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	06/09/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure each resident has the right to privacy and confidentiality for 1 of 7 residents (R) reviewed (R7). During the survey, a camera (an electronic monitoring and recording device) was observed to be used in R7's room. Two of R7's family members have saved recordings with video and voice footage including all cares performed in the room (e.g., pericare, tube feedings, transfers, trach care, dressing, bathing, etc.). The facility does not turn off the camera or cover it up at any time to respect R7's privacy. Evidenced by:R7 was admitted on [DATE]. R7's most recent Minimum Data Set (MDS) with an assessment reference date of 5/4/26 indicates under section C that R7s Cognitive Skills for Daily Decision Making is Severely impaired-never/rarely made decisionsOn 5/5/26 at 12:21 PM, during a Care Conference, the facility documents, in part, as follows. Family would like to put a camera in his (R7's) room. R7's does not have a Care Plan for electronic monitoring and recording devices.Surveyor requested a copy of the facility's electronic monitoring and recording devices policy. On 5/27/26 at approximately 9:45 AM, Surveyor spoke with R7's family member in-person while she was at the facility. Surveyor observed a camera in R7's room pointed toward R7's bed where he was sleeping. R7's family member stated to Surveyor that she and another family member installed a camera in R7's room on 5/9/26 due to concerns regarding cares. Surveyor observed signage/notification to any resident, family, and staff who may enter R7's room that the room was under surveillance by a camera. R7's family member shared saved recordings with video and voice footage. On 5/27/26 at 4:00 PM, Surveyor interviewed NHA A (Nursing Home Administrator), CNO D (Chief Nursing Officer), and DON B (Director of Nursing). NHA A stated the facility does not have a policy and procedure for electronic monitoring and recording devices. Surveyor asked NHA A, should the camera be turned off or covered during resident care. NHA A stated, the facility reviewed this with an Ombudsman (not the facility's Ombudsman) who told them it is the Family Member/Guardian's right to have the electronic monitoring and recording device. Surveyor asked NHA A if electronic monitoring and recording devices are appropriate in resident care areas. NHA A stated, yes. Surveyor shared with NHA A, CNO D (Chief Nursing Officer), and DON B (Director of Nursing) that electronic monitoring and recording devices are not appropriate in resident care areas. Surveyor shared with the facility that the videos with voice recordings from this device are saved and R7's Guardian and close family members have access. Using the reasonable person concept, a person would want their privacy and dignity maintained during cares and while undressed. NHA A stated, That's new. Surveyor asked NHA A, did the facility complete an assessment for the electronic monitoring and recording device. NHA A stated, it was not put in (installed) by the resident so, no.

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	06/09/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 2 of 3 residents (R1 & R2) reviewed for grievances. R1 reported finding a paperclip in her cereal to CNA O (Certified Nursing Assistant), who did not follow up appropriately to address this concern. R2 voiced a concern and the facility did not follow its grievance policy. This is evidenced by: The facility policy, titled Grievance Policy, dated 9/15/25, states in part: Policy Statement: The facility ensures that all residents have the right to voice grievances without discrimination, reprisal, or fear of retaliation.Residents and representatives will be informed throughout the process, and grievances will be promptly investigated and resolved. Policy Interpretation and Implementation: .Investigation and Resolution: Investigations may include interviews, medical record reviews, and consultation with staff or family members. Written resolutions will summarize the grievance, investigation steps, findings, actions taken, and the completion date.All grievances will be reviewed in collaboration with the appropriate department leadership to ensure the corrective actions address the underlying concern effectively. Grievances should be resolved as promptly as possible, with a goal of resolution within five (5) working days. If resolution cannot be achieved within this timeframe.the resident and/or representative will be notified of the reason for the delay and provided with an updated expected timeframe for completion.The facility maintains grievance logs for three (3) years. Example 1 R1 admitted to the facility on [DATE]. R1's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/8/26, lists her BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating R1 is cognitively intact. On 5/26/26 at 10:00 AM, Surveyor interviewed R1. R1 indicated she had found a paperclip in a bowl of cereal she had for breakfast on 5/12/26. The date was verified by a picture R1 had taken that morning. R1 indicated that she told CNA O (Certified Nursing Assistant) right away and CNA O followed up with the kitchen staff. R1 indicated she never heard anything back about this issue, and was concerned, as she had previously found a piece of wax paper and plastic wrap in her food as well. On 5/27/26 at 8:57 AM, Surveyor interviewed [NAME] S. [NAME] S indicated she had never been informed about items being found in a resident's food. [NAME] S indicated she was unsure who would have been told about this, but noted their previous dietary manager quit two weeks ago. On 5/27/26 at 11:30 AM, Surveyor interviewed CNA O. CNA O indicated R1 told her about the paperclip in her cereal and she had observed it. CNA O then reported this issue to kitchen staff. CNA O could not recall who she told or what staff said they would do about this issue. (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	06/09/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the grievance log for May 2026 provided by the facility and did not see R1's food issue recorded on the log. On 5/27/26 at 4:15 PM, Surveyor spoke with DON B (Director of Nursing). DON B indicated she was not aware of any resident issues regarding finding items in food. Surveyor informed DON B of the concern and that CNA O had followed up with kitchen staff. DON B indicated the CNA should have reported this issue to management so they could follow up on it properly instead of reporting it to kitchen staff. DON B indicated she would start education on the facility's grievance process with staff and wrote down the concern and said she would follow up on it. Example 2: R2 was admitted on [DATE], with diagnoses that include Major Depressive Disorder, Recurrent, Unspecified, Generalized Anxiety Disorder, and Chronic Pain Syndrome. R2's admission MDS (Minimum Data Set) with a target date of 5/7/26, indicates, in part: Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating R2 is cognitively intact. On 5/26/26 at 9:34 AM, Surveyor interviewed R2 who voiced frustrations about her desire to be transferred to a facility closer to her daughter. R2 stated that she had asked facility management over and over to move her closer to her only living relative, which is her daughter. R2 indicated that she had spoken to the social worker and had even written a letter to management asking to be transferred. R2 stated that at the end of the day, facility management gets to go home and be with their families, and she's not being allowed to be with her family. R2 stated that she doesn't think it is too much to ask to be allowed to move to a facility closer to her daughter. R2 also indicated that the food at the facility is awful and very bad quality. R2 stated that they don't get the minimum amount of protein required for healing, and that many times for breakfast there is no protein in the meal. R2 stated that the food is always cold, and that they have run out of milk and coffee a lot lately. R2 showed Surveyor a dietary form that stated there are no alternatives offered for breakfast. A review of R2's EHR (Electronic Health Record) include the following progress notes: On 4/14/26 a Social Services Note: Baseline care plan meeting held. Unknown discharge plan at this time, resident would like to have referrals sent closer to home. On 5/5/26 a Social Services Note: Writer was informed that resident wanted to meet, writer met with resident who requested referrals be sent out. Prefer closer to home but would consider other options. On 5/24/26: NHA received complaint from Regional Ombudsman. regarding resident [Resident Name]. Complaint included concerns related to resident's requests for transfer to [County name] not being followed up on and concerns regarding food services. Plan to coordinate care conference with resident to discuss concerns and follow up accordingly. On 5/26/26 at 3:15 PM, Surveyor interviewed SSA C (Social Services Assistant) who stated that she had been in her role for only 2 weeks. Surveyor asked SSA C what the process was for residents who desired to be transferred to another facility. SSA C stated that she would go and talk with the resident to find out if they had any facilities or a particular area in mind. Surveyor asked SSA C what an acceptable time frame for making those referrals would be. SSA C stated that she would make the referrals the same day if possible. Surveyor asked SSA C where she was in the process of referrals (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	06/09/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for R2. SSA C stated that she was just on her way to talk to R2 about that today. Surveyor asked SSA C if she had sent any referrals for R2. SSA C indicated that she personally had not sent any, and that if the previous social worker had sent any, she would have entered a progress note on it. On 5/26/26 at 3:34 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CNO D (Chief Nursing Officer) about the facility's referral process. DON B indicated that if a resident had a preferred facility or one that was closer to their desired region, social services was responsible for sending out the referrals. Surveyor asked what an acceptable timeframe would be for sending out referrals. NHA A stated that the referrals are usually sent out immediately. Surveyor asked where social services were at in R2's referral process. NHA A stated that he was having the previous social worker send out referrals for R2, but he was not sure who accepted her or what facilities might be full, etc. Surveyor asked where that information would be documented. DON B indicated that there should be a progress note in R2's chart on that. Surveyor asked if a resident asked to be transferred to a facility closer to family, if 6 weeks was an acceptable timeframe to wait for referrals to be sent out. CNO D stated that would not be an acceptable timeframe, but she would check to see if they had more information about R2's referrals. On 5/27/26 a Social Service Note in R2's EHR indicated Writer faxed 4 referrals to skilled nursing facilities. Waiting to hear back. No other information or follow-up was provided by the facility.

