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 02/04/2026
NAME OF PROVIDER OR SUPPLIER Marquardt Memorial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Hill St Watertown, WI 53098	

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(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 staff, resident, and resident representative interview and record review, the facility did not ensure grievances were thoroughly investigated and resolved for 3 residents (R) (R1, R4, and R5) of 4 sampled residents.Family Member (FM)-I filed a grievance on behalf of R1 on 1/7/26 that included concerns about a missed appointment, wound care, and assistance with cares. The facility did not investigate or provide resolution for the grievance. R4 reported in September 2025 that R4 did not receive scheduled showers. The facility did not document, investigate, or provide resolution for the grienvance.R5 reported to staff that Registered Nurse (RN)-R swore at R5. Staff reported to the concern to a supervisor; however, the facility did not file a grievance or follow-up on the concern. Findings include: The facility's Policy and Procedure for Grievances indicates: .The facility fosters an environment of direct communication, prompt resolution, and continuous process improvement. Grievances may be brought to any staff member at any time orally, in writing, or made anonymously. Grievances will be forwarded to the designated Grievance Officer and investigated through the Quality Assurance Performance Improvement (QAPI) Committee .B: Formal Grievance: 1. All staff have access to a formal Grievance Form. A Formal Grievance is to be submitted to the Grievance Officer upon completion. 2. The Grievance Officer will log all formal complaints onto the Grievance Tracking Log. The Grievance Officer will provide a Quality Assurance designee with the written Grievance Form and keep a copy. The Quality Assurance designee will assign a manager to complete the investigation. 3. The assigned manager will investigate the grievance and respond to the individual, Guardian, and/or individual representative within five working days, unless further investigation is needed. 4. The investigation will be reviewed through the Quality Assurance Committee. Process Improvement Projects will be chartered as appropriate to ensure systemic improvements .6. Investigations of Grievances will be kept for three years . 1.On 2/2/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including complete paraplegia, diabetes mellitus type 2, anxiety, obesity class 3, neuromuscular dysfunction of bladder, and neurogenic bowel. R1's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. On 2/2/26, Surveyor reviewed the facility's grievance file which contained a grievance, dated 1/7/26, from FM-I. The Receipt of Grievance form indicated the concern was reported to Referral Specialist (RS)-J. A section that stated Describe concern using factual terms had Please see attached written below. The remainder of the document was incomplete. An attachment contained the following concerns expressed by FM-I and written by RS-J: (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ FM-I communicated the need in advance for hired transport to take R1 to a scheduled appointment for suprapubic catheter placement. Transportation was not scheduled and R1's appointment had to be rescheduled. ~ R1's pressure injury worsened and another pressure injury was discovered when R1 was admitted to the hospital. The facility did not have the correct wound care supplies to care for R1's pressure injury. ~ R1 was observed on multiple occasions with a soiled brief and stool dripping on the floor. ~ Staff did not return FM-I's phone calls. On 2/2/26 at 12:30 PM, Surveyor interviewed Registered Nurse Consultant (RNC)-C who confirmed FM-I called the facility and reported the concerns. RNC-C stated R1 was not going to return to the facility at that time. RNC-C confirmed the facility did not complete an investigation or follow-up on FM-I's concerns. On 2/3/26 at 12:30 PM, Surveyor interviewed RS-J who stated FM-I was not happy when FM-I called on 1/7/26 and reported the concerns. RS-J stated grievances should be documented on a Receipt of Grievance form. After RS-J filled out what RS-J could, RS-J provided the form and attachment to Nursing Home Administrator (NHA)-A. (Of note: The facility did not provide additional documentation for the grievance. An NHA and Director of Nursing (DON) change occurred in January 2026.) 2. On 2/4/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side. R4's MDS assessment, dated 12/11/25, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. The MDS assessment also indicated R4 was dependent on staff for showers. R4 was R4's own decision maker. On 2/4/26 at 3:22 PM, Surveyor interviewed R4 who stated R4 filed a grievance about not receiving a shower for three weeks in September (2025). R4 did not recall anyone asking R4 about the concern. R4 stated R4 informed FM-L (who worked at the the facility) about the missing showers. On 2/4/26 at 4:10 PM, Surveyor interviewed FM-L who stated FM-L informed the facility that R4 did not receive showers and complained about it. FM-L did not recall if there was an investigation. FM-L stated R4's showers were back on track after FM-L reported the concern; however, R4 did not receive any showers in November and December (2025). On 2/4/26 at 4:43 PM, Surveyor interviewed NHA-A, DON-B, and RNC-C regarding a grievance for R4 from September (2025). RNC-C indicated the facility would check to see if there was a grievance and get back to Surveyor by the end of 2/6/26. RNC-C indicated if Surveyor had not received information from the facility by 2/6/26, a grievance was not filed. At the time of this writing, Surveyor had not received any information. 3. On 2/4/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, morbid obesity, peripheral vascular disease, history of pulmonary embolism, and dependence on supplemental oxygen. R5's MDS assessment, dated 12/11/25, indicated R5 was dependent on staff for toileting, bathing, dressing, hygiene, and transfers and required set-up assistance for eating and oral hygiene. R5 had a BIMS score of 15 out of (continued on next page)

