facility on [DATE]. R63 utilizes a power wheelchair for mobility.</p> <p>On 11/4/24 at 2:00 PM during an interview COTA HH indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms.</p> <p>On 11/4/24 at 2:08 PM Surveyor observed R63's power wheelchair's charging unit to be plugged into the wall in his bedroom. R63 stated, I charge it right in my room, as he pointed to the outlet with the charger connected.</p> <p>On 11/4/24 at 2:12 PM CNA II indicated the facility charges all the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them.</p> <p>On 11/4/24 02:16 PM DON B indicated power wheelchairs should not be charging in resident rooms.</p> <p>On 11/4/24 at 2:24 PM INHA D indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door.</p>

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 11/14/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>Based on interview and record review, the facility failed to ensure the medication regimen was free from unnecessary medications for 1 of 5 residents (R10) reviewed for unnecessary medications.</p> <p>R10 does not have a timely Abnormal Involuntary Movement Scale (AIMS) test.</p> <p>This is evidenced by:</p> <p>The facility policy Use of Psychotropic Med implemented 4/24/24, states, in part: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . Residents who receive an antipsychotic medication will have an AIMS test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN (As Needed) or as per facility policy.</p> <p>R10 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, dementia with psychotic disturbance, and anxiety disorder.</p> <p>R10's physician orders dated 11/7/24 include Risperdal (an antipsychotic medication) 0.5 mg three times a day for Mood disturbance related to dementia.</p> <p>R10 had an AIMS test completed on 10/2/23.</p> <p>Of note, the AIMS test was completed over 1 year ago and R10 should have had at least 3 quarterly assessments in the last year.</p> <p>On 11/7/24 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding AIMS testing. DON B indicated AIMS test should be completed per policy. DON B indicated R10's AIMS test was not completed per policy.</p>		

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 11/14/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228</p> <p>Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 31 opportunities that affected 1 out of 3 residents (R1) included in the medication pass task, which resulted in an error rate of 6.45%.</p> <p>LPN N (Licensed Practical Nurse) did not prime R1's insulin pens before administration. (Of note, if insulin pens are not primed the resident may not receive the correct dose of insulin.)</p> <p>This is evidenced by:</p> <p>The facility policy entitled, Medication Administration, dated 3/1/19, states, in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. (Of note, the facility policy did not contain information on priming of insulin pens)</p> <p>The facility policy entitled, Medication Errors, dated 3/1/19, states, in part: .1. The facility shall ensure medications will be administered as follows: .b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services. 2. The facility must ensure that is free of medication error rates of 5% or greater as well as significant medication events.</p> <p>Manufacturer's recommendations for administration of Fiasp, from the manufacturer's website (https://www.novomedlink.com/diabetes/products/treatments/fiasp/dosing-and-administration/administration-options.html) notes in part: .Priming your FIASP FlexTouch Pen Step 7: Turn the dose selector to select 2 units. Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0:. The 0 must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of insulin, change the needle, and repeat steps 7 to 9. Selecting your dose: Step 10: Check to make sure the dose selector is set at 0. Turn the dose selector to select the number of units you need to inject.</p> <p>R1's Physician Orders state, in part:</p> <p>Fiasp PenFill Subcutaneous Solution Cartridge 100 UNIT/ML (insulin Aspart (with Niacinamide) Inject 20 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS. May use insulin lispro kwikpen until supply is out.</p> <p>Fiasp PenFill Subcutaneous Solution Cartridge 100 UNIT/ML Inject as per sliding scale: if 151-200=2; 201-250=4; 251-300=6; 301-350=8; 351-400=10; 401-450=12; update MD (medical doctor) if BG (blood glucose) <70 (less than 70) or >451 (greater than 451) per [NAME] NP, subcutaneously with meals related to Type 2 Diabetes Mellitus with unspecified complications. May use insulin lispro kwikpen until supply is out.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Insulin Glargine Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject 50 unit subcutaneously every morning and at bedtime for diabetes hold if BG (blood glucose) under 150 or NPO (nothing by mouth)</p> <p>On 11/6/24 at 8:40 AM, Surveyor observed LPN N prepare Fiasp (short acting insulin) and Insulin glargine (long-acting insulin) pens for R1. LPN N applied a needle to Fiasp pen and dialed the pen to 28 units (20-unit initial dose plus 8 units for blood glucose of 332). LPN N applied needle to Insulin glargine pen and dialed the pen to 50 units. LPN N gathered supplies and the dosed pens and turned from cart to proceed into R1's room. Surveyor stopped LPN and asked if the pens were ready for administration. LPN N stated yes. Surveyor asked if anything else needed to be done to the pens prior to administration. LPN N stated no. Surveyor asked if anything need to be done regarding the needle prior to administration. LPN N stated no. Surveyor asked if insulin pens need to be primed prior to administration to ensure proper dosing. LPN N stated that the Fiasp did not, then stated that the insulin glargine did need to be primed. Surveyor asked if either pen had been primed. LPN N stated no. Surveyor asked if all insulin pens need to be primed prior to dialing the dose for administration. LPN N stated yes.</p> <p>On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) and asked about procedure for administering insulin via pen. DON B stated that order needs to be verified, blood sugar needs to be checked, needle needs to be applied and pen needs to be primed. Surveyor asked if nurses are expected to prime insulin pens prior to administration of insulin. DON B stated yes.</p>		

