

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2025
NAME OF PROVIDER OR SUPPLIER Marquardt Memorial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Hill St 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure an opportunity to create a Power of Attorney (POA) document or a document that designated an alternate decision maker in the case of incapacity was provided for 1 resident (R) (R1) of 5 sampled residents. The facility did not offer R1 an opportunity to create a POA document or any document to designate a decision maker if R1 became incapacitated. Findings include: The facility's Individual Advanced Care Planning policy, dated 2/21/24, indicates: .A. Upon admission: .2. Per the Patient Self Determination Act, information about Wisconsin advanced health care directives will be provided to individuals upon their admission to the facility .B. Upon admission/re-admission, change in condition, and at care conferences: 1. Advanced care planning will be discussed and/or verified. 2. The resources available in the skilled nursing facility to treat symptoms and conditions will be discussed as appropriate. On 10/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including spina bifida, paraplegia, anxiety disorder, rectocele, neuromuscular dysfunction of bladder, neurogenic bowel, retention of urine, severe sepsis, and stage 4 pressure ulcer of sacral region. R1's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1's cognition was intact. R1 was responsible for R1's healthcare decisions. On 10/6/25 at 2:13 PM, Surveyor interviewed R1 who was uncertain if R1 had a POA document or its location. R1 stated a family member previously served as R1's activated POA but the designation was revoked by Adult Protective Services (APS). R1 expressed discomfort with making healthcare decisions and stated R1 cannot read or write and does not complete or fill out forms which the facility should be aware of. R1 indicated the process is overwhelming and expressed a desire for a Guardian or a POA to assist with decisions. R1 indicated Social Worker (SW)-E discussed a Guardian upon R1's initial admission, however, R1 was not aware if anything was started. On 10/6/25 at 3:51 PM, Surveyor interviewed SW-E who was unaware that R1 could not read or write. SW-E confirmed SW-E discussed completing a POA document with R1 but was uncertain about whether a document already existed. SW-E attempted to obtain POA information from APS; however, APS declined to provide information about R1's history, Guardianship, or POA status. On 10/7/25 at 10:08 AM, Surveyor interviewed APS Social Worker (APS)-F who stated R1 previously had an activated POA that APS-F voided. APS-F verified R1 was R1's own decision maker and was entitled to complete a new POA document if R1 wanted. APS-F was aware that R1 found R1's healthcare situation overwhelming and confirmed that R1 was illiterate. APS-F stated the facility should use its resources to support R1 with completing a new POA document. APS-F had not spoken with SW-E but did speak with Nursing Home Administrator (NHA)-A. APS-F did not recall if the capacity to make decisions was discussed during that conversation. On 10/6/25 at 5:30 PM, Surveyor interviewed NHA-A via phone with SW-E present in the room. During the interview, NHA-A indicated NHA-A had spoken to APS-F but denied asking if APS-F was aware that R1 requested an advocate or representative. NHA-A stated APS-F made it clear that R1 was R1's own decision maker. SW-E and NHA-A indicated no further action had been taken to fulfill R1's request to complete a new POA document.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure an allegation of abuse was reported to the State Agency (SA) for 1 resident (R) (R1) of 1 sampled resident. R1 reported to staff that another staff call R1 stupid. The allegation of abuse was not reported to the SA. Findings include: The facility's Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program policy indicates: It is the policy of the facility that each resident will be free from abuse. The Executive Director or designee will report abuse to the State Agency per state and federal requirements. G. Reporting and Response: The facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials (including the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Executive Director. On 10/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including spina bifida, paraplegia, anxiety disorder, rectocele, neuromuscular dysfunction of bladder, neurogenic bowel, retention of urine, severe sepsis, and stage 4 pressure ulcer of the sacral region. R1's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1's cognition was intact. R1 was responsible for R1's healthcare decisions. On 10/6/25 at 11:13 AM, Surveyor interviewed R1 who stated there is a Certified Nursing Assistant (CNA) that I don't like. R1 did not know the name of the CNA but stated the CNA provided assistance to R1 quite a few times and would say, Hi, stupid! when the CNA walked into R1's room. R1 also stated the CNA addressed R1 as stupid which a couple of staff members heard when the CNA brought R1 a dinner tray. R1 told an unidentified staff about the name calling who said they would inform Social Worker (SW)-E and instruct the CNA not to work with R1 that day. On 10/6/25 at 12:31 PM, Surveyor interviewed SW-E who was not aware that a CNA called R1 stupid. SW-E stated SW-E would interview R1 and initiate an investigation. SW-E was not aware of any similar allegations from R1 or other residents. On 10/6/25 at 1:07 PM, Surveyor and SW-E entered R1's room. R1 described the CNA's physical appearance and stated the CNA worked with R1 four times; one weekend two weeks ago and then again after R1 told staff that the CNA called R1 stupid. R1 