

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide a clean, comfortable, homelike environment for 3 residents of 19 sampled Residents (R14, R10, & R13). R14's room walls and privacy curtains had visible stains/marks on them. R10 was observed with a gown saturated with colostomy leakage, flies were on R10's blankets. R13's room was not clean. Findings Include: The facility 's Homelike Environment Policy, effective date July 2026, states: The facility is committed to maintaining a home-like environment that supports resident dignity, privacy, independence, choice, and quality of life. *Keep resident rooms and common areas clean, safe, comfortable, and welcoming. Example 1: On 7/7/26 at 11:20 AM, Surveyor observed numerous dark brown colored marks scattered on the wall along the side of R14's bed between bed and wall light. Area affected was approximately 2.5 feet in length by 3.5 feet in width. Bedspread on bed had scattered dark areas of discoloration present toward head of bed. Privacy curtain had scattered dark areas of discoloration at the mid to lower end of curtain. R14 admitted to the facility on [DATE] with multiple wounds due to peripheral vascular disease including areas to fingers and hands that require daily dressing changes. R14 is known to remove dressings from fingers independently. On 7/8/26 at 9:00 AM, Surveyor observed same areas of discoloration on the wall and privacy curtain as previous day. R14 was sleeping in bed with clean sheet on and no bedspread in use. On 7/8/26 at 9:15 AM, Surveyor interviewed Hskp V (Housekeeper) who was shown privacy curtain (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor of the bathroom between the right side of the toilet and the wall of the bathroom. FM O (Family Member) was also in R13's room at the time and noted that the water had been observed on the floor of R13's bathroom for several days. On 7/8/26 at 11:05 AM, Surveyor observed standing water on the floor of R13's bathroom in the same place as the previous day. Surveyor spoke with R13 about the water on the bathroom floor. R13 indicated the water is not healthy or clean and said she does not like it. LPN I (Licensed Practical Nurse) entered the room, and Surveyor had her observe the water on the floor next to R13's toilet. LPN N indicated she did not know if the toilet was leaking or why the water was there, but she would follow up on it. On 7/8/26 at 11:25 AM, AA H (Assistant Administrator) entered R13's room and looked at the toilet and the standing water next to it. AA H indicated he did not know what was wrong with the toilet, but he submitted a work order so MD P (Maintenance Director) could look at it. On 7/8/26 at 2:41 PM, Surveyor spoke with Hskp Q (Housekeeper). Hskp Q had recently cleaned R13's room and indicated the water next to the toilet was a maintenance issue. On 7/8/26 at 2:45 PM, Surveyor followed up with AA H to find out if MD P had determined what was causing the standing water next to the toilet. AA H indicated this was still on their list to look at but they had not gotten to it yet. On 7/8/26 at 2:41 PM, Surveyor notified INHA W (Interim Nursing Home Administrator) and CNO N (Chief Nursing Officer) about R13's environmental concern with her toilet.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure written bed holds were completed for 1 of 1 resident (R5) reviewed for bed holds out of a sample of 19.R5 was transferred to the hospital. The facility did not provide a written bed hold notice to R5 and/or R5's resident representative. This is evidenced by:The facility's policy, titled Bedhold Notice Upon Transfer, implemented 3/1/26, states in part: Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed.Policy Explanation and Compliance Guidelines: .1. Before a resident is transferred to a hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. C. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility. 2. In the event of an emergency transfers [sic] of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan.5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. R5's medical record indicated R5 was sent to the hospital on 6/15/26. R5's medical record did not contain a written bed hold notice. On 7/8/26 at 3:15 PM, ADON M (Assistant Director of Nursing) informed Surveyor that the facility did not have a bed hold for R5's hospital admission on [DATE] but should have had one. On 7/8/26 at 3:25 PM, Surveyor notified INHA W (Interim Nursing Home Administrator) and CNO N (Chief Nursing Officer) about R5's missing bed hold form.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the comprehensive care plan was being followed for 1 (R9) of 19 care plans reviewed out of a total sample of 19 residents.R9's care plan indicates staff assistance of 2 for all cares. Staff are consistently assisting R9 using only one staff member.Evidenced by:The facility policy, titled, Care Planning - Interdisciplinary Team, dated March 2026, states, in part, Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 1. Resident care plans are developed according to the timeframes and criteria established . 