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 11/14/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49434</p> <p>Based on interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 of 1 resident's (R329).</p> <p>R329 had an order for Novolin 70/30 FlexPen (Insulin) and Metoprolol Tartrate 25 MG (Lowers blood pressure), that was not administered on 10/12/24 and 10/13/24, missing a total of two doses of his daily insulin and four doses of his blood pressure medication.</p> <p>This is evidenced by:</p> <p>The facility policy titled, Medication Administration, dated 3/1/19, states in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Guidelines: . 8. Obtain and record vital signs, when applicable or per physician orders . 10. Review MAR (Medication Administration Record) to identify medication to be administered . 14. Administer medication as ordered in accordance with manufacturer specifications . 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR . 19. Report and document any adverse side effects or refusals. 20. Correct any discrepancies and report to nurse manager.</p> <p>The facility policy titled, Medication Error, dated 3/1/19, states in part: . Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders . 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with prescriber's order. Examples include, but not limited to: . ii. Medication omission .</p> <p>R329 was admitted to the facility 10/11/24 and has diagnosis that include in part: fracture of superior rim of left pubis (pelvic fracture), paroxysmal atrial fibrillation, type 2 diabetes mellitus with proliferative diabetic retinopathy, legal blindness, and essential (primary) hypertension.</p> <p>R329's Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/16/24, indicated that R329 has a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that he is cognitively intact.</p> <p>R329's Physician Orders state in part:</p> <p>Novolin 70/30 FlexPen (70-30) 100 UNIT/ML (units per milliliter) Suspension pen-injector Inject 28 unit subcutaneously one time a day for T2DM (type 2 diabetes mellitus) Order Date: 10/12/24.</p> <p>Metoprolol Tartrate 25 MG (milligram) Tablet Give 1 tablet by mouth two times a day for HTN (hypertension) hold if SBP (systolic blood pressure) <110 Pulse <60 Order Date: 10/12/24.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R329's Medication Administration Record (MAR) indicates staff did not administer Novolin 70/30 as ordered on 10/12/24 and 10/13/24. The MAR contains blank spaces for both entries signifying that no dose was administered.</p> <p>R329's MAR indicates staff did not administer Metoprolol Tartrate as ordered on 10/12/24 at 8:00 AM and 6:00 PM, and on 10/13/24 at 8:00 AM and 6:00 PM. The MAR contains blank spaces for both entries signifying that no dose was administered.</p> <p>These omissions resulted in six significant medication errors.</p> <p>Of note: R329 had his blood glucose level checked once on 10/11/24.</p> <p>On 11/5/24 at 10:21 AM, Surveyor interviewed R329. R329 states that he did not receive his insulin for his first two days at the facility.</p> <p>On 11/7/24 at 10:50 AM, Surveyor interviewed RN BB (Registered Nurse). RN BB states she has been working at the facility since March 2024, and always works the day shift on R329's unit. Surveyor asked RN BB when blood sugar should be checked. RN BB stated as ordered, before meals, and before administering insulin. Surveyor asked RN BB if R329 ever refused medications or blood sugar checks. RN BB states, no.</p> <p>On 11/7/24 at 4:24 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when should blood sugar be checked. DON B states, before giving insulin and according to physician orders. Surveyor asked DON B if blood sugars should be checked while administering insulin. DON B states, yes. Surveyor asked DON B what the blank spaces indicate on the MAR. DON B states, it means the medication wasn't signed out. Surveyor asked DON B if medications should be administered according to physician order. DON B states, yes. Surveyor reviewed the missing medications. DON B states she is aware of the issue and investigated the issue finding the order was not transcribed appropriately into the electronic medical record, so the order wasn't available to administer. DON B states she provided verbal education to LPN QQ, who was found to be responsible for the error by the facility. Surveyor asked DON B if she educated all nursing staff to ensure this issue did not reoccur, DON B stated she did not. Surveyor asked DON B if R329's medication should have been administered as ordered. DON B states, yes.</p>		

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 11/14/2024
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552</p> <p>Based on observation, interview, and policy review, the facility did not ensure that all residents receive food at a palatable temperature for 1 of 4 hallways and 1 of 1 test trays.</p> <p>Residents voiced concerns with receiving hot foods cold.</p> <p>Surveyor requested test tray. Hot foods temped cold and cold foods temped warm.</p> <p>R39 and R32 stated the food is cold.</p> <p>Evidenced by:</p> <p>The facility policy, Record of Food Temperatures, with no date, states, in part; .2. Hot foods will be held at 135 degrees or greater .11. No food will be served that does not meet the food code standard temperatures .</p> <p>Example 1</p> <p>On 11/5/24 at 11:40AM, Surveyor requested a meal tray down the 100 hallway. Pork with gravy temped at 114.2 F, potatoes 124.7 F, and red juice temped at 50.1 F. Hot foods were cold and drink was warm.</p> <p>On 11/6/24 at 4:58PM, DM R (Dietary Manager) indicated DM R completes weekly audits on room meal trays. DM R indicated the food temperatures really depend on the resident's personal preference. DM R indicated understanding when Surveyor shared the food temperatures from the meal tray and resident voices regarding hot foods served cold and cold foods served hot. DM R indicated the facility does have the bottom plate for the hot plates, but they are not using them because the bottom plate makes it more difficult for residents to be able to eat if they are eating in their beds.</p> <p>50228</p> <p>Example 2</p> <p>R39's MDS (Minimum Data Set) dated 9/19/24, indicates R39 has BIMS (Brief Interview for Mental Status) score of 15, indicating R39 is cognitively intact.</p> <p>On 11/5/24 at 9:54 AM, Surveyor interviewed R39 during initial screening. R39 indicated that food is cold when receiving meal trays in room.</p> <p>Example 3</p> <p>R32's MDS dated [DATE] indicates R32 has a BIMS score of 15, indicating R32 is cognitively intact.</p> <p>On 11/5/24 at 10:37 AM, Surveyor interviewed R32 during initial screening. R32 indicated that food is cold when receiving meal trays in room.</p>		

