STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525543	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquardt Memorial Manor	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are thoroughly investigated for 2 of 3 residents reviewed for abuse (R1 & R3).R1 reported verbally and in writing an allegation of neglect. The facility did not complete a thorough investigation of the allegation.CNA F (Certified Nursing Assistant) and CNA E heard R3 screaming from behind a closed door. When they entered they saw CNA H transferring R3 using a hoyer lift alone, without a second staff member. The facility did not complete a thorough investigation that included an interview by R3, interview with other residents, and skin assessments of non-interviewable residents.Evidenced by:Facility policy, titled Abuse, Neglect, Misappropriation of Resident Property, reviewed 2/11/26, includes: It is the policy of the facility that each resident will be free from abuse. Abuse is the willful infliction of injury, . intimidation, or punishment. includes verbal abuse, .mental abuse. Abuse also includes the deprivation by. caregiver or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Verbal abuse involves the use of speech, sound, writing, or gestures when communicating with a resident. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered will be given to the administrator. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Executive or designee will investigate the incident with the assistance will investigate the incident with the assistance of appropriate personnel. The investigation will include: who was involved, residents' statements, for nonverbal residents, cognitively impaired residents or residents who refuse to be interviewed. Attempt to interview resident first. If unable, observe the resident, complete an evaluation of resident behavior, affect, and response to interaction, and document findings. Involved staff and witness statements of events. Injuries present including a resident assessment. A summary of the investigation will be submitted to the State agency within five working days of the initial report. It is the policy of the facility that the resident will be protected from the alleged offenders. Immediately upon receiving a report of abuse. Ensuring safety and well-being for the vulnerable resident is of utmost priority. Safety, security, and support or the resident. and other residents with the potential to be affected will be provided. The alleged perpetrator will immediately be removed and resident protected. If the alleged perpetrator is a facility staff resident, the staff member will immediately remove the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instructions from administration. Examine, assess, and interview the resident and other residents potentially affected immediately to determine any injury and identify any immediate clinical interventions necessary.Example 1R1 admitted to the facility on [DATE] with the following diagnoses: complex regional pain syndrome 1, Mononeuropathy, muscle wasting and atrophy, pruritus, and a need for (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with personal care.R1's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/19/26 indicates R1's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15.R1's Comprehensive Care Plan, initiated 9/27/24, includes: Focus- R1 has an ADL (Activities of Daily Living) self-care performance deficit related to weakness, . right mandibular osteomyelitis with teeth extraction, . alcohol hepatitis. Interventions- toilet use: 2 staff assist. bed mobility- 2 staff assist. transfer- 2 staff assist with hoyer.R1's Grievance Form, dated 4/4/26, includes: Individual or Individual Representative initiating the grievance: Individual. Concern received in what form: writing. Does the Individual identify this event as abuse, neglect, or misappropriation: Yes. Describe concern using factual terms: CNA H. 1.25 hours for a bed pan change. Questioned me on re-wearing a clearly soiled brief. Spilled bed pan. Brought wrong color sling. Did not check for all strapped into sling before lifting hoyer. Attempted to lift me out of bed without pants despite me wearing them in the morning. Pants around my ankles. I had asked her why everything was wet at least 4 times before she said the bed pan spilled. Then did not re-clean the skin after laying on wet pad for 10 minutes while she got a new pad and sling. Overall careless. Additionally her hygiene is poor. She has bad body odor. I could smell it after she left my room. Typically, toileting takes 20 minutes from start to finish and supplies are gotten while I am using the bedpan. She used an hour more than necessary. Previously she offered me BioFreeze roll-on as deodorant and argued with me about it's purpose. NHA A statement: Writer received voicemail at 1:10 PM on Saturday, April 4, 2026, from R1's representative stating, Received disturbing phone call from R1. Um she was blatantly neglected by your caregiver. who my mother described left her on the bed pan with urine and feces for over an hour and a half and then would not let her get dressed before getting her up in the hoyer. Please I expect a call back no later than 24 hours, by Monday at the latest. This is unacceptable. Writer returned phone call at 1:15 PM. Writer thanked resident representative for