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	525543	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquardt Memorial Manor	1020 Hill St Watertown, WI 53098

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15 which indicated R5 had intact cognition. R5 was R5's own decision maker. On 2/4/26 at 11:20 AM, Surveyor interviewed R5 who stated RN-R entered R5's room on 1/9/26 at approximately 11:30 PM and tried to stick a spoon with medication in R5's mouth. R5 stated R5 could feed R5's self and R5's oxygen tubing needed to be changed. R5 stated RN-R turned around and walked out. R5 indicated RN-R returned at 1:30 AM and attempted to give R5 medication again. When R5 grabbed the spoon, RN-R stated, I'm not going to take your shit. RN-R then changed R5's oxygen tubing and walked out. R5 stated when the AM shift arrived, R5 reported the incident to RN-P and Certified Nursing Assistant (CNA)-O. R5 stated no one followed-up with R5 and all R5 wanted was for someone to say they were sorry. On 2/4/26 at 2:36 PM, Surveyor interviewed RN-P who verified R5 told RN-P that R5 and RN-R argued and RN-R swore at R5. RN-P stated RN-P reported the incident to an AM nurse who reported it to a supervisor. RN-P was not sure if there was any follow-up. On 2/4/26 at 2:42 PM, Surveyor interviewed CNA-O who stated R5 mentioned that RN-R called R5 stupid or something the night before. CNA-O stated CNA-O reported the information to Licensed Practical Nurse (LPN)-E. CNA-O was not sure if there was any follow-up. On 2/4/26 at 2:56 PM, Surveyor interviewed LPN-E who stated R5 was angry and thought RN-R swore at R5. LPN-E stated RN-R was an international nurse with a heavy accent and was hard to understand. LPN-E told R5 that LPN-E did not think RN-R swore at R5. LPN-E stated R5's accent could have caused a misunderstanding since RN-R denied that RN-R swore at R5. LPN-E stated there should be a progress note about the incident. (Of note: R5's medical record did not contain a progress note related to the incident). LPN-E reported the allegation to LPN-E's supervisor. On 2/4/26 at 3:16 PM, Surveyor interviewed RNC-C who verified a concern was reported that RN-R swore at R5. RNC-C verified RN-R had a heavy accent and stated it was a possible misunderstanding. RNC-C stated the facility did not complete an official investigation or a file a grievance. RNC-C stated someone spoke with RN-R and it was determined that RN-R's accent caused a misunderstanding. RNC-C was not sure if someone followed-up with R5.

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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 staff, resident, and resident representative interview and record review, the facility did not ensure scheduled showers/baths were provided for 3 residents (R) (R4, R1, and R3) of 13 sampled residents.R4 was scheduled for a weekly shower on Tuesday evening. R4 did not receive showers as scheduled.R1 did not receive a shower while at the facility because the facility did not have a functioning bariatric shower chair.R3 did not receive weekly showers as scheduled. In addition, R3's preference to receive a shower instead of a bed bath was not consistently honored. The facility's undated Standard Activities of Daily Living (ADL) Protocol indicates: ADLS: .bathing .Individual will perform ADLs .with or without staff assist. Certified Nursing Assistant (CNA): Offer individual choices with care routines .Offer weekly bath or shower per individual preference .