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 11/14/2024
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 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882</p> <p>Based on interview and record review, the facility did not implement an established process of assessing a resident's cognitive ability to understand an arbitration agreement before obtaining a signature for residents; and did not ensure the staff responsible for the arbitration agreement had complete understanding of an arbitration agreement and was able to thoroughly explain the agreement for complete resident/reasonable party understanding. This deficient practice had the potential to affect all 71 residents who resided in the facility and went through the admission process as arbitration agreements is part of the facility's admission process.</p> <p>R25, R12, R128, R129 and R72's resident representative voiced concerns regarding not fully understanding the arbitration agreement they signed upon admission to the facility. R25, R128, and R129 indicated they wanted to revoke their arbitration agreement.</p> <p>RR OO indicated the arbitration agreement was not explained to him fully and he would not have wanted to sign the agreement if he knew he was signing away constitutional rights to use the judicial system to resolve disputes with the facility.</p> <p>Evidenced by:</p> <p>Facility policy, titled Binding Arbitration Agreement, dated 10/1/22, includes: The facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, this facility. Arbitration is a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments . binding arbitration is a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final can be enforced by a court and can only be appealed on very narrow grounds. Judicial proceeding is any action by a judge formally before the court including trials, hearings, petitions, or other matters . when explaining the arbitration agreement the facility shall explicitly inform the resident or his representative of his or her right not to sign the agreement as a condition of admission . Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands . ensure a resident or his or her representative acknowledges that he or she understands the agreement . the agreement must: provide for the selection of a neutral arbitrator agreed upon by both parties . provide for selection of a venue that is convenient to both parties . explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it . explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission . the agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials .</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Alternative dispute Resolution Agreement form, dated 3/2020, includes: arbitration is a method of resolving disputes without the substantial time and expense of using the judicial system. Disputes resolved through arbitration generally resolve more quickly than disputes resolved through civil litigation, which generally takes years to complete. By avoiding the judicial system many costs are eliminated. There are charges and fees involved in arbitration, but an arbitration hearing will generally resolve a dispute sooner and at less cost than a trial. It is important to understand however that there is only a limited right to appeal an arbitration award. Unless there is evidence of fraud on the part of the arbitrator or a serious procedural defect, an arbitration award will be final. Of course, the facility also agrees to be bound by the arbitrator's decision. This alternate dispute resolution agreement is optional. Admission to the facility is not conditional on the residents willingness to enter into this agreement. By signing this alternate dispute resolution agreement, you are giving up your constitutional right to a jury or court trial . if this agreement has been read on behalf of the resident by an authorized representative or agent of the resident the representative or agent has explained to the resident, to the extent of the resident's capability to understand such explanation, the nature of this agreement and its essential terms. The resident understands that he or she has the right to seek legal counsel concerning this agreement; the execution of this agreement is not a precondition to admission expedited admission or the furnishing of medical services to the resident buy the facility; and this alternative dispute resolution agreement may be revoked by providing notice to the facility from the resident within 10 days of signature. If not revoked within 30 days this agreement shall remain in effect for all care and services rendered at the facility, even if such care and services are rendered following the residents discharge and re admission to the facility .</p> <p>Facility's admission welcome packet includes an arbitration agreement with 28 pages.</p> <p>Example 1</p> <p>R25 admitted to the facility on [DATE].</p> <p>On 11/07/24 at 3:36 PM R25 and Surveyor reviewed R25's signed arbitration agreement, dated 10/8/24. R25 stated, I probably signed it with all the other paperwork. I do not want this. Can you fix it?</p> <p>Example 2</p> <p>R12 admitted to the facility on [DATE].</p> <p>On 11/07/24 at 3:30 PM R12 and Surveyor reviewed R12's signed arbitration agreement, dated 9/20/24. R12 stated, I signed a bunch of things. I am sure I signed it. Wish they did that on a different day than the day they do all admission papers. R12 indicated she did not fully understand what she was signing at the time.</p> <p>Example 3</p> <p>R128 admitted to the facility on [DATE].</p> <p>On 11/07/24 at 3:25 PM R128 and Surveyor reviewed R128's signed Arbitration agreement, dated 10/4/24. R128 stated, I would not want that signed. R128 indicated she did not understand what the form was for, and it was presented to her with all her admission paperwork.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Example 4</p> <p>R129 admitted to the facility on [DATE].</p> <p>On 11/07/24 04:29 PM during an interview R129 stated, They did not explain it to me. I would not sign that. Surveyor and R129 reviewed the last paragraph of the agreement and R129 stated, I would like it revoked.</p> <p>Example 5</p> <p>R72 admitted to the facility on [DATE] and has an activated power of attorney.