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).R9 was admitted to the facility on [DATE] with diagnoses that include, in part, Type 2 Diabetes Mellitus, Morbid Obesity, Pain in right leg, and Weakness. R9's most recent Minimum Data Set (MDS) Assessment, dated 5/26/26, indicates R9's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating that R9 is cognitively intact.R9's Comprehensive Care Plan includes, in part: Focus: I have a physical functioning deficit related to: Mobility impairment, Self-care impairment due to weakness, physical limitations, choosing to stay in bed and need for staff assistance. I prefer to not have my thighs touch when assisting in turning and repositioning me. Date Initiated: 5/22/26.Interventions: . Bed mobility assistance of 2 r/t (related to) possible behaviors. Date Initiated: 5/22/26. Dressing assistance of 2 r/t possible behaviors. Date Initiated: 5/22/26. Oral care assistance set up with 2 r/t possible behaviors. Date Initiated: 5/22/26. Personal Hygiene assistance of 2 r/t possible behaviors. Date Initiated: 5/22/26. Toileting assistance of 2 r/t possible behaviors. Date Initiated: 5/22/26. Transfer assistance of 2 with full body lift. Date Initiated: 5/22/26.R9's Certified Nursing Assistant (CNA) Kardex Report indicates, in part:*Dressing assistance of 2 r/t possible behaviors*Oral care assistance set up with 2 r/t possible behaviors*Personal Hygiene assistance of 2 r/t possible behaviors*Transfer assistance of 2 with full body lift*Provide 2 assistance to toilet*Bed mobility assistance of 2 r/t possible behaviorsOn 7/7/26 at 11:49 AM, Surveyor interviewed R9 who stated that sometimes two staff will come to assist her with dressing, toileting, and hygiene, but that most of the time it is just one staff member.On 7/8/26 at 11:38 AM, Surveyor interviewed CNA C (Certified Nursing Assistant) and asked her about providing cares for R9. CNA C stated that there was an incident last month where she went into R9's room to change them and R9 became combative with her, swinging her arm and trying to hit her. CNA C stated that she then went to get the nurse to assist her in providing cares to R9. CNA C indicated that she had never had a problem with R9 before this incident.Surveyor reviewed CNA C's staff statement of the incident, which was provided by the facility. CNA C's statement included the following, in part: . I answered [Resident Name]'s call light. and asked how she preferred to be turned. As I attempted to begin care [Resident Name] would not allow me to touch her. I attempted to provide incontinent care. [Resident Name]. swung her arm backward. I called for Nurse.On 7/8/26 at 1:34 PM, Surveyor interviewed CNA D about providing cares for R9. CNA D stated she wasn't sure if R9 was supposed to be assisted with one staff member or two.On 7/8/26 at 1:37 PM, Surveyor interviewed CNA E about providing cares for R9. CNA E stated that R9 was a one assist of staff for cares and a two-assist transfer using the Hoyer lift.On 7/8/26 at 1:38 PM, Surveyor interviewed CNA F about providing cares for R9. CNA F stated that R9 is a one assist of staff for cares, but that they are hard to roll over so other people sometimes provide cares using two staff members. CNA F stated she has a good rapport with R9 and can provide cares for (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them by herself. On 7/8/26 at 1:51 PM, Surveyor interviewed RN G (Registered Nurse) who stated that R9 was a one-assist for cares and that the CNAs don't call her to the room for assistance with R9. On 7/8/26 at 3:50 PM, Surveyor interviewed INHA W (Interim Nursing Home Administrator) and asked if he would expect R9's care plan to be followed for staff assistance of two for all care needs. INHA W stated yes, that if it was in R9's care plan, he would expect it to be followed. The facility did not ensure that R9's comprehensive care plan was being followed.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide elimination (incontinence) care and repositioning for 1 of 3 Residents (R18) reviewed for ADL care for dependent residents out of 19 sampled residents. R18 was not provided with incontinence care or repositioning for 3 hours and 40 minutes. Findings include: The facility's Activities of Daily Living (ADL), Supporting policy with a revision date of April 2026, indicates: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 5. Appropriate care and services are provided to residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care); c. elimination (toileting). On 7/7/26 at 3:05 PM, Surveyor heard moaning and grunting noises from room where R18 was assigned. Surveyor observed R18 rocking back and forth in a Broda chair (a reclining wheelchair). Under the Broda chair was a large puddle of clear liquid with a rolled-up blanket lying in it. R18 admitted to the facility on [DATE] with diagnoses that include traumatic brain injury, quadriplegia (a symptom of paralysis that affects all person's limbs from the neck down), and aphasia (the inability