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	06/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident's drug regimen is free from unnecessary drugs for 1 of 1 resident (R5) receiving a psychotropic medication. R5 was prescribed Quetiapine, an anti-psychotic medication, scheduled twice daily and PRN (as needed), Cymbalta, an anti-depressant, scheduled daily, Lorazepam, an anti-anxiety medication PRN, Haldol, an anti-psychotic medication PRN, and Remeron, an anti-depressant, scheduled daily. R5's care plan does not address the use of anti-psychotic medications. This is evidenced by: Please note: the survey team requested a psychotropic medication policy but did not receive one from the facility. Per the SOM (State operations manual) An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. S483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-S483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. R5 was admitted on [DATE] with diagnosis that include Vascular Dementia, Severe, With Agitation, Repeated Falls, Generalized Anxiety Disorder, and Restlessness and Agitation. R5's Physician Orders include, in part:--Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day for Anxiety. Take 30mg daily. Order Date: 5/14/26.--QUEtiapine Fumarate Oral Tablet 25 MG (Seroquel) Give 3 tablets by mouth in the evening for dementia. Order Date: 5/14/26. Discontinue Date: 5/22/26.--QUEtiapine Fumarate Oral Tablet 25 MG (Seroquel) Give 1.5 tablet by mouth two times a day for dementia related agitation, restlessness. Take 1.5 tablets (=37.5mg) twice daily. Order Date: 5/23/26.--QUEtiapine Fumarate Oral Tablet 25 MG (Seroquel) Give 1 tablet by mouth every 8 hours as needed for Agitation until 6/6/26. Order Date: 5/23/26.--Haloperidol Oral Tablet 0.5 MG (Haldoll) Give 1 tablet by mouth every 4 hours as needed for Agitation, delirium, nausea for 14 Days. Order Date: 5/22/26.--LORazepam Oral Tablet 0.5 MG (Ativan) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Anxiety, Nausea, Restlessness until 11/23/26. Comfort Med, call Agrace prior to first dose. May crush or dissolve. Order Date: 5/23/26.--Remeron Oral Tablet (Mirtazapine) Give 7.5 mg by mouth at bedtime for Anxiety. Take 7.5 mg at bedtime. Order Date: 5/25/26.(Of note: Symptoms of dementia include memory problems, communication difficulties, mood changes, disorientation, confusion, poor judgement and difficulty with everyday tasks. This includes an increase in anxiety, depression, and/or agitation etc.,) R5's Medication Administration Record (MAR) for May indicates the following as needed (PRN) medications were administered:-Haldol PRN given on 5/22/26, 5/23/26, twice on 5/24/26, and 5/26/26-Lorazepam PRN given on 5/19/26, 5/20/26, twice on 5/21/26, twice on 5/22/26, 5/24/26, 5/25/26, and twice on 5/26/26 R5's Comprehensive Care Plan, states in part:Focus: Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication. Date Initiated: 5/14/26.Goals: Will be free of psychotropic drug related complications. Date Initiated: 5/14/26. Target Date: 8/19/26.Interventions: Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain. Date Initiated: 5/14/26. Provide Medications as ordered by physician and evaluate for effectiveness. Date Initiated: 5/14/26. Revision on: 5/14/26.Focus: I have diagnosis/exhibit signs of a mood disorder related to Diagnosis - Dementia, Loss of function, Such as yelling, grabbing at residents and their items, thinking that other residents belongings are his and will try to claim them as his. Date Initiated: (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	06/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/26. Goal: Resident will have improved mood state: Date Initiated: 5/20/26. Revision on: 5/26/26. Target Date: 8/19/26.Interventions: Administer meds as ordered. Monitor and document for side effects and effectiveness. Date Initiated: 5/20/26. Assist resident in developing program of activities that is meaningful and of interest. Date Initiated: 5/20/26. Assist resident/family/caregiver to identify strengths, positive coping skills and reinforce those. Date Initiated: 5/20/26. Encourage resident to express feelings in a productive way. Date Initiated: 5/20/26. Monitor/record mood to determine if problems seem to be related to external causes (medication, treatment, concern over diagnosis). Date Initiated: 5/20/26. Offer me food and beverages I like. Date Initiated: 5/20/26. Psychology/psychiatry consult as ordered. Date Initiated: 5/20/26. When resident appears to be looking for clothes, help assist resident in finding clothes. Date Initiated: 5/22/26.On 5/18/26 at 1:30 AM: Late Entry: At 1:09 AM Resident attempted elopement through the back of the facility towards the tunnel. The alarm sounded, staff redirected resident away from door and staff put in code to the door for alarm to be shut off. The resident was walking alongside staff writer went past Nurse's station to Supply closet and the other staff member present at the time went down the 400 hall. Writer was away from nurse's station for roughly 5 to 7 mins while writer was getting supplies. When writer was back at the nurse's station within the 7 min timeframe writer received a call from (hospital name) ER that resident had entered their ER ambulating with his walker. Writer assisted resident back to the facility. Resident was placed on 15 minute checks with close supervision. Resident remained within line of site through the duration of shift.On 5/27/26 at 2:17 PM, Surveyor interviewed CNA H (Certified Nursing Assistant) about R5's behaviors. CNA H indicated that R5 seems fine and doesn't have a lot of behaviors. CNA H stated that R5 walks around with his walker and doesn't bother others. CNA H stated that starting last week R5 began trying to exit the building and did get outside one night. CNA H indicated that since then R5 has had a change of behavior and staff are doing 15-minute checks on R5 and monitoring him closely. On 5/27/26 at 2:35 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) about R5's behaviors. LPN F stated that R5 sometimes bites, kicks, screams, wanders, and is aggressive with staff. LPN F stated that R5 wanders and exit seeks, and last week he got out of the building. Surveyor asked LPN F what interventions are in place when R5 has these behaviors. LPN F stated that they started R5 on 15-minute checks and he likes to talk about his job, so she tries to redirect him. LPN F also stated that hospice just gave new orders for morphine, lorazepam, and Seroquel. LPN F stated that they have not been giving morphine, because R5 does not exhibit signs of pain, but that they are giving the lorazepam and Seroquel which are helping calm him down some, however it depends on R5's mood and the situation. On 5/27/26 at 3:02 PM, Surveyor interviewed ADON Q (Assistant Director of Nursing) about R5's behaviors. ADON Q stated that R5 wanders, has been exit seeking, and can become anxious and agitated at times. ADON Q stated that R5's behaviors are persistent but not harmful. Surveyor asked ADON Q what interventions are in place when R5 has these behaviors. ADON Q stated that currently R5 was on 15-minute checks, and they offer him his preferred activities, such as writing and drawing in a notebook. ADON Q indicated that R5 doesn't stay on task or keep his attention on anything for more than 10-15 minutes. ADON Q stated that the PRN (as needed) medications they are giving R5 have been effective. ADON Q stated that R5 had been displaying symptoms of delirium last week, but since hospice started the PRN medications, those symptoms have reduced. Surveyor asked ADON Q to explain why R5 had been prescribed so many psychotropic medications. ADON Q indicated that R5 was on the Cymbalta and quetiapine when he came in, but the psych NP (Nurse Practitioner) split the doses because he was taking it all at night and then she changed it to twice daily. ADON Q stated that Remeron was started as an appetite stimulant, and the lorazepam and morphine were started by hospice. ADON Q indicated that the Haldol was ordered by hospice when R5 was displaying signs of delirium. Please note there is no documentation in R5's Electronic Health Record (EHR) indicating that R5 had symptoms of delirium. On 5/27/26 at 5:54 PM, Surveyor interviewed DON B (Director of Nursing) about R5's behaviors and medications. DON B stated that R5 attempts to exit seek, but that (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	06/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	now staff know him better they are better able to redirect him, however nothing keeps him sitting still for too long. Surveyor asked DON B to explain why R5 had been prescribed so many psychotropic medications. DON B indicated that R5 was originally admitted with the Cymbalta, and the Seroquel was originally 3 tablets once daily so the psych NP split the tablets to twice a day without changing the dosage. DON B stated hospice prescribed the lorazepam and morphine and also added on a PRN Haldol and Seroquel. Surveyor asked DON B if all of these psychotropic medications could be considered a chemical restraint. DON B stated no. Surveyor asked if the addition of more psychotropic medications in addition to what R5 had already been taking could be contributing to his frequent falls. DON B stated no because she talked to R5's daughter who was unable to manage his falls at home. Surveyor asked DON B if R5 had been displaying signs of delirium. DON B indicated that she was unaware of that because she had been on vacation last week. Surveyor asked DON B how she would know what's been effective or not effective when R5 has 3 scheduled and 4 PRN psychotropic medications. DON B stated that she notified the psych NP, who wants her to have a stern talk with hospice about R5's medication management.