1. On 2/4/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side. R4's Minimum Data Set (MDS) assessment, dated 12/11/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. The MDS assessment also indicated R4 was dependent on staff for showers. R4 made R4's own healthcare decisions.

On 2/4/26, Surveyor reviewed the facility's bath schedule and noted R4 was scheduled for a weekly bath on Tuesdays. The facility was unable to provide a November (2025) bath schedule or a December (2025) bath schedule for 12/1/25 to 12/21/25. The January (2026) bath log indicated R4 was ill on 1/27/26 with no follow-up shower or noted refusal.

R4's Medication Administration Record (MAR) indicated the following:

~ Complete weekly skin check and bath (according to shower schedule) one time a day every Tuesday .Document bath refusals (Start date: 3/18/25; Discontinue date: 1/27/26).

R4's MAR was blank for the following Tuesdays: 11/4/25, 11/18/25, 11/25/25, 12/2/25, 12/9/25, 12/16/25, 12/23/25, 12/30/25, 1/20/26, and 1/27/26.

On 2/4/26 at 10:29 AM, Surveyor interviewed R4 who stated R4 wanted a shower but did not receive a shower yesterday (2/3/26) or the Tuesday before (1/27/26). R4 stated R4 was told by an (unknown) staff that R4 would receive a shower in the last few weeks; however, R4 did not receive one. R4 stated R4 did not refuse showers.

On 2/4/26 at 4:10 PM, Surveyor interviewed FM-L who stated R4 did not receive showers and complained to staff. FM-L stated R4's showers were back on track and then R4 did not receive showers again in November and December (2025).

(See interviews under example 3.)

2. On 2/2/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including complete paraplegia, diabetes mellitus type 2, anxiety, obesity class 3, neuromuscular dysfunction of bladder, and neurogenic bowel. R1's most recent MDS assssment, dated 12/24/25, had a BIMS score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's TAR contained the following order: ~ Complete weekly skin check and bath (according to shower schedule) one time a day every Thursday. If any new skin abnormalities upon assessment, complete Skin Only Evaluation. Document bath refusals (Start date: 12/18/25; Discontinue date: 1/9/26). The order was documented as completed on 12/18/25, 12/25/25, and 1/1/26. (Of note: The facility did not have a working bariatric shower chair until after R1 discharged .) On 2/3/26 at 12:54 PM, Surveyor interviewed Scheduler and Central Supply (SCS)-H who stated a new bariatric shower chair was ordered specifically for R1 on 12/16/25 which was the day before R1 was admitted . SCS-H was made aware of the need to order the bariatric shower chair by Referral Specialist (RS)-J. SCS-H stated the facility had a bariatric shower chair; however, maintenance staff discovered the chair did not work. SCS-H e-mailed the company on 12/22/25 to check the delivery date for the new shower chair which was estimated to be 1/14/26. SCS-H stated maintenance staff were unable to fix the facility's bariatric shower chair and the new bariatric shower chair did not arrive until after R1 discharged . On 2/3/26 at 3:22 PM, Surveyor interviewed Registered Nurse (RN)-M who stated R1's scheduled shower would have been a bed bath because the facility did not have a bariatric shower chair. 3. On 2/4/26, Surveyor reviewed R3's medical record. R3's MDS assessment, dated 1/28/26, had a BIMS score of 10 out of 15 which indicated R3 had moderate cognitive impairment. The MDS assessment also indicated R3 was dependent on staff for bathing. R3 had an activated Power of Attorney (POA) since 1/22/12. On 2/4/26 at 11:55 AM and 1:17 PM, Surveyor interviewed R3 who stated R3 prefers showers over baths. R3 stated staff do not ask if R3's preference and give R3 bed baths. R3 stated R3 wants only showers and it bothers R3 that R3 does not receive showers. On 2/4/26 at 2:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-S who stated if a resident's MAR/TAR is checked off, it means a shower and skin check were completed. LPN-S stated there should not be any blanks in the MAR/TAR which indicate a shower/bath was not completed. On 2/4/26 at 1:23 PM, Surveyor Interviewed Director of Nursing (DON)-B who stated showers/baths are documented on a resident's MAR or TAR. DON-B stated if a resident refuses a shower/bath, the nurse should document the reason. DON-B stated a resident's MAR/TAR should not be left blank and staff should document that a shower/bath was offered instead of leaving a blank which indicates it wasn't completed. DON-B stated blank documentation is misleading and indicated if a resident's MAR/TAR is checked off, a skin check and shower/bath were completed. DON-B stated shower/bath preference is usually asked upon admission and residents should receive what they prefer.