</p> <p>On 11/11/24 at 2:21 PM during a phone interview RR OO (Resident Representative) indicated he is R72's activated power of attorney. RR OO indicated he was not fully aware of the arbitration agreement that he had signed, stating, It was well hidden amongst all the other paperwork. I know we are past the 30 days. Thank you. I will look for this in the future.</p> <p>On 11/07/24 at 3:44 PM Admissions Coordinator PP stated, I go through the agreement with all new admissions. Surveyor asked Admissions Coordinator PP to explain what the arbitration agreement is as if she was explaining it to a new admitting resident. Admissions Coordinator PP stated, It is about their rights to use the grievance process. They can talk to anyone here about concerns that they have, and we will resolve the concerns. Surveyor asked if Admission Coordinator PP explained to new admissions that if the resident signs the form, they forfeit their constitutional rights to use the judicial system to resolve disputes they may have with the facility. Admissions Coordinator PP indicated she was unaware that the form meant that. Surveyor and Admissions Coordinator PP reviewed paragraph one of the arbitration agreement together including: Arbitration is a method of resolving disputes without substantial time and expenses of using the judicial system . By signing this alternative Dispute Resolution agreement you are giving up your constitutional right to a jury or court trial. Surveyor asked Admission Coordinator PP if there was a timeframe the residents had to back out of the agreement. Admissions Coordinator PP indicated she was unsure. Surveyor and Admissions Coordinator PP reviewed the last paragraph of the arbitration agreement together including: . this Alternative Dispute Resolution may be revoked by providing notice to the facility within 10 days of signature. If not revoked within 30 days, this agreement shall remain in effect for all care and services rendered at the facility.</p> <p>On 11/7/24 at 4:44 PM INHA D (Interim Nursing Home Administrator) and Corporate RN C (Registered Nurse) indicated Admissions Coordinator PP should understand and be able to explain the binding arbitration agreement to new residents upon admission. INHA D indicated residents do not have to sign the agreement to admit and they have 30 days to revoke the agreement after it is signed.</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725</p> <p>Based on observation, interview, and record review, the facility does not have an effective infection control program to control the spread of infectious disease, in this case COVID-19; this has the potential to affect all 71 residents residing at the facility.</p> <p>Staff were observed going in and out of COVID positive rooms without appropriate PPE (Personal Protective Equipment).</p> <p>Staff were observed exiting COVID positive room with PPE on and doffing PPE in the hallway.</p> <p>Staff were observed not using source control.</p> <p>Staff were working with COVID symptoms and not tested .</p> <p>Facility is not utilizing dedicated equipment in COVID positive resident rooms.</p> <p>Privacy curtains are not being pulled between COVID positive and COVID negative residents.</p> <p>Staff were observed working with a COVID positive resident and then with same PPE about to work with a resident who was COVID negative.</p> <p>Observations of COVID positive residents smoking outside with non-COVID positive residents and not six feet apart.</p> <p>Food cart was left with the door open in front of a COVID positive resident room, the resident was sitting in the doorway of the room and coughing without using cough etiquette.</p> <p>The facility did not offer residents the most recent COVID-19 vaccine.</p> <p>The facility did not offer residents antiviral (drug or treatment effective against viruses) medication.</p> <p>The facility's failure to ensure appropriate infection control practices are in place and followed during a COVID-19 outbreak, created a finding of immediate jeopardy that began on 11/4/24. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 11/11/24 at 1:23 PM. The immediate jeopardy was removed on 11/11/24, however, the deficient practice continues at a scope/severity of F (potential for more than minimal harm/widespread) as evidenced by the following:</p> <p>The facility did not have complete water management control measure documentation.</p> <p>Poor hand hygiene was observed with wound care and medication administration.</p> <p>This is evidenced by:</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The facility's Policy and Procedure titled Infection Prevention and Control Program dated 10/1/22, documents in part: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies .5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Center for Disease Control and Prevention) guidelines. b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. c. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines .</p> <p>The facility's Policy and Procedure titled Infection Outbreak and Response dated 10/1/22, documents in part: .Outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time .2. Implementation of infection control measures: a. Symptomatic employees will be screened by the Infection Preventionist, or designee, and referred to appropriate medical provider. c. Standard precautions will be emphasized. Transmission-based precautions will be implements as indicated for the particular organism .</p> <p>The facility's COVID-19 Outbreak timeline documents the following:</p> <p>On 10/25/24, there was one resident with a cough, he tested positive for COVID. The facility updated his care plan, started COVID monitoring, tested residents on south side, and staff on that side of facility to test every two days.</p> <p>On 10/27/24, all residents on south side of facility were tested , all were negative.</p> <p>On 10/28/24, R63 tested positive on the south side of the facility.</p> <p>On 10/29/24, R329 and R37 tested positive on the north side of the facility and R14, R36, R24, and R64 tested positive on the south side of the facility. NM H (Nurse Manager) and LPN E (Licensed Practical Nurse) tested positive on this date as well. The facility identified this as an outbreak, hung signage on front door, initiated use of well-fitting mask throughout facility, updated care plans, started COVID monitoring, dietary began utilizing disposable dishware for positive residents, Activities distanced residents as needed, Therapy saw positive resident last, housekeeping increased their cleaning of high touch areas (light switches, door knobs, door frames, and handrails), testing for all staff and residents to be done every 2 days, families and providers updated, and updated Public Health.