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	06/09/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility personnel failed to provide basic life support to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 7 residents (R) reviewed (R4.)R4's chosen code status was full code. R4 was found pulseless and nonbreathing; facility staff delayed notifying 911 and delayed initiating cardio pulmonary resuscitation (CPR.) Facility staff failed to utilize life support equipment such as an AED (Automatic External Defibrillator) while providing CPR to R4.The facility's failure to provide proper basic life support to a resident who wished to be a full code, including immediately starting CPR, utilizing the AED, and promptly calling 911, created a finding of immediate jeopardy that began on [DATE].Surveyor notified CNO D (Chief Nursing Officer) and DON B (Director of Nursing) of the immediate jeopardy on [DATE] at 3:19 PM. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.This is evidenced by:The facility's policy titled Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support, undated, includes: Personnel are certified in cardiopulmonary resuscitation (CPR) for healthcare providers and basic life support (BLS,) including defibrillation for victims of sudden cardiac arrest. 1. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR for healthcare providers/BLS will administer CPR. General Sequence for Adult Basic Life Support 5. Ensure scene safety. 6. Check for response. 7. Shout for nearby help/activate the resuscitation team. 8. Check for no breathing or only gasping and check for pulse (ideally simultaneously.) 9. Retrieve and activate the AED/emergency equipment immediately after the check for no normal breathing and no pulse identifies cardiac arrest. 10. Immediately begin CPR and use the AED/defibrillator when available. 11. When the second rescuer arrives, provide 2-rescuer CPR and use the AED/defibrillator.The facility's policy, Automatic External Defibrillator, Use and Care of, dated 2001, includes: 4. In general, SCA (Sudden Cardiac Arrest) should be suspected if: a. the victim's symptoms appeared very suddenly; he or she is unresponsive; and c. his or her breathing has stopped. 5. If an individual is found unconscious and SCA (Sudden Cardiac Arrest) is suspected, begin the AED Protocol below. 1. Verify code status by looking [sic] facility CPR/DNR form found in [Electronic Health Record.] 2. Call (or direct someone to call) 911. 3. Apply personal protective equipment. 4. Assess the victim: a. Responsiveness - if unresponsive, retrieve (or direct someone to retrieve) the AED from its location and bring it to the victim. b. Breathing - open airway and look, listen, feel for breathing. If breathing is absent, deliver two rescue breaths. c. Circulation - if signs of circulation are absent, begin CPR until the AED is available. EMS (Emergency Medical Services) Arrival 1. Communicate the following information to the EMS personnel: a. Name of the victim; b. Any known medical history, allergies or conditions; c. The condition in which the victim was found; d. Time the victim was found; e. Number of shocks delivered; and f. Approximate length of CPR administration. Documentation 2. If the victim is a resident of the facility, document details of the event in the resident's medical record.R4 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a progressive, irreversible lung disease that restricts airflow, making it difficult to breathe,) acute respiratory failure with hypoxia (where the lungs cannot adequately oxygenate the blood,) tracheostomy (a surgically created opening through the front of the neck and directly into the windpipe (trachea). A breathing tube is placed into this hole to bypass the nose and mouth, providing an alternative airway for the patient to breathe,) dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life,) seizures, and quadriplegia (a form of paralysis that affects all four limbs and the torso.)R4's CPR (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	06/09/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	form, signed [DATE], states: Full Code. I understand that [Facility Name] performs onsite resuscitation. It is my desire to have a FULL CODE, which means that our facility will call 911 ([City Name] EMTs (Emergency Medical Technicians)) in the event of a cardiac or respiratory arrest and begin resuscitation measures including Cardiopulmonary Resuscitation. I am aware of the risks involved.R4's physician orders include Full Code. Order start date [DATE].R4's comprehensive care plan, printed [DATE], includes: Focus: Patient has an advance directive as evidenced by: Full Code. Date initiated [DATE]. Goal: Patient's wishes will be honored. Date initiated [DATE]. Interventions: CPR will be performed as ordered. Dated initiated [DATE].R4's nurse progress notes, dated [DATE], written by LPN F (Licensed Practical Nurse) state: Resident noted lying in bed unresponsive. Writer entered room and assessed resident; no pulse and no respirations noted. CPR initiated and 911 called. EMS arrived and assumed resuscitative efforts. EMS discontinued CPR at 1737 (5:37 PM) and resident was pronounced deceased . ME (Medical Examiner) notified. Resident's daughter notified and made aware of resident's passing. [County Name] was contacted and advised case would be referred to the [City Name] Medical Examiner.On [DATE] at 11:00 AM, Surveyor interviewed RN E regarding the code event for R4. RN E indicated that [DATE] was her first day of training and she was training with LPN F. RN E indicated she was not sure of the time everything took place but knew it was around dinner time because she was preparing for the evening medication administration. RN E indicated she entered R4's room to obtain vital signs for his medications. RN E stated she used the machine and was not able to get any vital sign results. RN E indicated she attempted to feel for a pulse but was unable to determine if she could feel a pulse. RN E stated she went across the hall to get LPN F. RN E indicated because it was her first day, she was not sure how a code worked at the facility. RN E stated LPN F came to R4's room and checked for a pulse. RN E stated LPN F indicated there was no pulse and LPN F left the room to see what R4's code status was. RN E stated LPN F returned to R4's room and started CPR. RN E stated she is unaware of how long it took for LPN F to return to the room after verifying R4's code status. RN E indicated there was a CNA and LPN F told the CNA to get the nurse supervisor. RN E stated LPN F started CPR after telling the CNA to get the nurse supervisor. RN E indicated she took over performing CPR and LPN F called 911. RN E indicated the nurse supervisor came and took over performing CPR.On [DATE] at 5:10 AM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding the code event for R4. LPN F indicated she was training RN E (Registered Nurse) on [DATE] for the evening shift. LPN F indicated sometime around 5:00 PM, she was in a room across the hall from R4. LPN F stated RN E went into R4's room to obtain vital signs prior to passing medications. LPN F stated RN E came across the hall, into the room LPN F was in, and notified LPN F that RN E was unable to obtain vital signs on R4. LPN F stated she left the room and went across the hall to R4's room. LPN F stated she checked R4's carotid artery (an artery in the neck) to feel for a pulse and was unable to obtain a pulse. LPN F stated R4 had no pulse. LPN F stated she left the room and went up the hall to the nurses' station to access R4's electronic medical record to verify his code status. LPN F indicated that once she obtained R4's code status and noted R4 was a full code, she instructed the two CNAs (Certified Nursing Assistants) who were in the nurses' station to get the nurse supervisor. LPN F indicated the nurse supervisor was across the building on a different unit. LPN F stated she returned to R4's room and instructed RN E to start CPR. LPN F stated she called 911 at 5:11 PM from her cell phone while in the resident's room. LPN F indicated CNA H came into the room and deflated the mattress and laid the bed flat. LPN F indicated once she was off the phone with 911, she assisted with performing CPR. LPN F stated once EMS (Emergency Medical Services) arrived, they took over performing CPR. LPN F stated she could not recall the times or timeframes the different actions took place but knew it started around 5:00 PM. LPN F stated the facility staff did not use the AED when providing CPR.On [DATE] at 2:10 PM, Surveyor interviewed CNA H regarding