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(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 - Minimal harm or potential for 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 staff interview and record review, the facility did not provide the necessary care and services to prevent pressure injuries from developing and/or promote healing for 1 resident (R) (R1) of 3 sampled residents.R1 had an unstageable deep tissue injury that was treated without a physician order. In addition, R1 had a stage 2 pressure injury that was not identified in the facility and was discovered while R1 was at a medical appointment. Findings include: The facility's Pressure Injury Prevention and Managing Skin Integrity policy and procedure, dated 5/8/25, indicates: Prevention measures are put in place to reduce the occurrence of pressure injuries .1. Risk Assessment: a. Upon admission: Braden Scale will be completed to evaluate individual's risk for developing a pressure injury at admission, and weekly for four weeks for all new admissions. b. Re-evaluation: Braden Scale will be completed upon change of condition and quarterly. c. Based on the individual's Braden Scale score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record. 2. Identify Interventions and Care Plan: a. Identify Interventions: i. The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown. 1. There will be collaboration with the Interdisciplinary Team (IDT) regarding the presence of breakdown and the intervention plan. 2. When indicated, a referral to additional resources (.ie., Wound Care Specialist, Registered Dietitian, Physical Therapist, Occupational Therapist) may occur. 3. Identification of risk factors present or acquired that compromise skin integrity will be considered .b. Care Plan: i. In developing a plan of care, the following will be considered: 1. Individual pressure injury history; 2. Cognitive changes or impairment of the individual; 3. Current state of skin integrity and personal hygiene practices of the individual that impact skin health; 4. Any cultural practices that impact the health or integrity of the skin; 5. Risk for pressure ulcer development (Braden Scale) .3. Skin Checks: a. Skin check will be done upon admission, readmission, or as clinically indicated. skinb. While providing routine care, a licensed nurse is to monitor the skin condition of each individual weekly and document the skin check in the medical record. 4. Weekly Wound Rounds: a. Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds; b. Registered Nurse (RN) or designee will: i. Conduct weekly skin evaluation; ii. Update the provider with any decline in wound appearance, or as necessary; iii. Update the care plan with any new interventions as applicable; iv. Update individual representative as indicated.5. Administrative Review: a. IDT reviews pressure ulcer/abnormal skin findings through Quality Assurance Committee .From 2/2/26 to 2/3/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including complete paraplegia (total loss of motor and sensory function in the lower half of the body), diabetes mellitus type 2, anxiety, obesity class 3, neuromuscular dysfunction of bladder, and neurogenic bowel. R1's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. A care plan, initiated 12/19/25, indicated R1 had a pressure injury on the coccyx and had the potential for skin breakdown/pressure ulcer development related to a need for assistance with mobility, anxiety/depression, catheter tubing, morbid obesity, and bowel incontinence. The care plan contained a goal for R1 to have intact skin, free of redness, blisters, or discoloration. The care plan contained interventions to administer treatments as ordered, monitor for effectiveness, and follow facility policies/protocols for the prevention/treatment of skin breakdown. The care plan also indicated R1 had bowel incontinence related to neurogenic bowel, a need for assistance (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with toileting, and laxative use. The care plan contained a goal to reduce skin breakdown, decrease episodes of incontinence as able, and maintain regular bowel pattern. The care plan contained interventions to apply barrier cream as ordered, clean peri-area with each incontinence episode, laxatives as ordered, and monitor skin for signs of breakdown related to incontinence. R1's admission information contained a hospital Discharge summary, dated [DATE], that did not contain wound information or orders. On 12/17/25, Registered Nurse (RN)-M completed R1's Admit/Readmit Screener for pressure injuries and documented one stage 2 coccyx pressure injury (partial-thickness loss of skin with exposed dermis). R1's skin assessments titled SW-Skin Issues indicated the following: ~ An assessment, dated 12/17/25, indicated R1 had coccyx bruising present upon admission that measured 14.79 centimeters (cm) (length) x 19.81 cm (width).~ An assessment, dated 12/21/25, indicated R1 had a new moisture-associated skin damage (MASD) left gluteal wound that measured 7.46 cm x 3.53 cm.~ An assessment, dated 12/22/25, indicated R1's coccyx bruising was improving and measured 16.15 cm x 10.1 cm. ~ On 12/24/25, R1's left gluteal MASD resolved. R1 had a new unstageable coccyx pressure injury that presented as a deep tissue injury (DTI) upon admission with an unknown onset. The wound measured 15.43 cm x 16.48 cm.~ On 12/30/25, R1's coccyx pressure injury was unstageable and deteriorating. The surrounding tissue was denuded (loss of top layer of skin) and there was a loss of epidermis (top layer of skin) caused by exposure to urine, feces, body fluid, wound exudate, or friction. There was no swelling or edema. The wound measured 13.65 cm x 9.96 cm and did not contain a dressing.~ On 12/31/25, R1's coccyx pressure injury was unstageable, stable, and measured 15.95 cm x 16.66 cm.