</p> <p>On 10/30/24, CNA I (Certified Nursing Assistant) tested positive.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 10/31/24, R130, R330, and R49 tested positive on the north side of the facility and R67, R66, and R26 tested positive on the south side of the facility. BOM RR (Business Office Manager) and SLP SS (Speech/Language Pathologist) tested positive on this date.</p> <p>On 11/2/24, R56 tested positive on the north side of the facility and R2 and R18 tested positive on the south side of the facility.</p> <p>On 11/3/24, R48 tested positive on the south side of the facility.</p> <p>On 11/4/24, R34 tested positive on the south side of the facility and LPN J tested positive.</p> <p>On 11/6/24, all residents tested , all negative, first round of no new positives.</p> <p>Staff Line List documents the following:</p> <p>On 10/2/24, LPN J (Licensed Practical Nurse) is listed as having a headache/migraine. There is no documentation that a COVID test was completed.</p> <p>On 10/4/24, NM H (Nurse Manager) is listed as having a headache. There is no documentation that a COVID test was completed.</p> <p>On 10/29/24, NM H tested positive for COVID, line list documents that symptoms started 10/25/24. NM H's punch detail documents that she worked 10/25/24 and 10/28/24, eight hours each day with a COVID positive test result on 10/29/24.</p> <p>On 10/29/24, LPN E tested positive for COVID, the staff line list documents that symptoms started on 10/27/24. LPN E's punch detail documents that she worked 10/29/24 the beginning half of the shift with COVID positive result on 10/29/24.</p> <p>On 10/30/24, CNA I (Certified Nursing Assistant) tested positive for COVID, the staff line list documents that symptoms started 10/29/24. CNA I's punch detail documents that she worked on 10/29/24 with COVID positive result on 10/30/24.</p> <p>On 11/4/24 at 11:56 AM, Surveyor observed CNA K enter R64's room. On the wall outside R64's room was an infection control sign indicating COVID precautions for R64's room. The infection control sign indicated staff should wear eye protection, N95 mask, gown, and gloves when entering the room. CNA K was wearing a surgical mask, gown, and gloves.</p> <p>On 11/4/24 at 12:00 PM, Surveyor interviewed CNA K regarding the required PPE (Personal Protective Equipment) when entering a COVID positive room. CNA K read the infection control sign outside the door indicating she should wear eye protection, N95 mask, gown, and gloves when entering the room. Surveyor asked CNA K if she should have put on eye protection and an N95 mask prior to entering the room. CNA K indicated she should have applied the appropriate PPE but did not.</p> <p>On 11/4/24 at 11:56 AM, Surveyor observed CNA L enter R67's room. On the wall outside R67's room was an infection control sign indicating COVID precautions for R67's room. The infection control sign indicated staff should wear eye protection, N95 mask, gown, and gloves when entering the room. CNA L was wearing a surgical mask, gown, and gloves.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 11/4/24 at 12:00 PM, Surveyor interviewed CNA L regarding the required PPE when entering a COVID positive room. CNA L read the infection control sign outside the door indicating he should wear eye protection, N95 mask, gown, and gloves when entering the room. Surveyor asked CNA L if he should have put on eye protection and an N95 mask prior to entering the room. CNA L indicated he should have applied the appropriate PPE but did not.</p> <p>On 11/4/24 at 2:02 PM, Surveyor observed CNA T (Certified Nursing Assistant) don (put on) 2 surgical masks and an N95 over the top of the surgical masks, a gown, and gloves. Then CNA T entered R14's room to assist R14 who was COVID positive.</p> <p>(It is important to note CNA T did not don eye protection and had on a total of 3 masks.)</p> <p>On 11/4/24 at 12:00 PM, Surveyor observed R36 watching TV with the room curtain divider pulled back. R36 is COVID positive and R36's roommate, R30, is not.</p> <p>On 11/4/24 at 2:56PM, CNA T (Certified Nursing Assistant) answered the call light for R30. Surveyor observed CNA T put on gown, gloves, and a face shield. Surveyor observed CNA T wear a surgical facemask and enter R30's room. CNA T walked past R36's side of the room. R36 is R30's roommate and is COVID positive. CNA T came out of the room and still had the surgical facemask on. Surveyor asked who CNA T assisted. CNA T indicated she answered call light for R30 and R30 is not COVID positive. CNA T indicated she puts on the full PPE for precaution since R30's roommate is COVID positive. CNA T indicated if she was assisting someone who is COVID positive she will don all PPE, gown, gloves, face shield, 2 surgical face masks, and 1 N95. CNA T indicated she wears the 3 face masks for extra protection. CNA T indicated staff are constantly reminding R36 to keep his facemask above his nose when he is out in common areas.</p> <p>On 11/4/24 at 12:11 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding appropriate PPE for COVID positive rooms. LPN F indicated staff should wear eye protection, N95 mask, gown, and gloves when entering a COVID positive room.</p> <p>On 11/7/24 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding appropriate PPE for COVID positive rooms. DON B indicated staff should wear eye protection, N95 mask, gown, and gloves when entering a COVID positive room. DON B was aware of Surveyor's observations of CNA K (Certified Nursing Assistant,) CNA L, and CNA T. DON B indicated the CNAs should have worn eye protection and an N95 mask when entering the COVID positive rooms.</p> <p>On 11/4/24 at 2:02 PM, Surveyors observed 5 residents smoking in a circle outside. Residents were not 6 feet apart and two of the residents were positive for COVID.</p> <p>On 11/07/24 05:51 PM, Surveyor interviewed DON B (Director of Nursing) regarding COVID positive residents going outside to smoke. DON B indicated COVID positive residents should go out to smoke separately but if the COVID positive residents go outside to smoke with COVID negative residents, then they should stay 6 feet apart.