the code event for R4. CNA H indicated he was in the room with LPN F assisting a resident across the hall from R4. CNA H indicated RN E entered the room and told LPN F that RN E was unable to get vital signs on R4. CNA H indicated LPN F left the room. CNA H (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	06/09/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated he stayed in the room to finish assisting the resident he had been working with. CNA H indicated after he finished across the hall, which took about two minutes or so, he walked past R4's room. CNA H stated he saw LPN F starting CPR on R4. CNA H indicated he heard LPN F yell to get the nurse supervisor. CNA H indicated he was going to get the nurse supervisor when he saw another CNA going to notify the nurse supervisor, so CNA H stated he went back down to R4's room. CNA H indicated when he got to the room, he adjusted the mattress and bed. CNA H stated RN E took over CPR and LPN F called 911. CNA H stated he was trying to keep track of the times but it all was happening so fast. CNA H did not recall the times the different events took place but did recall that EMS arrived at 5:19 PM.Of note, there were two nurses in R4's room when CNA H walked past. CNA H walked past R4's room at least 2 minutes after R4 was noted to have no vital signs. LPN F had just started CPR and 911 had not yet been called for emergency services. Of note, taking into consideration the observations of the staff interviewed, there was a delay in starting CPR for R4 once he was found to have no vital signs. RN E was unable to obtain R4's vital signs through the vital sign machine. RN E then attempted to feel R4's pulse. RN E walked across the hall to inform LPN F of the situation. LPN F had to walk across the hall to R4's room. LPN F attempted to feel a pulse. LPN F had to go up the hall to the nurses' station and access the electronic health record to verify R4's code status. LPN F then went back down the hall to R4's room. CNA H indicated it was two minutes before he left the other resident's room. LPN F indicated she instructed the CNA to get the nurse supervisor prior to starting CPR. LPN F started performing CPR prior to calling 911 when RN E was in the room. On [DATE] at 12:39 PM, Surveyor interviewed LPN G regarding the code event for R4. LPN G indicated she is the nurse supervisor. LPN G stated a CNA came and told her to go to R4's room. LPN G indicated she could not recall which CNA came to get her. LPN G indicated when she arrived at R4's room, LPN F was on the phone with 911 and RN E was performing CPR. LPN G indicated she took over performing CPR for RN E. LPN G indicated she performed 2 rounds of CPR, for approximately 4 minutes, before LPN F took over performing CPR. LPN G indicated while LPN F was performing CPR, EMS arrived. LPN G indicated once EMS took over, she left the room.On [DATE] at 11:28 AM, Surveyor interviewed RN J regarding the code event for R4. RN J indicated she was working the evening shift on [DATE] but was not notified there was a code event until after EMS arrived. RN J stated she was working on the unit nearest to R4's unit. RN J indicated the AED is located at the beginning of the hall near the nurses' station on her unit. RN J indicated the AED was not removed until after EMS arrived.R4's EMS report, dated [DATE], includes:Unit Notified: [DATE] 17:12:17 (5:12 PM)Primary Symptom: Cardiac arrest, cause unspecifiedArrest Date/Time: [DATE] 17:06 (5:06 PM)At Patient: [DATE] 17:20 (5:20 PM)Who First Applied the AED: EMS ResponderNarrative: .dispatched for a male in cardiac arrest. went enroute with use of lights and sirens without delay. On arrival.found the.in cardiac arrest. Nurses at the healthcare facility were actively performing CPR, nurse stated that had been doing CPR for roughly 10 minutes prior to EMS arrival.Police incident report, dated [DATE], written by PO K (Police Officer), includes:Reported Date/Time: [DATE] 17:35:18 (5:35 PM)Arrival Date/Time: [DATE] 17:43:29 (5:43 PM)Initial Information: On [DATE] at around 1735pm (5:35 PM) I, PO K of the [City Name] Police Department, responded to [Facility Address, R4's Room] for a report of a sudden death. My body worn camera was active and the video later entered into evidence.Scene: Upon arrival, I first spoke with fire department personnel. They stated when they arrived on scene, there was [sic] no signs of life from the patient. I spoke with 2 nurses on scene. R4 was last checked at 16:40pm (4:40 PM). He had been fine at that time. While the nurses doing their rounds of administering medication, RN E observed that R4 was not breathing. RN E asked LPN F for assistance. This was around 1703pm (5:03 PM). LPN F noticed he did not have a pulse and was not breathing. LPN F checked to make sure that R4 did not have a DNR order (do not resuscitate.) They then began CPR at about 1711pm (5:11 PM) and called 911. EMS arrived on scene at around 1720pm (5:20 PM).On [DATE] at 8:45 AM, Surveyor contacted the police department and spoke with DT I (Detective.) DT I provided surveyors with the body camera footage from PO K. The following is from (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	06/09/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PO K's body camera footage dated [DATE]: At 5:43 PM, PO K entered R4's room. At 5:45 PM, LPN F entered R4's room. The following conversation occurred:PO K: What's going on?LPN F: Unexpected death.PO K: Who was the last person to see him?LPN F: I was.PO K: What time did you do your last check?LPN F: It was 1640 that last time he was last known well. She came in here while I was with another patient. She found him unresponsive with no pulse. Code status was verified.PO K: inaudible question askedLPN F: It was 1700 (5:00 PM). Code status verified. Initiated CPR at 17 like 1703 (5:03 PM,) 1704 (5:04 PM.) EMS was called at 1711 (5:11 PM.) They arrived at 1720 (5:20 PM.)PO K: How do you know all these times off the top of your head? Inaudible question.LPN F: No because I have them written down and I just told everyone else them three times.Of note, CPR was not initiated until 3 minutes after R4 was found pulseless and nonbreathing. EMS was not called until 7 or 8 minutes after CPR was initiated.On [DATE] at 10:54 AM, Surveyor interviewed DON B (Director of Nursing) regarding R4's code event. DON B indicated CPR needs to be started immediately. DON B indicated the AED should be utilized during CPR. DON B indicated the time frame of 3 to 4 minutes after finding R4 pulseless and nonbreathing to initiate CPR is not timely. DON B indicated 911 should be called immediately. DON B stated waiting 7 to 8 minutes to call 911 after starting CPR is not timely. According to the American Red Cross CPR Facts and Statistics: Survival chances decrease by 10% for every minute that immediate CPR and use of an AED is delayed.Immediate CPR can triple the chance of survival.https://www.redcross.org/take-a-class/resources/articles/cpr-facts-and-statistics?srsltid=AfmBOoomUf failure to provide proper basic life support, including immediately starting cardiopulmonary resuscitation, utilizing the AED, and promptly calling 911, created a reasonable likelihood of serious harm for R4, which created a finding of Immediate Jeopardy. The facility removed the immediate jeopardy on [DATE], however, the deficient practice continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan.On [DATE], DON began educating licensed staff on emergency response procedure for CPR including ensuring emergency medical supplies are used appropriately, 911 is called promptly, starting CPR immediately.Education included proper and prompt use of AED.Education reviewed on perform CPR per AHA (American Heart Association) guidelines.All licensed staff will be educated prior to their next tour of duty.On [DATE], facility reviewed the policy and procedure on CPR in coordination with the medical director and AHA guidelines.Nursing managers will conduct random audits four times weekly, then weekly for four weeks, followed by QAPI process for ongoing monitoring and compliance. Audits will consist of a complete review of a code event to ensure adherence to facility policy, documentation requirements, and staff response expectations. In addition, random mock code drills will be conducted to evaluate staff preparedness, response times, communication, and adherence to emergency procedures. The mock drills will be conducted randomly weekly for 4 weeks.An audit was conducted on [DATE] for the past 30 days to review any codes that has occurred. The audit included reviewing how the code was conducted and performed.