~ A first wound evaluation progress note by Advanced Practice Nurse Practitioner (APNP)-N, dated 12/24/25, indicated R1 was non-ambulatory due to paraplegia and had ongoing issues with sacral pressure injuries for the last several months. The note indicated to clean the wound, apply chamosyn (skin barrier) cream twice daily (BID) (second application should be after bowel program), and aggressively offload for pressure-induced deep tissue damage of the sacral region with scattered open areas. The wound measured 15.43 cm x 16.48 cm and was deep purple with scattered granulated areas, scant bleeding to open areas, and no odor or sign of infection. ~ A wound note by APNP-N, dated 12/31/25, indicated R1 had a stable DTI of the sacrum with scattered open areas that measured 15.95 cm x 16.66 cm. The wound was deep purple with scattered granulated areas, scant bleeding to open areas, and no odor or sign of infection.On 2/2/26, Surveyor requested R1's medical records from the hospital where R1 was discharged on 1/5/26. Surveyor received the records on 2/3/26. (Of note: The hospital R1 was at prior to admission to the facility on [DATE] was not the hospital where R1 discharged to on 1/5/26.) R1's hospital record contained burn and wound surgical service consult follow-up note, dated 1/29/26, that indicated R1 had a suprapubic cather placed on 1/5/26 at 11:51 AM. The records indicated R1 had a pressure injury on the left calf proximal (dated 1/17/26); A penis/scrotum wound (dated 11/2/25); and Buttocks bilateral friction/shear (dated 10/27/25). (Of note: R1's penis/scrotum wound (dated 11/2/25) was identified during that hospitalization and also noted upon admission to the same hospital on 1/5/26.) The facility received hospital notes for R1, dated 1/5/26 through 1/7/26, which were scanned into R1's medical record. The notes included a consult note, dated 1/6/26, that stated R1 and Family Member (FM)-I were not aware of the scrotal (also referred to in documentation as penile area, scrotum, and penis) wound until R1's admission to the hospital on 1/5/26. Two wounds were documented which included an unstageable pressure injury on the buttocks and left posterior thigh and one wound on the scrotum. The note indicated R1 would likely require continued bedside debridement as the eschar continued to soften but did not require surgical debridement or antibiotics at that time. The provider could not determine the depth or if the wound was a full-thickness wound and would continue to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor. The note also indicated R1's scrotal wound may have been due to pressure from an object or clothing in the skin fold. An assessment, dated 1/6/26, indicated R1 would benefit from wound care and development of an appropriate outpatient wound plan for the sacral wound. While extensive, there was no sign of infection. Imaging did not indicate an abscess or osteomyelitis and antibiotics were not prescribed. The assessment indicated R1 also had a penile wound that was noted during suprapubic catheter placement (not related to the placement).A progress note, dated 1/7/26, indicated R1 had an unstageable sacral pressure wound with eschar per documentation from 1/6/26. Burn consultants recommended a daily Silvadene (cream used for burn care) wound care plan and aggressive pressure offloading. The note included photos of the sacral and penile wounds. R1's Order Summary Report from the facility (printed 2/2/26) included the following orders: ~ Coccyx wound: Clean with soap and water followed by chamosyn cream BID and as needed (PRN). As needed for wound care (Start date: 12/24/25)~ Coccyx wound: Clean with soap and water followed by chamosyn cream BID and PRN two times daily for wound care (Start date: 12/24/25)~ Coccyx wound: Clean with soap and water followed by chamosyn cream BID and PRN. DO NOT COVER WITH ANY DRESSING. As needed for wound care (Start date: 12/31/25)~ Coccyx wound: Clean with soap and water followed by chamosyn cream BID and PRN. DO NOT COVER WITH ANY DRESSING. Two times daily for wound care (Start date: 12/31/25) ~ Complete weekly skin check and bath (according to shower schedule) once daily every Thursday. If any new skin abnormalities upon assessment, complete Skin Only Evaluation. Document bath refusals (Start date: 12/18/25)~ Offer repositioning every 2 hours due to skin break down. Every 2 hours for wound care (Start date: 12/24/25)On 2/3/26 at 9:29 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who charted on R1's wound on 12/21/25 as if R1's wound was new because LPN-E was unsure if the buttocks wound was new or not. LPN-E stated LPN-E placed a 4 x 4 foam border adhesive bandage on R1's buttocks where the wound appeared to be open. LPN-E indicated R1 had a history of loose stools which made it difficult to keep bandages on. LPN-E stated when LPN-E returned from time off, the facility determined the adhesive from the foam border dressing did more damage than good and changed treatment to just cream. LPN-E could not find an order in R1's medical record for a 4 x 4 foam border adhesive dressing during the dates LPN-E applied the dressings. LPN-E stated LPN-E sent a message to the provider when LPN-E noticed an open spot on R1's buttocks which was also when LPN-E started applying bandages and barrier cream. LPN-E stated due to R1's diarrhea, LPN-E kept applying new bandages after incontinence care because the bandages came off. LPN-E stated LPN-E worked on the weekend which is when the bandages were applied. LPN-E reviewed R1's medical record and noted the wound team saw R1 on 12/24/25 and changed the order to include not to apply bandages. On 2/3/26 at 2:35 PM, Surveyor interviewed RN-M. When Surveyor asked if R1 had another pressure injury besides the coccyx/buttocks wound at the time of admission, RN-M stated RN-M conducted a head-to-toe skin check for R1 on 12/17/25 and did not observe any other pressure injuries besides the coccyx pressure injury. RN-M stated one to three Certified Nursing Assistants (CNAs) assisted RN-M with repositioning R1 so RN-M could complete R1's bowel management program and skin check. RN-M stated R1 had what appeared to be a stage 2 pressure injury on R1's backside/buttocks. RN-M took a photo of the wound and documented in the facility's wound application. RN-M stated there was not a dressing on the wound and instructed the CNAs to apply barrier cream until the wound team saw R1. RN-M stated there were no wound orders on R1's discharge summary from the hospital. RN-M stated if RN-M had seen a penile pressure injury, RN-M would have documented the wound during the admission process.On 2/3/26 at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who stated a skin assessment should be done upon admission and should include viewing all of a resident's skin. DON-B stated (LPN-E) should have informed the provider as soon as R1's wound was (continued on next page)