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 11/5/24 at 11:32 AM, Surveyor observed two staff members bring a meal tray cart onto the 200 unit. The cart was placed within six feet of the door to the right of R49's room who was COVID positive. At the time, R49 was sitting in his wheelchair in the threshold of his doorway, not wearing a mask, and actively coughing. Staff members were passing trays and leaving the tray cart door open at this time.</p> <p>On 11/5/24 at 11:39 AM, Surveyor observed the tray cart moved from the right to the left of R49's room. The tray cart was still within six feet of the resident, and at this time within arm's reach. R49 remained in the threshold of his doorway and was still actively coughing without a mask.</p> <p>On 11/5/24 at 11:41 AM, DSS W (Director of Social Services) came onto the unit and moved the tray cart down to the other end of the hall away from R49.</p> <p>On 11/5/24 at 11:43 AM, Surveyor observed DSS W exit R330's room, who was COVID positive, still wearing all her PPE. Surveyor observed DSS W doff all her PPE in the hallway and dispose of her PPE in the medication cart trash can.</p> <p>On 11/5/24 at 11:54 AM, Surveyor interviewed DSS W. Surveyor asked DSS W if she was passing trays on the 200 hall. DSS W stated yes. Surveyor asked DSS W if she passed a tray to R330's room who is on special isolation precautions for COVID. DSS W stated yes. Surveyor asked DSS W if she walked out of the room with all her PPE on. DSS W stated yes. Surveyor asked DSS W if she should have doffed her PPE prior to exiting R330's room. DSS W stated yes.</p> <p>On 11/6/24 at 8:05 AM, Surveyor observed LPN N (Licensed Practical Nurse) leave R56's bedside, go into the resident's bathroom, remove gloves, cleanse hands, and don new gloves. R56 is COVID positive. LPN N then walked to R56's roommate's side of the room, past the privacy curtain. Surveyor intervened as LPN N passed around the corner of R56's roommate's bed and asked LPN N to come to the doorway. Surveyor asked LPN N if she was going to see R56's roommate. LPN N stated yes. Surveyor asked why LPN N was wearing PPE in the room. LPN N stated that R56 has COVID and is on precautions. Surveyor asked if PPE worn with a COVID positive resident could be worn with another resident. LPN N stated no. LPN N removed the PPE, cleansed hands, and went to the medication cart. LPN N pushed the medication cart to the next room down the hall and opened the medication cart and began preparing medications. Surveyor asked if any PPE was required to be worn by staff while in the hallways of the building due to the COVID outbreak. LPN N stated yes, a surgical mask. Surveyor asked LPN N if she was wearing a mask at the present time. LPN N took a mask from the isolation cart in the hallway and applied the mask.</p> <p>On 11/7/24 at 8:24 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that the preferred order to see residents sharing a room is to see the resident without COVID first, then remove PPE, cleanse hands, apply new PPE, then see the COVID positive resident. DON B stated that after seeing a COVID positive resident, PPE must be removed and hand hygiene must be performed. DON B stated that a surgical mask needs to be worn by staff in the building while there is a COVID outbreak.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 11/5/24 at 4:47 PM, Surveyor interviewed HLS Q (Housekeeping and Laundry Supervisor). Surveyor asked HLS Q if the cleaning products they use are good for COVID; HLS Q stated yes. Surveyor asked HLS Q what surfaces are they cleaning with these products; HLS Q said all high touch areas (doorknobs, light switches, doorframes, handrails). Surveyor asked HLS Q if cleaning changed once there was a COVID outbreak; HLS Q stated yes, we increased cleaning of high touch areas by one time per day (already being done three times per day regularly).</p> <p>On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G (Licensed Practical Nurse/Infection Preventionist). Surveyor asked LPN/IP G once the facility had a positive COVID resident in the building, were residents who declined the vaccine to use a mask; LPN/IP G stated all residents were encouraged to wear a mask. Surveyor asked LPN/IP G if there was consultation about beginning an antiviral medication; LPN/IP G said she had spoken to their Medical Director prior to this outbreak and the medical director didn't seem to want to go there. Surveyor asked LPN/IP G if masks are being offered to residents when the residents are out of their rooms; LPN/IP G stated yes, not all residents are compliant. Surveyor asked LPN/IP G what PPE is to be worn in COVID positive rooms, LPN/IP G replied gown, gloves, N95, and eye protection. Surveyor asked LPN/IP G what PPE is to be worn throughout the facility when not in a COVID positive room; LPN/IP G said a well-fitting mask (surgical mask). Surveyor asked LPN/IP G if it is acceptable to wear two surgical masks with an N95 over the top, LPN/IP G stated no.</p> <p>On 11/7/24 at 11:32 AM, Surveyor interviewed LPN/IP G again. Surveyor asked LPN/IP G if COVID boosters/vaccines have been offered, LPN/IP G explained they offer, on admission, then for the next three days if they refuse, if still refused then offered quarterly. Surveyor asked LPN/IP G if NM H had symptoms that started 10/25/24, should she have tested on [DATE]? LPN/IP G stated yes, she should have. LPN/IP G stated she was unsure if she had access to testing. Surveyor asked LPN/IP G if she didn't have access to testing 10/25/24, should she have tested on [DATE] before working; LPN/IP G said yes.</p> <p>On 11/7/24 at 4:36 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when would you expect a staff member to test for COVID if they have symptoms? DON B said when the symptoms start. Surveyor asked DON B if she would expect staff to be working if they have COVID symptoms; DON B stated no, they should test before they work.</p> <p>The facility's failure to ensure appropriate infection control practices are in place and followed during a COVID-19 outbreak created a reasonable expectation of serious outcome resulting in a finding of immediate jeopardy. The facility removed the immediate jeopardy on 11/11/24 when the facility completed the following:</p> <p>~A record review was completed on all residents to ensure no unreported signs and symptoms of infection were present.</p> <p>~An audit was completed on all residents COVID-19 vaccination status with vaccines offered if appropriate.