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	06/09/2026

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** Based on observation, interview, and record review, the facility did not ensure 1 resident (R) of 3 residents reviewed for pressure injuries received the necessary care and services to promote healing and/or prevent pressure injuries from developing (R7.) R7 was admitted to the facility on [DATE] with a Stage 3 pressure injury (PI) to his sacrum and inability to turn and reposition himself. The facility failed to implement a turning and repositioning schedule until 5/5/26 (8 days later.) On 5/5/26, R7 was discovered with an avoidable Stage 2 PI to his left buttock. Subsequently, on 5/12/26, the PI to R7's left buttock worsened to an Unstageable PI. On 5/12/26, Physician T (a wound physician) documented Bed rest please following a PI assessment. Per DON B (Director of Nursing) this was likely the day Physician T discussed offloading pressure with R7's Guardian, who liked R7 to be up in his Broda chair. DON B indicates the root cause analysis for R7's PI to his left buttock is friction, shear and a little bit of moisture and R7's Guardian demanding he be up in the chair for a long time. The facility did not provide R7 with a cushion for his Broda chair per Physician T's order and R7's Care Plan. The facility did not identify the deficient practices associated with R7's facility acquired PI nor educate staff. Evidenced by:The facility's policy, Pressure Injuries Overview, revised March 2020, documents in part, as follows: Purpose: The purpose of this procedure is to provide information regarding definitions and clinical features of pressure injuries. General definitions are derived from the State Operations Manual, Appendix PP (F686.) Pressure injuries for purposes of staging reference the National Pressure Injury Advisory Panel Classification System.General Definitions (State Operations Manual, Appendix PP): Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. Pressure ulcers/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue.Avoidable/Unavoidable Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed:Evaluation of the resident's clinical condition and risk factors;Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice;Monitoring or evaluation of the impact of the interventions; orRevision of the interventions as appropriate Friction/Shearing Friction is the mechanical force exerted on skin that is dragged across any surface. Shearing occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermisPartial-thickness loss of skin with exposed dermis.The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-intact blister.Adipose (fat) is not visible and deeper tissues are not visible.Granulation tissue, slough and eschar are not present.Commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 Pressure Injury: Full-thickness skin lossFull-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.Slough and/or eschar may be visible.The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.Undermining and tunneling may occur.Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.If slough or eschar obscures the wound bed, this is an Unstageable PI. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue lossFull-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. R7 was admitted to the facility 4/27/26 with diagnoses (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	06/09/2026

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	including, but not limited to, the following: Stage 2 PI sacrum (Partial-thickness skin loss with exposed dermis,) nontraumatic intracranial hemorrhage (a blood vessel leaks or ruptures inside the skull-a life-threatening emergency,) muscle wasting and atrophy (loss of muscle mass which leads to weakness,) somnolence (excessive sleepiness,) diabetes mellitus type 2 (the body resists the effects of insulin or does not produce enough to maintain normal blood sugar,) and trach status (a surgically created opening in the neck leading to the windpipe to help the person breathe.) R7's admission Minimum Data Set (MDS) dated [DATE] documents R7 is at risk for PIs; R7 is admitted with one (1) Stage 2 PI; R7 has no Stage 3 or 4 PIs.Of note, according to Physician T, R7 has a Stage 3 PI (physician assessment completed the day after R7's admission to the facility) to his sacrum (at the base of the lumbar spine and between the hip bones.) R7's family member is his legal Guardian. It is important to note, R7 does not have a care plan for turning and repositioning until 5/5/26, eight days after admission and the same day the second PI was discovered. R7's care plan indicates the following Focus area: (Date Initiated 4/27/26): At risk for/actual altered skin integrity related to CVA (cerebrovascular accident-stroke) with mobility problems, weakness, and need for staff assist.Active: PI Left Buttock 5/5/26Pressure to thoracic spinePressure to coccyx (admit)Goal: Affected area will heal without complicationsInterventions:(Date Initiated: 4/28/26) Air mattress setting at 7(Date Initiated: 4/27/26) Assist to elevate bilateral heels *(Date Initiated: 5/5/26) Assist to reposition every 1-2 hr (hours)(Date Initiated: 4/27/26) Complete Braden scale per facility policy(Date Initiated: 4/27/26) Complete weekly skin inspection*(Date Initiated: 5/12/26) Encourage me to remain in bed and assist me with repositioning every hour(Date Initiated: 5/5/26) Heel boots in bed(Date Initiated: 4/27/26) Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings(Date Initiated: 4/27/26) Notify practitioner if symptoms worsen or do not resolve(Date Initiated: 4/27/26) Nutritional and Hydration support(Date Initiated: 5/19/26) Offer me assistance out of bed for 1 hr per day(Date Initiated: 4/27/26) Provide pressure reducing wheelchair cushion(Date Initiated: 4/27/26) Provide pressure reduction/relieving mattress(Date Initiated: 4/27/26) Provide thorough skin care after incontinent episodes and apply barrier cream(Date Initiated: 4/27/26) Skin assessment to be completed as per facility protocol(Date Initiated: 4/27/26) Treatments as ordered(Date Initiated: 4/27/26) Weekly wound evaluation R7's Braden Assessment on 4/27/26 is 13 (Moderate Risk of PIs.) On 4/28/26 at 12:45 PM, Physician T documented the following: Sacrum (Note, this was present on admission) 1.21 cm (centimeters) x 0.25 cm x 0.00 Color: Yellow 0.05 cm (centimeters) squaredObservations: Etiology: Pressure Ulcer - Stage 3 Margin Detail: Attached edgesWound bed Assessment: Fully granulatedDrainage Amount: SmallDrainage Description: SerousOdor: Normal odorPeriwound: Clean, dry, intactCurrent Formularies:Cleanser: Cleanse wound with salineCreams/Ointments: Zinc barrier cream TID (three times a day)/PRN (as needed)Nutrition: Discussed nutrition and its impact on wound healingCurrent Formularies: Pressure Relief/Offloading: Follow Facility Pressure Ulcer Prevention Policy/Protocol, Pressure Redistribution Mattress per Facility Policy/Protocol, Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol, Offload heels per Facility Policy/ProtocolPlan of Care: Plan of Care discussed with Facility Staff Note, R7's Stage 3 to his sacrum healed. However, on 5/5/26, a new PI is discovered. On 5/5/26 at 11:15 AM, Physician T documented the following:Left ButtockMeasurements: 0.85 cm (centimeters) x 0.47 cm x 0.10 cmObservations:Etiology: Pressure Ulcer - Stage 2Margin Detail: Attached edgesWound bed Assessment: Clean, non-granulatingDrainage Amount: ModerateDrainage Description: SerousOdor: Normal odorPeriwound: Clean, dry, intactCurrent Formularies:Cleanser: Protect periwound with Skin Prep; Cleanse with salineSecondary dressings: Cover wound with superabsorbent dressingDressing frequency: Change daily and PRN (as needed) soiling/saturation of dressingNutrition: Discussed nutrition and its impact on wound healingPressure Relief/Offloading: Follow Facility Pressure Ulcer Prevention Policy/Protocol, Pressure Redistribution Mattress per facility Policy/Protocol, Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol/Offload heels per Facility Policy/ProtocolPlan of Care: Plan of Care discussed with (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	06/09/2026

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	Facility Staff On 5/12/26 Physician T documented the following:Left ButtockMeasurements: 4.83 x 4.62 x 0.10Observations:*Etiology: Pressure Ulcer - UnstageableMargin Detail: Attached edgesWound bed Assessment: Granulation 26-50%, Slough 26-50%Drainage Amount: SmallDrainage Description: SerousOdor: Normal odorPeriwound: Clean, dry, intactCurrent FormulariesCleanser: Protect periwound with Skin Prep, Cleanse with 1/2 strength Dakin's solutionPrimary dressing: Apply nickel thick Santyl to wound bedSecondary dressing: Cover wound with Bordered GauzeDressing frequency: Change daily and PRN (as needed) soiling/saturation of dressingNutrition: Discussed nutrition and its impact on wound healingCurrent Formularies: Pressure Relief/Offloading: Follow Facility Pressure Ulcer Prevention Policy/Protocol, Pressure Redistribution Mattress per facility Policy/Protocol, Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol/Offload heels per Facility Policy/ProtocolPlan of Care: Plan of Care discussed with facility staff Wound Notes: 5/12/25 at 11:15 AM: Bed rest please On 5/19/26 at 11:47 AM, Physician T documented the following:Left ButtockMeasurements: 4.13 cm x 2.67 cm x 0.10 cmObservations:Etiology: Pressure Ulcer - UnstageableMargin Detail: Attached edgesWound bed Assessment: Granulation 26-50%, Slough 26-50%Drainage Amount: SmallDrainage Description: SerousOdor: Normal odorPeriwound: Clean, dry, intactCurrent Formularies:Current Formularies: Pressure Relief/Offloading: Follow Facility Pressure Ulcer Prevention Policy/Protocol, Pressure Redistribution Mattress per facility Policy/Protocol, Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol/Offload heels per Facility Policy/ProtocolPlan of Care: Plan of Care discussed with facility staff Wound Notes: 5/12/25 at 11:15 AM: Bed rest please On 5/26/26 at 11:00 AM, Physician T documented the following:Measurements: 2.93 