provided a physical description of the staff that R1 reported the incident to which matched Scheduler (SCH)-G. R1 stated, I'm getting a little frustrated and upset because (he/she) called me that. The police were contacted and arrived at 1:22 PM. On 10/6/25 at 1:28 PM, Surveyor interviewed SCH-G who stated R1 told SCH-G that an unidentified staff called R1 stupid in September of 2025. SCH-G relayed the information to Director of Nursing (DON)-B at that time. SCH-G informed Surveyor that R1 asked SCH-G that day (10/6/25) at approximately 10:30 AM (of note, the reported time was prior to Surveyor's first interview with R1), Do you remember when I told you about the CNA? R1 then provided a name to SCH-G (which was not the correct CNA). SCH-G informed R1 that SCH-G would relay the concern to the AM supervisor or SW-E. On 10/6/25 at 5:00 PM, Surveyor interviewed DON-B and SW-E who stated the previously named CNA was incorrect. The correct CNA was identified and suspended based on the facility's investigation. DON-B stated DON-B was not aware of the allegation of abuse until 10/6/25 and stated if the allegation was reported sooner, DON-B would have initiated an investigation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R1) of 1 sampled resident observed during the provision of care. Licensed Practical Nurse (LPN)-C and Certified Nursing Assistant (CNA)-D did not wear appropriate personal protective equipment (PPE) during wound care for R1. In addition, LPN-C did not complete proper hand hygiene or ensure a treatment cart and supplies were free from infectious agents during and after the provision of wound care. Findings include: The facility's Enhanced Barrier Precautions policy and procedure, dated 2/6/25, indicates: The organization will promote decreased transmission of Centers for Disease Prevention and Control (CDC)-targeted and epidemiologically important multidrug-resistant organisms (MDROs) by utilizing Enhanced Barrier Precautions (EBP) .a. The infection Prevention and Control Program establishes EBP to reduce transmission of MDROs utilizing targeted gown and glove use during high-contact resident care activities. b. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. c. EBP is indicated for residents with any of the following: .ii. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. 1. Wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However the intent of EBP is to focus on residents with higher risk of acquiring an MDRO over a prolonged period of time. This includes residents with chronic wounds, not those with only shorter lasting wounds, such as skin breaks or skin tears covered with a band-aid or similar dressing. Examples of chronic wounds include .pressure ulcers, diabetic foot ulcers. and chronic venous stasis ulcers . e. For residents whom EBP is indicated, EBP is employed when performing the following high-contact resident care activities: .viii. Wound care: any skin opening requiring a dressing .The facility's Hand Hygiene policy and procedure, dated 12/5/24, indicates: The organization will promote clean hands as the single most important factor in preventing the spread of pathogens, antibiotic resistance, and incidence of infections .A. Specific Indications for Hand Hygiene: 1. Immediately before touching a patient; 2. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. 3. Before moving from work on a soiled body side to a clean body site on the same patient; 4. After touching a patient or the patient's immediate environment; 5. After contact with blood, body fluids, or contaminated surfaces; 6. Immediately after glove removal .The facility's Personal Protective Equipment policy and procedure, dated 12/5/24, indicates: The organization will provide personal protective equipment (PPE) to staff and visitors to reduce the spread of communicable disease, as indicated or directed .A. Standard precautions are indicated for all individuals. B. Additional transmission-based precautions will be used to the extent required and will be disease specific. C. Barriers will be available .1. Gloves: Clean, disposable gloves are worn during direct contact with blood/body fluids, mucous membranes, non-intact skin, or any other potentially infectious material. They are also worn when exposure is planned or anticipated for the following: a. Blood or body fluids; b. Stool; c. Saliva; d. Mucous membranes; e. Wound drainage; f. Non-intact skin; g. When performing veni-puncture or invasive procedures .2. Masks: a. Must be worn when it is anticipated that blood or body fluids could splash back exposing employee mucous membrane to potential infection. b. In accordance with CDC guidance. c. In accordance with the entity's Respiratory Protection Program Policy. 3. Gowns should be worn any time there is potential for soiling employee clothing with blood/body fluids. 4. Eye protection should be worn: a. When the potential for splash-back of contaminated blood/body fluids exists. b. In accordance with CDC guidance. On 10/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including spina bifida, paraplegia, anxiety disorder, rectocele, neuromuscular dysfunction of bladder, neurogenic bowel, retention of urine, severe sepsis, and stage 4 pressure ulcer of the sacral region. R1's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1's cognition was intact. R1 was responsible for R1's healthcare decisions. On 10/6/25 at 10:00 AM, Surveyor observed LPN-C and CNA-D complete wound care for R1 who was on EBP as indicated by a sign posted near R1's door. LPN-C and CNA-D entered R1's room without donning gowns. LPN-C brought a treatment cart into the room and placed a gauze package, a bottle of wound cleanser, and bandage scissors on R1's bedside table. LPN-C did not disinfect the table or place a</p>		