</p> <p>~All staff had a competency completed on DONning and DOFFing PPE as well as hand hygiene and will be completed prior to next shift worked.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>~All staff were educated on the appropriate use of PPE on all types of precautions and COVID specific precautions to include donning gown, gloves, mask, and eye protection when entering COVID positive rooms, and removing PPE prior to leaving the resident room.</p> <p>~Education also included not wearing a surgical mask under a N95 and that surgical masks are to be worn in the halls during a COVID outbreak.</p> <p>~All staff were education on appropriate hand hygiene.</p> <p>~All nursing staff were educated on offering Antiviral medications for residents with a positive COVID result and offering the most recent COVID vaccines.</p> <p>~All staff were educated on the use of privacy curtains in positive COVID rooms as well as disinfecting equipment and doffing PPE after working with a COVID positive resident.</p> <p>~All staff were educated on taking COVID positive smoking residents out separately than non-positive smoking residents.</p> <p>~All staff were educated on dining carts cannot be left open during meal tray pass in the hallways.</p> <p>~All staff were educated on testing for COVID prior to working if symptoms are present. Education will be completed prior to next shift worked.</p> <p>~Infection Control and vaccines policy and procedures were reviewed with no updates at this time.</p> <p>~DON or designee will audit 5 residents weekly x8 weeks to ensure residents are up to date with current COVID-19 vaccinations.</p> <p>~DON or designee will audit 5 employees weekly x8 weeks to ensure appropriate DONNING/DOFFING PPE, privacy curtains are being closed in a COVID positive room and appropriate hand hygiene is being completed.</p> <p>~Dietary Manager or designee will complete 5 observations weekly x8 weeks to ensure dining carts are being closed during meal tray pass in the hallways.</p> <p>~SSD or designee will complete 5 observations weekly x8 weeks to ensure COVID positive residents are being taken out after non COVID residents have finished smoking.</p> <p>~Audits will be reported and reviewed to QAPI for further direction.</p> <p>Example 2:</p> <p>The facility is lacking documentation on the water management control measures.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The facility's Policy and Procedure titled Infection Prevention and Control Program dated 10/1/22, documents in part: .16. Water Management .b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program .</p> <p>The facility's Water Management Plan has multiple control measures in it that are to be tested on a regular basis. Testing/documentation of testing of these control measures are in place until May or July.</p> <p>On 11/7/24 at 3:30 PM, Surveyor interviewed AIT S (Administrator in Training). Surveyor asked AIT S why the documentation for the control measures stop in either May or July? AIT S explained that the facility has been without a full-time Maintenance Director since July, they do have Maintenance from other facilities or their Corporate Office covering but the documentation has not been completed.</p> <p>49436</p> <p>Example 3:</p> <p>The facility policy Hand Hygiene not dated, states in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Staff will perform hand hygiene when indicated, using proper technique consistent with the accepted standards of practice.</p> <p>On 11/6/24 at 9:30 AM, Surveyor observed RN M (Registered Nurse) perform wound care for R43. During the observation, RN M removed the old dressing from R43's left lower leg. R43 has two separate wounds on her left leg, one on the posterior (back) left calf and one on the anterior (front) left leg. RN M washed and dried the posterior wound then proceeded to wash and dry the anterior wound.</p> <p>It is important to note, RN M did not perform hand hygiene in between caring for the two separate wounds.</p> <p>On 11/6/24 at 9:39 AM, Surveyor interviewed RN M regarding hand hygiene during wound care. RN M indicated since the two wounds on R43 were in different locations, she should have treated the wounds separately. RN M indicated she should have performed hand hygiene after treating the posterior left calf wound before proceeding to the anterior left leg wound.</p> <p>On 11/6/24 at 9:39 AM, Surveyor interviewed DON B (Director of Nursing) regarding hand hygiene during wound care. DON B indicated the two wounds on the left leg should have been treated separately. DON B indicated RN M should have performed hand hygiene after treating the posterior left calf wound before treating the anterior left leg wound.</p> <p>50228</p> <p>Example 4:</p> <p>LPN N did not remove gloves and cleanse hands following administration of insulin. LPN N contaminated a medication cup with her finger.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 11/6/24 at 9:20 AM, Surveyor observed LPN N performing medication administration. LPN N donned gloves and administered insulin to R32. Following the medication administration, LPN N touched the following with her contaminated gloves: R32's door and the medication cart. LPN N then removed and disposed of gloves. LPN N touched computer keyboard and med cart drawer following removal of gloves. Surveyor intervened and asked LPN N if there was anything that should be done following administration of insulin. LPN N stated that gloves should have been removed and hands sanitized prior to touching any items. LPN N went on to take R32's oral medications from the medication cart. LPN N picked up a medication cup and flipped it upright by placing her index finger inside the cup. LPN N then placed a medication card onto the cup and positioned the card to dispense the medication into the cup. Surveyor asked LPN N where medication cups should be touched by staff. LPN N stated on the outside near the bottom. Surveyor asked if it is ok to touch inside the cup. LPN N stated no.</p> <p>On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that gloves are to be removed and hand hygiene performed following insulin administration and prior to touching other things. DON B indicated that medication cups are to be handled from the outside and fingers are not to touch the inside of the cup.</p>		

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 11/14/2024