cm x 1.83 cm x 0.20 cmObservations:Etiology: Pressure Ulcer - UnstageableMargin Detail: Attached edgesWound bed Assessment: Granulation 1-25%, Slough 51-75%Drainage Amount: SmallDrainage Description: SerousOdor: Normal odorPeriwound: Clean, dry, intactCurrent FormulariesCurrent FormulariesCleanser: Protect periwound with Skin Prep, Cleanse with 1/2 strength Dakin's solutionPrimary dressing: Apply nickel thick Santyl to wound bedSecondary dressing: Cover wound with Bordered GauzeDressing frequency: Change daily and PRN (as needed) soiling/saturation of dressingNutrition: Discussed nutrition and its impact on wound healingCurrent Formularies: Pressure Relief/Offloading: Follow Facility Pressure Ulcer Prevention Policy/Protocol, Pressure Redistribution Mattress per facility Policy/Protocol, Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol/Offload heels per Facility Policy/ProtocolPlan of Care: Plan of Care discussed with facility staff Wound Notes: 5/12/25 at 11:15 AM: Bed rest please On 5/27/26 at 3:00 PM, Surveyor spoke with LPN U (Licensed Practical Nurse.) Surveyor asked LPN U what skin interventions are in place for R7. LPN U stated, reposition every 2 hours, and R7 has a wound to his coccyx, boots to bilateral feet in bed, and an air mattress. Surveyor asked LPN U, has R7 been turned and repositioned every 2 hours since admission. LPN U stated repositioning is something we established to prevent further skin breakdown. LPN U added, turning and repositioning was not in place upon admission and was started at a later date. Surveyor asked LPN U, should turning and repositioning be in place upon admission. LPN U stated, yes, especially when R7 is unable to make his needs known and reposition himself independently. LPN U stated, R7 does not have a cushion in his Broda chair. LPN U stated, she overheard Physician T recommending that R7 have a cushion in his Broda chair. LPN U stated, R7's Guardian was very insistent on having R7 up in the chair very often. LPN U added, it wasn't until skin breakdown started occurring that Physician T indicated that R7 needs to lay in bed with repositioning. LPN U stated, it's understandable that R7's Guardian has no knowledge of what is going on and the importance of turning and repositioning side to side (to offload pressure.) Surveyor asked LPN U if R7 refuses care or has behaviors. LPN U stated, no, he's very cooperative. 5/27/26 at 3:10 PM, Surveyor observed ADON Q (Assistant Director of Nursing) pull back R7's dressing to his left buttock. Surveyor asked ADON Q what she observed. ADON Q stated, there is 50% slough and 50% granulation in the wound bed. ADON Q stated, R7's PI to his left buttock is drastically improved. Surveyor asked ADON Q if R7 has a cushion in his Broda chair. ADON Q stated, (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	06/09/2026

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	no. Surveyor asked ADON Q if R7 should have a cushion in his Broda chair. ADON Q stated, the facility does not normally put cushions in Broda chairs. ADON Q stated, currently Physician T wants R7 in bed to offload pressure. ADON Q stated, we will discuss the appropriateness of a cushion in R7's Broda when he is back up in his chair. Note, the Care Plan indicates R7 is to have a cushion in his wheelchair and Physician T ordered a wheelchair cushion. On 5/27/26 at 3:54 PM, Surveyor spoke with DON B (Director of Nursing.) Surveyor asked DON B what is the root cause analysis for R7's PI to his left buttock. DON B stated, it is originally from friction and shear, a little bit of moisture, and R7's Guardian demanding that R7 be in the chair (Broda) for a long time. Surveyor asked DON B, between 5/5-5/12/26 did the facility educate staff regarding the root cause analysis and how to prevent the PI from worsening and prevent new PIs. DON B stated, No. Surveyor stated to DON B, R7's Care Plan documents that turning and repositioning was not put in place until 5/5/26. DON B checked the EHR (Electronic Health Record.) DON B stated, that is correct, repositioning was not put in place until 5/5/26. Surveyor asked DON B what her expectation was for turning and repositioning. DON B stated she expects turning and repositioning to be in place upon admission due to R7's existing PI and inability to turn and reposition. Surveyor asked DON B, should R7 have a wheelchair (Broda) cushion in place per his Care Plan and order from Physician T. DON B stated yes, it is an order. DON B added, R7's Broda chair can also be reclined to help relieve pressure. DON B stated, the facility ordered a cushion for R7's Broda chair on 5/20/26. DON B stated there has been a delay in shipment and the cushion should arrive sometime this week.

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	06/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision for 1 of 3 residents (R5) reviewed for elopement. On 5/18/26, R5 attempted to exit the building, setting off the door alarm. There was a 3-minute delay in the door alarm resetting. During this delay, the staff failed to adequately supervise R5, who was then able to exit the building and was found in the ER (Emergency Room) waiting room next door to the facility. This is evidenced by: Facility policy titled Elopement, undated, states in part: Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care. Policy Explanation and Compliance Guidelines: . 3. The facility is equipped with door locks/alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering. implementing interventions to reduce hazards and risks. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: . d. Adequate supervision will be provided to help prevent accidents or elopements. R5 was admitted on [DATE] with diagnoses that include Vascular Dementia, Severe, With Agitation, Repeated Falls, Generalized Anxiety Disorder, and Restlessness and Agitation. R5's admission Minimum Data Set (MDS) with a target date of 5/21/26, indicates a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating R5 is moderately cognitively impaired. R5's Comprehensive Care Plan states in part: Focus: At risk for elopement related to: Attempts to leave Living Center, Wandering. I had an elopement incident 5/18/26. Date Initiated: 5/18/26.Goals: Will remain safe during placement at Living Center Date Initiated: 5/18/26 Target Date: 8/19/26.Interventions: 15 minute checks to be completed to ensure resident safety. Date Initiated: 5/18/26. Assess for risk of elopement per living center policy. Date Initiated: 5/18/26 . Educate family/responsible party on talking positively about Living Center Placement. Date Initiated: 5/18/26. Encourage family to bring in personal possessions. Date Initiated: 5/18/26. Evaluate effect of cognitive impairment upon resident's ability to understand changes in surroundings.Date Initiated: 5/18/26. Involve patient in preferred activities including reading books, drawing, writing in note pad, art like activities, and puzzles. Date Initiated: 5/18/26. Revision on: 5/19/26. Provide redirection, reassurance, and diversion activities when resident demonstrates exit-seeking behaviors. Date Initiated: 5/18/26. Redirect patients from doors. Date Initiated: 5/18/26. Talk to me in a calm unhurried voice when providing redirection. Date Initiated: 5/19/26. A review of R5's Electronic Health Record (EHR) includes the following progress notes:On 5/18/26 at 1:30 AM: Late Entry: At 1:09 AM Resident attempted elopement through the back of the facility towards the tunnel. The alarm sounded, staff redirected resident away from door and staff put in code to the door for alarm to be shut off. The resident was walking alongside staff writer went past Nurse's station to Supply closet and the other staff member present at the time went down the 400 hall. Writer was away from nurse's station for roughly 5 to 7 mins while writer was getting supplies. When writer was back at the nurse's station within the 7 min timeframe writer received a call from (hospital name) ER that resident had entered their ER ambulating with his walker. Writer assisted resident back to the facility. Resident was placed on 15 minute checks with close supervision. Resident remained within line of site through the duration of shift. On 5/19/26 at 2:08 AM, Resident is up, wandering, striking out at staff, and not easily redirected. He has tried to exit 2x (two times). Will monitor closely. On 5/19/26 at 11:45 AM, Some agitation noted - cont (continue) to wander halls via w/c (wheelchair) mobility or ambulation - on q (every) 15 min (every 15 minute) checks. On 5/19/26 at 7:29 PM, . Patient continues to wander around the unit . On 5/26/26 at 5:16 PM, Resident continues on 15 minute checks, anxious and in need (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	06/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of redirection. confused and disoriented most of the time. Fidgeting often. No attempts of eloping at this time. On 5/26/26 at 10:11 PM, Resident continues on 15 minute checks. At risk of elopement. Has been anxious and pacing. On 5/27/27 at 2:39 AM, Late Entry: Residents continues on 15 minute checks for elopement risk. Resident had been at the nurse's station with staff all night long. He was sitting in his wheelchair and dozed off. A staff went about resident care one of the CNAS (Certified Nursing Assistant) Called into a residence room when I came back to the nurse's station other nurse on staff was bringing him back from the Northside stated that he was tempting to elope. RESIDENT CONTINUES ON 15 MIN CHECKS. The facility completed a Self-Report Summary for R5's elopement, which included the following, in part: . Incident Description: On May 18, 2026, at approximately 1:10 AM, [Resident Name] was observed exiting through the 300 Hall common area door. Staff immediately responded and redirected the resident back into the facility. LPN F (Licensed Practical Nurse) entered the alarm code to reset the door alarm system while staff escorted the resident away from the exit area. Upon re-entering the facility with staff, the resident stated, ?the alarm is going off, I can't go out that way,' indicating awareness that the alarm system