to speak). R18's admission Minimum Data Set (MDS) dated [DATE] was in progress with the Brief Interview for Mental Status (BIMS) in progress status. R18 had an activated Power of Attorney for Healthcare to assist with medical decisions. R18 was dependent on staff for all ADLs including incontinence care, personal hygiene, and repositioning. R18 has a feeding tube in place for nutrition and hydration needs. Food and fluids are not given orally and would not be in R18's room. On 7/7/26 at 3:20 PM Surveyor interviewed RN K (Registered Nurse) who was working with R18 during the day shift. Surveyor asked RN K to observe R18 in the Broda chair in the room and RN K verified there was a puddle of clear liquid on the floor under the Broda chair that R18 was sitting in. Surveyor asked RN K when R18 was last repositioned or assisted with toileting, RN K stated they would verify with the Certified Nursing Assistant (CNA) working on unit. On 7/7/26 at 3:25 PM Surveyor conducted an interview with CNA L who worked with R18 during the day shift. Surveyor asked CNA L how often residents who need assistance with toileting or incontinence care should be changed or toileted and repositioned. CNA L stated residents are to be changed and repositioned every 2 hours. Surveyor asked when R18 was last repositioned or had incontinent care provided. CNA L stated R18 was last changed and repositioned at 11:50 AM. Surveyor asked CNA L about clear puddle of liquid under R18's Broda chair and was observed by CNA L. CNA L stated R18 sometimes rips incontinence brief off. On 7/7/26 at 3:30 PM Surveyor observed incontinence care of R18 by CNA L. CNA L, RN K, and an additional unidentified staff assisted with transferring R18 from Broda chair to bed with a Hoyer lift (mechanical device to transfer dependent residents who cannot stand). A wet brief was removed from R18 by CNA L, and RN K stated sling that was under R18 in Broda chair and R18's shorts were wet. CNA L previously stated R18 was last changed at 11:50 AM. R18 did not have incontinence care or repositioning for 3 hours and 40 minutes. CNA L placed a clean brief on R18 without peri care performed or barrier cream applied to skin. CNA L put clean dry shorts on R18. A clean dry sling was being brought to room by other staff. Surveyor reviewed R18's current plans of care 7/7/26-7/8/26. The following interventions were not followed: Assist to reposition every 2-3 hours Provide thorough skin care after incontinent episodes and apply barrier cream On 7/8/26 at 10:30 AM Surveyor interviewed ADON M (Assistant Director of (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing). Surveyor asked ADON M when repositioning and incontinence care would be performed for a dependent resident by staff. ADON M stated residents should be repositioned and have incontinence care or toileting every 2-3 hours. Surveyor indicated R18 had not had incontinence care or repositioning for 3 hours and 40 minutes and there was a large puddle of clear fluid under the Broda chair R18 was sitting in. CNO N (Chief Nursing Officer) was also present at time of interview.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide appropriate colostomy care for 1 of 1 Residents out of a total sample of 19 Residents (R10). R10 has an open abdominal wound leaking bowel contents. This was a recognized complication after intestinal fistula repair with anticipated future surgical repair. R10's leaking colostomy was not care planned or identified on the Kardex treatment record resulting in staff not providing timely colostomy cares. Findings include: The facility's Colostomy/Ileostomy Care Policy, revised 10/2025, indicates: the purpose of this procedure is to provide guidelines that will aid in preventing expose of the resident's skin to fecal matter. Preparation 1. Review the resident's care plan to assess for any special needs of the resident. The facility's Care Planning - Interdisciplinary Team Policy, revised 02/2026, indicates: . Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 1. Resident care plans are developed according to the timeframes and criteria established . 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). R10 was admitted to the facility on [DATE] and had diagnoses including fistula of intestine. R10's Minimum Data Set (MDS) assessment, dated 5/21/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. On 7/7/26, Surveyor reviewed R10's medical admission records, dated 2/18/26, indicating R10 was admitted for rehabilitation following a recent intestinal fistula and laceration of the sigmoid colon, which necessitated colostomy placement and drainage of abdominal incision. Medical orders: ~Midline abdominal fistula care change wound Friday and immediately after leaking colostomy appliance change to be performed prior to wound change every 8 hours as needed for wound care. Apply skin barrier, utilize replica and ostomy ring to help facilitate seal. May reinforce with tape if needed. Dated 5/9/26 ~Fistula wound care: Cleanse with warm water and washcloths. If there's skin breakdown: sprinkle a thin layer of stoma powder over the area and spray with 3M cavilon barrier film to seal the powder. If no skin breakdown just spray the barrier spray. Use ostomy rings to build up edges of wound to help with leaking issues at lower abdomen. Place cut out wound manager firmly to fistula. Use replica to line edge of pouch to aid with seal. Every Friday and as needed, dated 5/9/26. On 7/8/26, Surveyor reviewed R10's Care Plan and Kardex Care Card, there were no goals or interventions documented regarding R10's colostomy, frequency of cares, and/or monitoring for a leaking colostomy. On 7/7/26 at 11:28 AM, Surveyor observed R10 resting in bed with blanket pulled over head. On 7/7/26 at 2:18 PM, Surveyor interviewed R10 who indicated that staff leave R10 soiled for long periods of time, staff don't like to take off my ostomy bag and if it is not emptied frequently, it causes it to leak more and overflows. On 7/8/26 at 9:35 AM, Surveyor interviewed and observed R10 lying in bed with a strong odor and flies on top of the blankets. Surveyor lifted blanket, gown was saturated with colostomy drainage. R10 indicated that keeps blankets up above head to keep the flies off self and feels having to lay like this for hours was cold, cruel, and callous treatment. R10 indicated that staff had not changed bed or linens yet that day only repositioned R10 earlier. On 7/8/26 at 9:45 AM, Surveyor interviewed CNA X (Certified Nursing Assistant) who indicated that they had bathed, changed gown, and changed bed linen at 7:40 AM and noted that flies were present at that time. CNA X verified that gown was saturated and indicated that R10 often picks at the colostomy site. CNA X indicated that they review cares from the Kardex and was not aware of who updates the Kardex. CNA X informs the nurse when the colostomy was leaking which happens frequently. On 7/8/26 at 9:58 AM (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that snacks were provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care for 1 of 1 resident (R12) reviewed for snacks out of a sample of 19. R12 did not receive a snack at 2:00 PM as ordered. This is evidenced by: The facility's policy, titled Therapeutic Diets, undated, states the following, in part: Policy Statement: Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Policy Interpretation and Implementation: 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether a resident is prescribed a therapeutic diet.9. Snacks will be compatible with the therapeutic diet. R12 was admitted to the facility on [DATE] with diagnoses that include the following, in part: unspecified protein-calorie malnutrition. R12's most recent Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 4/23/26 states that R12 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she is cognitively intact. On 7/7/26 at 11:27 AM, Surveyor interviewed R12. R12 indicated she is supposed to get a snack at 2:00 PM but did not remember the last time she received one. R12 indicated that she prefers to have yogurt for this snack. Surveyor reviewed R12's physician orders and noted the following snack order: Offer 2pm snack (resident likes yogurt); record amount consumed in the afternoon for supplement - Order start date: 2/1/24. On 7/7/26 at 2:25 PM, Surveyor followed up with R12 to see if she received her 2:00 PM snack. R12 said no. On 7/7/26 at 2:31 PM, Surveyor observed CNA R (Certified Nursing Assistant) taking a tray of snacks to the wing where R12's room is. Each snack was labeled with a resident's name. The snacks come from the kitchen and are labeled based on resident preference and if the resident is ordered to have a snack at that time. Surveyor asked CNA R to look through the snacks for the residents on R12's hallway. R12 did not have a labeled snack on the tray. On 7/8/26 at 10:15 AM, Surveyor spoke with DM S (Dietary Manager) and asked to review the sheet the kitchen keeps on file with the list of residents who receive snacks. The sheet lists resident preferences and the time of the day that residents get snacks. Surveyor did not see R12's name on any of the snack lists. Surveyor asked DM S if R12 should be on the snack list if she has an order for a 2:00 PM snack. DM S indicated R12 should be on the snack list if she has an order. DM S indicated this was her first time hearing about R12 not receiving a snack at that time. DM S indicated she recently started in this position and R12 may have been missed if she hadn't been on the snack list when DM S took over the position, as DM S meets with newly admitted residents to review their choices. DMS S indicated that she would look into this issue. On 7/8/26 at 2:41 PM, Surveyor notified INHA W (Interim Nursing Home Administrator) and CNO N (Chief Nursing Officer) about the issue with R12's scheduled snack not being given.