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>38725</p> <p>Based on interview and record review the facility did not ensure that their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use was in place for 2 supplemental residents (R64 and R35).</p> <p>R64 was treated with an antibiotic when she didn't meet the facility's standard of practice (McGeer).</p> <p>R35 was treated with an antibiotic when she didn't meet the facility's standard of practice.</p> <p>This is evidenced by:</p> <p>The Facility's Policy and Procedure entitled Antibiotic Stewardship Program undated, documents in part: .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR (Situation, Background, Assessment, and Recommendation) form prior to notifying the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility use McGeer Criteria to define infections. iv. Criteria specific to each state are used to determine whether or not to treat an infection with antibiotics .</p> <p>Example 1</p> <p>Per McGeer Criteria for Long Term Care Surveillance Definitions for Infections Updated 2012:</p> <p>Cellulitis/soft tissue/wound: At least 1 criteria must be present: Pus present at a wound, skin, or soft tissue site and/or New or increasing presence of at least 4 of the following sub criteria: Heat at the affected site, Redness at the affected site, Swelling at the affected site, Tenderness or pain at the affected site, Serous drainage at the affected site.</p> <p>The following was on the September resident line list:</p> <p>R64, 9/11/24, cellulitis, S/Sx (signs and symptoms) warmth, redness, and swelling.</p> <p>R64's Infection Surveillance Data Collection tool documents in part:</p> <p>Dated 9/11/24 .New or increasing presence of 4 or more of the following Cellulitis .heat at site, redness at site, swelling at site .Meets minimum criteria for an infection yes .</p> <p>R64's physician orders include the following:</p> <p>Cephalexin 500 mg (milligrams) by mouth every 6 hours for cellulitis for 5 days (9/11/24-9/16/24).</p> <p>On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G (Licensed Practical Nurse/Infection Preventionist). Surveyor asked LPN/IP G if R64's symptoms meet McGeer Criteria, LPN/IP G stated no, you must have 4 symptoms.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided additional information for this example. The provided documentation is R64's pain levels. R64 has pain scores of 3-6 from 9/2/24-9/5/24 and then pain scores of 2-7 9/9/24-9/28/24. It is not clear that this pain was related to this cellulitis encounter.</p> <p>Example 2</p> <p>Per McGeer Criteria for Long Term Care Surveillance Definitions for Infections Updated 2012:</p> <p>Pneumonia: MUST HAVE: Chest x-ray demonstrating pneumonia, probable pneumonia, or new infiltrate. AND MUST HAVE at least 1 of the following- New or increased cough, O₂ (oxygen) sat<94% or < 3% baseline, pleuritic chest pain, fever (see CC table 2), New or increased sputum production, New or changed lung exam abnormalities, respiratory rate.</p> <p>(>25/minute), MUST HAVE at least 1: Constitutional Criteria (Fever, ADL, Mental change)</p> <p>Table 2: Definitions for Constitutional Criteria in Residents of Long-Term Care Facilities (LTCFs)</p> <p>Fever- 1. Single oral temperature >100 F OR 2. Repeated oral temperatures >99 F OR 3. Single temperature >2 F over baseline from any site (oral, tympanic, axillary)</p> <p>Leukocytosis- 1. Neutrophilia (>14,000 leukocytes/mm³) (cells per cubic millimeter) OR 2. Left shift (>6% bands or 1,500 bands/mm³)</p> <p>Acute change in mental status from baseline- All criteria must be present:</p> <ol style="list-style-type: none"> 1. Acute onset (Evidence of acute change in resident's mental status from baseline) 2. Fluctuating course (Behavior fluctuating: e.g., coming and going or changing in severity during the assessment) 3. Inattention (Resident has difficulty focusing attention: e.g., unable to keep track of discussion or easily distracted) 4. Either disorganized thinking or altered level of consciousness a. disorganized thinking (Resident's thinking is incoherent: e.g., rambling conversation, unclear flow of ideas, unpredictable switches in subject) OR b. Altered level of consciousness (Resident's level of consciousness is described as different from baseline: e.g., hyperalert, sleepy, drowsy, difficult to arouse, nonresponsive) <p>Acute functional decline- 1. A new 3-point increase in total activities of daily living (ADL) score (range, 0-28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependence) Bed mobility, Transfer, Locomotion within LTCF, Dressing, Toilet use, Personal hygiene Eating.</p> <p>The following was on the October resident line list:</p> <p>R35, 10/5/24, pneumonia, S/Sx cough.</p> <p>It is important to note that there was no chest x-ray completed at this time.</p> <p>(continued on next page)</p>		

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 11/14/2024
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R35's Infection Surveillance Data Collection tool documents in part:</p> <p>Dated 10/5/24 .Criteria 1. Must have chest x-ray demonstrating pneumonia or presence of infiltrate AND Criteria 2. Must have at least 1 of the following (constitutional criterion) fever, leukocytosis, acute change in mental status from baseline or acute functional decline AND Criteria 3. Must have at least 1 of the following (respiratory sub criteria Respiratory/Pneumonia .cough .Describe constitutional criteria box .Meets minimum criteria for an infection yes .</p> <p>It is important to note that the box for the constitutional criteria was blank.</p> <p>R35's physician orders include the following:</p> <p>Amoxicillin-Pot Clavulanate 875-125 mg give 1 tablet by mouth every 12 hours for PNA (pneumonia) for 10 days (10/5/24-10/15/24).</p> <p>On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G. Surveyor asked LPN/IP G if R35's symptoms meet McGeer Criteria, LPN/IP G stated no.</p> <p>The facility provided additional information for this example. The provided documentation is R35's Infection Surveillance Data Collection tool dated 9/20/24 that has the same documentation recorded as above for 10/5/24 except the constitutional criteria box says PNA. The facility also provided R35's chest x-ray dated 9/20/24, it documents the following results: .1. Cardiomegaly (enlarged heart), 2. Left moderate pleural effusion. Further evaluation with clinical correlation and possible follow-up imaging is recommended .</p> <p>Of note, this chest x-ray is not indicative of pneumonia.</p>		