had initially activated during the resident's first exit attempt. Staff reported the resident was observed walking alongside staff back into the facility. LPN F stated she was under the impression CNA (Certified Nursing Assistant) staff were continuing to escort the resident back toward his room while she returned to resident care duties. During the facility investigation, staff reported it is believed the resident turned back toward the 300 Hall exit door while staff resumed resident care duties. Due to the delay in alarm reactivation following code entry, the resident was able to re-exit the facility before the alarm system fully reset and without the alarm immediately sounding. At approximately 1:19 AM, Watertown Hospital contacted the facility and notified LPN F that [Resident Name] was present in the emergency room waiting area. Investigative Findings/Root Cause Analysis: . The investigation identified that once the code was entered, the door alarm system had an approximate three-minute delay before reactivation. During that delay period, the resident was able to re-exit the facility without the alarm immediately sounding. On 5/26/26 at 3:15 PM, Surveyor observed R5 actively attempting to exit seek the building. Surveyor observed CNA P (Certified Nursing Assistant) retrieve R5 and redirect him away from the door. On 5/27/26 at 2:17 PM, Surveyor interviewed CNA H about R5's elopement. CNA H indicated that last week R5 started wandering and tried to escape. CNA H stated that when R5 initially tried to elope, he put the code in to keep R5 away from the door and then he went back to the other side of the building where he was working for the night. CNA H stated that is when R5 went out the exit door. CNA H indicated that the door alarm didn't automatically go back on when he entered the code. Surveyor asked CNA H if R5 still attempts to exit seek. CNA H replied no because R5 remains with a staff member throughout the shift. On 5/27/26 at 2:35 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) about R5's elopement. LPN F stated that R5 wanders and exit seeks, and last week he got out of the building. LPN F indicated that R5 was trying to leave when the door alarm rang. LPN F stated her and CNA H were in the nurses' station and the CNA from 400 Hall came over so all three of them were with R5 by the exit door. LPN F stated they punched in the alarm code, and they told R5 to come with them. LPN F stated she then went to get some supplies, and it was at that time that R5 must have doubled back and went out the exit door. LPN F stated that CNA H went back to the nurses' station and the CNA from 400 Hall went back to that side of the building. LPN F indicated that after she received the call from Watertown Hospital and brought R5 back to the facility, she immediately started him on 15-minute checks. Surveyor asked LPN F if R5 still attempts to exit seek. LPN F stated yes, and that last night R5 tried to elope again. LPN F stated that R5 was in the nurses' station asleep when she left him to go suction another resident and when she came back the nurse from the north side of the building was bringing R5 back. LPN F indicated she had only left R5 alone for 3-4 minutes. On 5/27/26 at 2:45 PM, Surveyor interviewed CNA P about R5's elopement. CNA P indicated that she was not working that day, but that R5 still continues to exit seek. CNA P stated that last night on 3rd shift in the middle of rounds, R5 was found on the other side of the building, and (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	06/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse had to bring him back to this side. CNA P stated that R5 does that often. On 5/27/26 at 3:25 PM, Surveyor interviewed MD R (Maintenance Director) and NHA A (Nursing Home Administrator) about R5's elopement. NHA A indicated that R5 went out the smoker's door, down the sidewalk and through the hospital parking lot, straight ahead to the ER entrance. MD R indicated that he adjusted the door reactivation alarm so that now there is only a 15-second delay.

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	06/09/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain acceptable parameters of nutritional status and consult with the residents' Physician on this for 1 of 3 residents (R7) reviewed for nutrition. R7 did not have a nutrition care plan. R7 experienced a significant weight loss of 4.29% in one week (13.5# loss) and the facility did not notify the physician. Evidenced by: Facility policy: Weight Monitoring states in part: . Process. Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status. 1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors. b. Evaluating and analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary. 2. A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. 3. Information gathered from nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible: a. Identified causes of impaired nutritional status. b. Reflect the residents personal goals and preferences. c. Identify resident specific interventions. d. Time frame and parameters for monitoring. e. Updated as needed such as when the residents condition changes, goals are met, interventions are determined to be ineffective or a new causes of nutrition related problems are identified. g. The resident and/or resident representative will be involved int he development of the care plan to ensure it is individualized and meets persal goals and preferences. 6. A weight monitoring schedule will be developed upon admission or all residents. b. Newly admitted residents-monitor weight weekly x 4 weeks. c. residents with weight loss-monitor weight weekly d. if clinically indicated-monitor weight daily. e. All other monitor weight monthly. 6. Weight analysis: A significant weight is defined as: a. 5% change of weight in a month (30 days). 7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. e. The Registered Dietician should be consulted to assist with interventions, actions are recorded int he nutrition progress notes. R7 was admitted to the facility on [DATE] with diagnoses of: Non traumatic intercranial hemorrhage (bleeding in the brain), Chronic respiratory failure (lungs can't move oxygen into blood and carbon monoxide out causing ongoing fatigue and shortness of breath), Type II Diabetes Mellitus (body stops making enough insulin or not responding properly to insulin), Tracheostomy (small hole in front of neck directly into windpipe to place a breathing tube allowing the person to breathe without using their nose or mouth), Gastrostomy tube (soft, flexible tube placed directly into the stomach through a small hole in the belly; acts as a direct tunnel for liquifood, water, and medications when eating or drinking by mouth isn't safe (dysphagia)). As of 5/27/26 R7 did not have a nutrition care plan with specific interventions and goals for weight loss/gain. R7's admission Nutritional assessment dated [DATE] at 13:20 PM states R7's weight at 321.6# Goal: resident will have no significant weight changes per MDS criteria, however gradual weight loss desired due to high BMI. Of note R7 had a significant weight loss of 4% or 13.5# since 5/12/26 R7's physician order: 4/27/26 Enteral Feed Order-every shift Jevity 1.5 at rate of 70 mL/hr (milliliters/hour) with 150 free water flush Q4 (every four) hours. Weekly weight x (times) 4 weeks every day shift every Tue for 4 Weeks. Current Weights: 4/28 336.04/29 332.9 4/30 337.95/2 335.75/3 335.75/5 335.75/12 335.15/19 321.6 (this is a 3% change from the last weight, decrease of 13.5 lbs.) 5/27 316.4 (note: this is another 5.2 pounds lost, or a 5.58% loss in 15 days) No documentation was provided to show that a provider was updated on R7's weight loss. On 5/27/27 at 3:22 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) Surveyor asked LPN F where she would find a significant weight loss in the chart. LPN F stated that a significant weight loss will turn (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	06/09/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	red on banner where it says weight. Surveyor asked LPN F what would you do if you saw this weight loss. LPN F stated she would try to find out why, assess the resident, check for trends, and call the MD. Surveyor asked who else would you notify. LPN F stated DON, and immediate floor manager. Surveyor asked if a significant weight loss would be considered a COC (change of condition). LPN F stated yes, she would do a COC note and paste it into the progress note. On 5/27/26 at 3:45 PM, Surveyor interviewed RD L (Registered Dietician). Surveyor asked how do you get notified of a weight loss. RD L stated that they talk about it at our resident at risk meetings. Surveyor asked RD L how often do the resident as risk meetings happen. RD L states pretty much weekly. Surveyor asked if you didn't have a meeting how would you get notified. RD L stated ADON Q (Assistant Director of Nursing) tells me. I couldn't do anything because you (state surveyors) have been here the last two weeks, so we haven't had a meeting. Surveyor asked RD L should the physician be notified of a significant weight loss? RD L stated we determine that in resident at risk meeting. I don't get notified until there is a 5% weight loss so that is why we talk about it at the meeting. Surveyor asked RD L should a significant weight loss be considered a change of condition. RD L reported that he (R7) is meeting his required intake, he was obese when he came to us. Surveyor asked RD L if the resident has not had a change in his tube feed order, would you be concerned about a significant weight loss. RD L indicated yes. Surveyor asked RD L what would you do then. RD L stated I would talk with the NP (Nurse Practitioner), RD L indicate she hasn't yet, but would request labs possibly a pre albumin, and check kidney function, keep NP on the same page. On 5/27/26 at 4:45 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you consider a significant weight loss in a week a change of condition. DON B stated yes. Surveyor asked DON B would you expect staff to notify the physician with a significant weight loss in one week. DON B stated yes.