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 02/04/2026
NAME OF PROVIDER OR SUPPLIER Marquardt Memorial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Hill St Watertown, WI 53098	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified. DON-B indicated there is a provider on-call at all times and staff should not apply a foam border dressing without an order.

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 02/04/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R1) of 1 sampled resident received timely placement of a suprapubic catheter (a tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine). R1 did not have transportation from the facility to a medical appointment on 12/31/25 that was scheduled to remove R1's indwelling urinary catheter (a flexible tube inserted through the urethra into the bladder to continuously drain urine into an external bag) and replace it with a suprapubic catheter. R1 scheduled a new appointment for 1/5/26 for placement of the suprapubic catheter. Findings include: On 2/2/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including complete paraplegia, diabetes mellitus type 2, anxiety, obesity class 3, neuromuscular dysfunction of bladder (loss of normal bladder control due to nerve damage), and neurogenic bowel. R1's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. R1's medical record indicated R1 was admitted to the facility with an indwelling urinary catheter that was scheduled to be replaced with a suprapubic catheter on 12/31/25. According to a grievance, dated 1/7/26, R1 was scheduled to have a suprapubic catheter surgically inserted on 12/31/25. The facility did not ensure stretcher transportation was scheduled upon Family Member (FM)-I's request. As a result, R1's appointment had to be rescheduled for 1/5/26. On 2/2/26, Surveyor requested the facility's policy and procedure for appointments and transportation. The facility did not have a policy and procedure for appointments and transportation. On 2/3/26 at 1:05 PM, Surveyor interviewed Scheduling Coordinator (SC)-G who stated staff request transportation for appointments through the facility's electronic medical record system in the resident's medical record. After staff fill out a request, the request is sent to SC-G. If SC-G is on vacation, another staff processes the request. SC-G stated sometimes staff do not fill out a request properly and SC-G is not aware of the request. SC-G stated staff know how to submit a request and it is not often that requests do not go through. SC-G stated at times staff check the calendar in the resident's medical record and do not see the requested appointment or transportation scheduled. Staff then call SC-G. SC-G reviewed requests submitted for R1 and did not see an appointment or transportation request for 12/31/25. On 2/3/26 at 1:37 PM, SC-G informed Surveyor that SC-G looked further into R1's transportation request on 12/31/25 and found a last minute call from staff to SC-G's coworker. The staff requested stretcher transport for R1's appointment on 12/31/25; however, the faciity was unable to secure stretcher transport which is difficult to schedule at the last minute.