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure they maintained complete medical records on each resident in accordance with professional standards of practice. This has the potential to affect 2 residents (R6 and R12) out of 19 residents reviewed for medical records out of a total sample of 19 residents. R6's medical record was incomplete. R12's medical record was incomplete. Findings include: The facility policy, titled Documentation in the Medical Record, dated 3/2026, includes, in part: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Principles of documentation include, but are not limited to: . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. R6 was admitted to the facility on [DATE]. On 6/9/26 at 11:54 AM, a progress note in R6's medical record indicates, Change in Condition report. Abnormal vital signs, seems different than usual, tired, weak, confused or drowsy. Nursing observations, evaluation, and recommendations are: Informed by assigned CNA that resident appears different than usual. Res (resident) appears more tired today but easy to arouse. VSS (vital signs stable) obtained. Tylenol given. NP (Nurse Practitioner) notified, NOR (new order received) for UA (urinalysis) and labs. [Family Name] notified, no concerns at this time. POC (plan of care) ongoing. On 6/9/26 at 6:56 PM, an emergency room (ER) report provided by the facility indicates that R6 was transferred to the hospital via ambulance. The ER report indicates the following, in part: Pt (patient) here for AMS (altered mental status). is SOB (short of breath). has a fever. Pt (patient) is normally A and O (alert and oriented) x4 per staff, but today is x1 so a non-emergent ambulance was called, per staff Pt (patient) has been this way all day. Of note, there is no other documentation in R6's medical record indicating that R6 was sent to the hospital, or what occurred in the hours prior to being sent to the ER. On 6/12/26 at 11:02 AM a progress note in R6's medical indicates, Patient is at [Hospital Name] (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns for stroke. On 7/8/26 at 11:19 AM, Surveyor interviewed LPN H (Licensed Practical Nurse) about R6's change in condition. LPN H indicated that usually R6 is alert and oriented but that day R6 was more sleepy and their blood pressure was elevated. LPN H stated that they reached out to the provider to get orders to send R6 out to the hospital. LPN H stated that the situation with R6 was brought to her attention by the nurse working on R6's floor, and that she just assisted her. On 7/8/26 at 2:49 PM, Surveyor interviewed LPN I about R6's change in condition. LPN I stated that R6 just seemed lethargic that day, that normally they converse but that day R6 wasn't talkative. LPN I indicated that R6 didn't look like their normal self so she had DON B come to assess R6, and at that time they reached out to the NP (Nurse Practitioner) to have R6 sent out to the hospital. LPN I stated that at first the NP requested that a urine sample be tested for R6, but as the day went on they weren't turning around. LPN I stated that they reached out again to the NP and it was determined at that time to send R6 to the ER. On 7/8/26 at 3:31 PM, Surveyor interviewed DON B (Director of Nursing) about R6's change of condition. DON B stated that the staff came and got her around noon because R6 wasn't acting like their normal self, so they got an order for UA (urinalysis) and lab work. DON B stated that staff came and got her later and that R6 wasn't appearing themselves and wasn't moving like they normally did. DON B stated she called the NP, sometime after 3:00 PM, and asked if they could send R6 out because they weren't better or worse, but they weren't able to get the UA. DON B indicated that R6's vital signs weren't way off, and their assessment wasn't too crazy but something was definitely off with R6. DON B indicated that the NP was okay with sending R6 to the hospital via non-emergency transport. On 7/8/26 at 3:50 PM, Surveyor interviewed INHA W (Interim Nursing Home Administrator) about the events that happened with R6 on 6/9/26, and the lack of documentation of these events in R6's medical record. INHA W stated that yes, these events should have been documented for a complete medical record. The facility did not maintain medical records on each resident that were accurate and complete. Example 2: R12 was admitted to the facility on [DATE] with diagnoses that include the following, in part: unspecified protein-calorie malnutrition. R12's most recent Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 4/23/26 states that R12 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she is cognitively intact. On 7/7/26 at 11:27 AM, Surveyor interviewed R12. R12 indicated she is supposed to get a snack at 2:00 PM but does not remember the last time she received one. R12 indicated that she prefers to have yogurt for this snack. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R12's physician orders and noted the following snack order: Offer 2pm snack (resident likes yogurt); record amount consumed in the afternoon for supplement & Order start date: 2/1/24. Surveyor reviewed R12's Medication Administration Record (MAR) for July 2026 and noted RN G (Registered Nurse) had charted that R12 had received her snack at 2:00 PM on 7/7/26 and had consumed 100% of it. On 7/7/26 at 2:25 PM, Surveyor followed up with R12 to see if she received her 2:00 PM snack. R12 said no. On 7/7/26 at 2:31 PM, Surveyor observed CNA R (Certified Nursing Assistant) taking a tray of snacks to the wing where R12's room is. Each snack was labeled with a resident's name. The snacks come from the kitchen and are labeled based on resident preference and if the resident is ordered to have a snack at that time. Surveyor asked CNA R to look through the snacks for the residents on R12's hallway. R12 did not have a labeled snack on the tray. On 7/7/26 at 2:35 PM, Surveyor interviewed RN G (Registered Nurse) about the facility's snack process and how nursing staff knows to chart if a resident receives a snack or not. RN G indicated a tray comes up from the kitchen and nursing staff knows the resident gets the snack because they can see CNAs taking them down the hallway. RN G indicated the snacks are usually for the same people each time. Surveyor asked RN G why she had charted that R12 had received her snack at 2:00 PM when Surveyor had not observed a snack for R12 on the snack tray and R12 had indicated that she had not received one. RN G indicated she was not sure why R12 had not received a snack that day and suggested maybe her snack order fell through the cracks somehow. RN G indicated she had assumed R12 had received a snack but should have checked to see if R12 had actually received the snack before completing documentation on it. On 7/8/26 at 2:41 PM, Surveyor notified INHA W (Interim Nursing Home Administrator) and CNO N (Chief Nursing Officer) about the nursing documentation for R12's snack administration not being accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe and sanitary environment to prevent the transmission of communicable disease and infection for 1 of 19 sampled Residents (R15).LPN BB (Licensed Practical Nurse) did not follow Enhanced Barrier Precautions (EBP) or complete hand hygiene between glove changes while providing tracheostomy care for R15.Findings include:Facility policy titled Infection Prevention and Control Program with a revised date of 7/2025 indicated: 7. Enhanced Barrier Cautions (EBP) a. EBP use gowns and gloves during high contact care to prevent the spread of resistant germs b. EBP is recommended for residents with medical devices, regardless of MDRO status. c. High contact resident care vii. Device care or use (.tracheostomy.)Facility policy titled Handwashing / Hand Hygiene with a revision date of December 2025 indicated: Indications for gloves: 2. The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed. Applying and Removing Gloves. 1. Perform hand hygiene before applying non-sterile gloves. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. [NAME] he removed glove in the gloved hand and remove the otehr glove by rolling it down the hand and folding it into the first glove. 4. Perform hand hygiene.R15 was admitted to the facility on [DATE] and had diagnoses that included tracheostomy status. R15 had a quarterly Minimum Data Set (MDS) dated [DATE] at section O indicated R15 required tracheostomy care. On 7/7/26 at 4:02 PM, Surveyor observed LPN BB provide tracheostomy care to R15. Surveyor noted that R15 had a sign outside of R15's door that indicated Enhanced Barrier Precautions. LPN BB pulled the tracheostomy kit out of R15's drawer. Surveyor observed LPN BB wash hands and put gloves on. LPN BB did not don (put on) a gown.During this observation, Surveyor noted the following moments when LPN-BB changed gloves but did not complete hand hygiene between glove changes.~LPN BB removed R15's inner cannula, LPN BB realized the garbage was across the room. LPN BB picked up the garbage can with gloved hands and then moved it next to LPN BB. LPN BB then removed gloves and put a new pair of gloves on. LPN BB did not complete hand hygiene. ~LPN BB removed R15's old dressing, LPN BB changed gloves but did not complete hand hygiene prior to donning new gloves. ~LPN BB was attempting to suction R15, the suctioning did not work. LPN BB was adjusting the suctioning machine with gloved hands, then a piece of the trach kit fell on the floor. LPN-BB got out a new trach kit and opened it with the gloved hand that was adjusting suctioning machine. LPN-BB doffed gloves and set up the new kit. LPN BB did not complete hand hygiene prior to donning new gloves. Near the end of this observation, Surveyor asked LPN BB if LPN BB should be wearing a gown. LPN BB indicated they would wear a gown if an individual had something contagious or was on some kind of contact precaution. We exited the room. Surveyor pointed to the sign outside of R15's door which indicated a gown should be worn. LPN BB acknowledged this sign. Surveyor informed LPN BB of not completing hand hygiene when changing gloves. On 7/8/26 at 11:30 AM, Surveyor interviewed Director of Nursing (DON-B) and Chief Nursing Officer (CNO-N) who confirmed a gown should have been worn, and hand hygiene should have been completed when changing gloves.		