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	06/09/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and record review, the facility did not provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 3 residents (R2) reviewed for transfer referrals.R2 had been requesting for 6 weeks for social services to make the necessary referrals for her to move to a facility closer to family. The facility failed to make the requested referrals.Evidenced by:The facility policy, titled Social Services, dated 11/2025, indicates the following, in part: . Policy Explanation and Compliance Guidelines: . 2. The facility, regardless of size, will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, or psychosocial well-being. 3. Any need for medically-related social services will be documented in the medical record. 4. The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include: . g. Making referrals. i. Transitions of care services (e.g. assisting with transfer arrangements to other facilities). 6. The resident's plan of care will reflect any ongoing medically-related social service needs, and how these needs are being addressed.R2 was admitted , on 4/10/26, with diagnoses that include Major Depressive Disorder, Recurrent, Unspecified, Generalized Anxiety Disorder, and Chronic Pain Syndrome.R2's admission Minimum Data Set (MDS) with a target date of 5/7/26, indicates, in part: Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating R2 is cognitively intact. On 5/26/26 at 9:34 AM, Surveyor interviewed R2 who voiced frustrations about her desire to be transferred to a facility closer to her daughter. R2 stated that she had asked facility management over and over to move her closer to her only living relative, which is her daughter. R2 indicated that she had spoken to the social worker and had even written a letter to management asking to be transferred. R2 stated that at the end of the day, facility management gets to go home and be with their families, and she's not being allowed to be with her family. R2 stated that she doesn't think it is too much to ask to be allowed to move to a facility closer to her daughter. A review of R2's Electronic Health Record (EHR) include the following progress notes:On 4/14/26 a Social Services Note: Baseline care plan meeting held. Unknown discharge plan at this time, resident would like to have referrals sent closer to home.On 5/5/26 a Social Services Note: Writer was informed that resident wanted to meet, writer met with resident who requested referrals be sent out. Prefer closer to home but would consider other options.On 5/24/26: NHA received complaint from Regional Ombudsman. regarding resident [Resident Name]. Complaint included concerns related to resident's requests for transfer to Waukesha County not being followed up on and concerns regarding food services. Plan to coordinate care conference with resident to discuss concerns and follow up accordingly.On 5/26/26 at 3:15 PM, Surveyor interviewed SSA C (Social Services Assistant) who stated that she had been in her role for only 2 weeks. Surveyor asked SSA C what the process was for residents who desired to be transferred to another facility. SSA C stated that she would go and talk with the resident to find out if they had any facilities or a particular area in mind. Surveyor asked SSA C what an acceptable time frame for making those referrals would be. SSA C stated that she would make the referrals the same day if possible. Surveyor asked SSA C where she was in the process of referrals for R2. SSA C stated that she was just on her way to talk to R2 about that today. Surveyor asked SSA C if she had sent any referrals for R2. SSA C indicated that she personally had not sent any, and that if the previous social worker had sent any, she would have entered a progress note on it.On 5/26/26 at 3:34 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CNO D (Chief Nursing Officer) about the facility's referral process. DON B indicated that if a resident had a preferred facility or one that was closer to their desired region, social services was responsible for sending out the referrals. Surveyor asked what an acceptable timeframe would be for sending out (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	06/09/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referrals. NHA A stated that the referrals are usually sent out immediately. Surveyor asked where social services were at in R2's referral process. NHA A stated that he was having the previous social worker send out referrals for R2, but he was not sure who accepted her or what facilities might be full, etc. Surveyor asked where that information would be documented. DON B indicated that there should be a progress note in R2's chart on that. Surveyor asked if a resident asked to be transferred to a facility closer to family, if 6 weeks was an acceptable timeframe to wait for referrals to be sent out. CNO D stated that would not be an acceptable timeframe, but she would check to see if they had more information about R2's referrals.On 5/27/26, a Social Service Note in R2's EHR indicated, Writer faxed 4 referrals to skilled nursing facilities. Waiting to hear back.No other information or follow-up was provided by the facility.

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	06/09/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident received food and drinks that are safe and appetizing temperature. This has the potential to affect all 92 residents who reside at the facility. Surveyor received a test tray with cold foods that were not cold enough. Surveyor received a test tray with hot foods that were not hot enough. R2 voiced concerns about food quality and temperature. This is evidenced by: The facility policy, titled Preventing Foodborne Illness – Food Handling, reviewed 1/25, states in part: Policy Statement: Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. Policy Interpretation and Implementation: 1. The facility recognizes that the critical factors implicated in foodborne illness are: .b. Inadequate cooking and improper holding temperatures. The Food and Drug Administration (FDA) Food Code 2022, includes in part: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. Time/Temperature control for safety - food shall be maintained: (1) At 57 degrees C (135 degrees F) or above.(2) At 5 degrees C (41 degrees F) or less. Example 1 R2 was admitted on [DATE]. R2's admission MDS (Minimum Data Set) with a target date of 5/7/26, indicates in part: Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating R2 is cognitively intact. On 5/26/26 at 9:34 AM, Surveyor interviewed R2 who stated she eats most of her meals in her room. R2 indicated the food at the facility is awful and very bad quality. R2 stated they don't get the minimum amount of protein required for healing, and that many times for breakfast there is no protein in the meal. R2 stated the food is always cold, and they have run out of milk and coffee a lot lately. R2 showed Surveyor a dietary form that stated there are no alternatives offered for breakfast. A review of R2's EHR (Electronic Health Record) include the following progress notes: On 5/24/26: NHA received complaint from Regional Ombudsman. regarding resident [Resident Name]. Complaint included concerns regarding food services. Plan to coordinate care conference with resident to discuss concerns and follow up accordingly. Example 2: On 5/26/26 at 12:04 PM, Surveyor received a lunch test tray from the kitchen with cold foods on it. The test tray was served directly from the kitchen's cold food holding area after staff had taken trays to resident rooms and served lunch to the last resident eating in the dining room. The temperature of (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	06/09/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the chicken salad (served on white bread) was 57.2 degrees F. The temperature of the potato salad was 42.3 degrees F. The temperature of the chocolate milk was 48.4 degrees F. Example 3: On 5/27/26 at 12:30 PM, Surveyor received a lunch test tray from the kitchen with hot foods on it. The test tray was served directly from the kitchen's hot food holding area after staff had taken trays to resident rooms and served lunch to the last resident eating in the dining room. The temperature of the sloppy joe meat (served on a bun) was 125.6 degrees F. The temperature of the tater tots was 121.6 degrees F. The temperature of the peas was 122.5 degrees F. On 5/27/26 at 1:55 PM, Surveyor followed up on the meal trays with [NAME] N. (Of note: the facility's new dietary manager started on 5/26/26 and was not in the building on 5/27/26.) [NAME] N indicated cold foods should be served around 40 degrees F. Surveyor discussed the temperatures of the chicken salad, potato salad, and milk on 5/26/26. [NAME] N indicated the recorded temperatures were too high. [NAME] N indicated hot food temperatures are typically between 165-175 degrees F when food is coming out of the oven and should be served hot to residents. Surveyor discussed the temperatures of the sloppy joe meat, tater tots, and peas with [NAME] N. [NAME] N indicated those temperatures were not high enough. [NAME] N indicated they would work on the temperatures. On 5/27/26 at 2:00 PM, Surveyor discussed the food temperature issues with NHA A (Nursing Home Administrator) and DON B (Director of Nursing.) On 5/27/26 at 2:45 PM, Surveyor discussed the food temperature issues with RD L (Registered Dietician.)