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 02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquardt Memorial Manor	1020 Hill St Watertown, WI 53098

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R5) of 3 sampled residents received oxygen therapy.R5's oxygen tubing was changed on 1/9/26. Following the change, staff did not turn R5's oxygen back on. As a result, R5 was without supplemental oxygen for approximately 6 hours. Findings include:The facility's undated Standard Respiratory Protocol indicates: Problem: Impaired or potential impairment of gas exchange related to chronic respiratory disease. Goal: Individual will have an effective respiratory rate, depth, and rhythm. Registered Nurse: .Apply oxygen, continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP) as ordered.On 2/4/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, morbid obesity, alveolar hypoventilation, peripheral vascular disease, history of pulmonary embolism, and dependence on supplemental oxygen. R5's Minimum Data Set (MDS) assessment, dated 12/11/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. The MDS assessment also indicated R5 was dependent on staff for toileting, bathing, dressing, personal hygiene, and transfers and required set-up assistantce for eating and oral hygiene. R5 was R5's own decision maker. R5's Treatment Administration Record (TAR) contained the following orders:~ Oxygen 2-4 liters via nasal cannula to keep saturation greater than 90% every shift. (Documentation for 1/9/26 indicated R5's oxygen saturation level on the night shift was 98%.)~ Change and date oxygen tubing every 7 days and as needed.On 2/4/26 at 11:20 AM, Surveyor interviewed R5 who stated Registered Nurse (RN)-R changed R5's oxygen tubing on the night of 1/9/26 but did not turn R5's oxygen back on. R5 stated R5 turned on the call light and called the nurses' station but nobody answered. R5 stated Certified Nursing Assistant (CNA)-O turned R5's oxygen back on in the morning. On 2/4/26 at 2:42 PM, Surveyor interviewed CNA-O who stated when CNA-O checked on R5 on the morning of 1/9/26, R5's oxygen was not on. CNA-O turned R5's oxygen on and confirmed that R5 stated RN-R changed R5's oxygen tubing but did not turn R5's oxygen back on. CNA-O stated R5 was without oxygen most of the night. On 2/4/26 at 3:16 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-C who was not aware that R5 went without oxygen.