calling and advocating for R1 and describing details of the incident resulting in allegations of neglect. Explained. next steps that writer will be taking in pursuit of allegation of neglecting R1, investigation including to first suspend CNA H from caregiving pending investigation to ensure safety and security of residents.Facility Self Report, submitted 4/5/26, includes: Brief Summary of Incident- In R1's words on receipt of Grievance, Saturday, 4/4/26: Took 1.25 hours for a bed pan change. Questioned me on re-wearing a clearly soiled brief. Spilled bed pan. Brought wrong color sling for lift. Did not check for all strapped into sling before lifting hoyer. Attempted to lift me out of bed without pants despite me wearing them in morning. Pants around my ankles. I had asked her why everything was wet at least 4 times before she said the bed pan spilled. Then did not re-clean the skin after laying on wet pad for 10 minutes while she got a new pad and sling. Overall careless. Additionally her hygiene is poor. She has bad body odor. I could smell it after she left my room. Typically, toileting takes 20 minutes from start to finish and supplies are gotten while I am using the bedpan. She used an hour more than necessary. Previously she offered me BioFreeze roll-on as deodorant and argued with me about it's purpose. R1 identified this event, and checked the box on the written Grievance form as Abuse, Neglect, Misappropriation. Writer also received a phone call on Saturday 4/4/26 from the daughter of R1, at 1:10 PM describing that she had received a very disturbing phone call from my mother. in your facility. Um she was blatantly neglected by your caregiver. who my mother described left her on the bed pan with urine and feces for over an hour and a half and then would not let her get dressed before getting her up in the hoyer. Law Enforcement was not contacted. Writer immediately left home and reported to the facility by 1:45 PM on 4/4/26. Writer met with staff and suspended the accused immediately pending further investigation to protect both R1 as well as other residents under the accused staff's care in the future if investigation substantiates accusations of neglectful caregiver conduct. Briefly explain the incident- On Saturday, April 4, 2026, R1 received cares and services from CNA H. Alleged by R1 and supported by witness statements of other CNAs working the shift, that appear to have met the State of Wisconsin Office of Caregiver Quality definition of Neglect. Describe the effect that the incident had on the affected person: The incident caused much anger and frustration and humiliation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to R1 per her description, which manifested through many tears and sadness. Explain the steps the entity took upon learning of the incident to protect the affected person or persons and others from potential misconduct: Immediately upon learning of incident, writer left home. It was a Saturday. and went to the facility to speak with CNA H in the presence of RN D (Registered Nurse). Informed CNA H of the receipt of grievance and phone call from R1's Representative. Informed CNA H of writer's obligation to suspend CNA H pending further investigation to ensure the safety and security of the resident alleging neglect by her, as well as to ensure that all other residents in the facility are safe and secure. Before gathering her personal belongings, RN D handed writer the letter that CNA H handed her earlier which stated that she was resigning effective immediately. RN D's Witness Statement, dated 4/5/26, includes: While I was providing cares to a resident, CNA F instructed me to go to R1's room. Upon arrival, I observed R1 is on the phone talking with her family member; visibly upset and crying. CNA E was also present in the room. After ending the call, R1 explained the situation regarding an incident involving CNA H. R1 reported that CNA H used a hoyer lift with an incorrect sling size and applied the sling improperly. She also stated that during care CNA H accidentally tipped over a bed pan containing urine and feces onto the bed. Although CNA H cleaned the bed afterwards, R1 reported that her back was not cleaned following the incident, which caused her to be significantly upset, distressed, and frustrated.CNA E's Witness Statement, dated 4/5/26, includes: Upon entering the dining room on 4/4/26 I saw R1 crying. I gave her a side hug and asked what was going on. She proceeded to tell me that she had a bad experience with CNA H. I asked her what happened and it was quite a long list. For starters she said she was on the bedpan for over an hour and a half and it typically takes about 20 minutes. She had then stated CNA H held her dirty brief up to her and asked if it was still good to wear. R1 obviously declined to wear it. CNA H then tried putting R1 into sling with her pants still down by her ankles. While getting her up she was trying to convince R1 to use BioFreeze roll on for deodorant. By the time R1 was able to get down to the dining room she was in full tears and almost missed lunch. Also when getting ready to transfer R1, CNA H did not put the straps on to the lift and R1 had to tell CNA H to do it. When taking out the bedpan she spilled it into the bed and refused to tell R1 what happened until like the fourth time she asked. I did not actually see any of this happen but was told.Med Tech G's Witness Statement, dated 4/5/26, includes: Yesterday on 4/4/26 when I was in the dining room for lunch, I was informed about CNA H that she transferred R3 by herself and R3 was screaming and crying about it. I told the other aides they needed to report it. I was also informed about her transferring R1 by herself and R1 was very upset and did not feel safe with CNA H. I didn't actually see any of it happen, but was told by R1, R3, and staff.CNA E's Witness Statement, dated 4/5/26, includes: I saw CNA H self-transfer R3 and R1 in and out of bed. When we saw this CNA F and I went to Nurse Supervisor I to let her know that CNA H was self-transferring. Before she started to transfer R3, CNA F asked her if she needed help with her and she said No, I got it. And closed the door. I was working with another resident when all of a sudden I heard R3 screaming Help me, and Oww. So I ran over to see her in bed and CNA H was unhooking her from the hoyer.CNA F's Witness Statement, dated 4/4/26, includes: I heard R1 crying. I asked her what was wrong and gave her a hug. She said she never was treated so badly in her life. That CNA H left her on the bed pan for an hour, used BioFreeze as deodorant. She didn't know how to use the lift. Put a dirty pad in her face. Spilled the bedpan in bed and wasn't going to clean her. I didn't actually see any of this happen.(It is important to note CNA H is accused of putting a dirty pad in R1's face, treating her badly, using BioFreeze for deodorant, not cleaning R1, and leaving her on a bed pan for an hour.)CNA E's Witness Statement, dated 4/4/26, includes: On Saturday, April 4, I heard R3 screaming at the time CNA H was putting her to bed by herself. I asked if she needed help and CNA H responded, No. She also transferred R1 by herself. I did report it to Nurse Supervisor I.Nurse Supervisor I's Witness Statement, dated 4/9/26, includes: On Saturday April 4th, I had been working. when 2 staff members had approached me about some issues that happened with CNA H. The first incident happened when one of the staff heard R3 scream/yell loudly from her room. She had gone (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into her room to find R3 was in the lift and sling and was sitting on bed leaning to the left side. CNA H was asked if she needed any help and CNA H had stated no that she was ok now. I had gone to talk to CNA H after hearing the report of the one person transfer. I had reminded CNA H to stick to her assignment, to follow resident care plans, and to use proper procedure for transfers. Later staff noted R1 in the lunchroom sobbing and had asked her what was wrong. She too had been very roughly handled by CNA H. Her cares had been done poorly and she too had also been transferred alone with a hoyer.(It is important to note this investigation does not include interviews of R1, R3, other residents who were cared for by CNA H this shift, and it does not include assessments of non-interviewable residents who also may have been affected by CNA H's conduct.)On 7/1/26 at 12:30 PM NHA A (Nursing Home Acting Administrator) indicated she is not a licensed NHA, rather she is an Interim Acting Administrator while she waits for INHA C (Interim Nursing Home Administrator) to take her last test. NHA A indicated this was an allegation of neglect that she thought affected one resident. NHA A indicated she did not get interviews by other residents that CNA H cared for that night and she did not have the nursing staff perform skin checks on the non-interviewable residents. NHA A indicated she did not get a statement by or conduct an interview with R3. NHA A indicated she did not get a statement by R1 about how this incident made her feel. NHA A indicated a thorough investigation was not completed and should have been. NHA A indicated she talked with the IDT (Interdisciplinary Team) about this situation and the team thought since CNA H resigned the residents were not in any more danger and there were no lingering concerns so nothing more needed to be done.On 7/1/26 at 1:39 PM INHA C (Interim Nursing Home Administrator) and DON B (Director of Nursing) indicated the investigation was not thorough and should have included interviews by other residents, including R3, and skin checks of the non-interviewable residents. Example 2(A second incident involving R3 was reported through written statements during the facility's self report investigation for R1.)R3 admitted to the facility on [DATE] with the following diagnoses: Rheumatoid arthritis, polyneuropathy, Non-[NAME] Lymphoma, Osteoarthritis, and dependence on other enabling machines and devices.R3's most recent MDS with ARD of 5/27/26 indicates R3's cognition is intact with a BIMS score of 13 out of 15.R3's Comprehensive Care Plan, initiated 5/13/24, includes: Focus- R3 has an ADL (Activities of Daily Living) self-care performance deficit related to weakness. Interventions- bed mobility: 2 staff assist. toileting- 2 staff assist. transfer- 2 staff assist with hoyer.CNA F's Witness Statement, dated 4/4/26, includes: On Saturday, April 4, I heard R3 screaming at the time CNA H was putting her to bed by herself. I asked if she needed help and CNA H responded, No. She also transferred R1 by herself. I did report it to Nurse Supervisor I.CNA E's Witness Statement, dated 4/5/26, includes: I saw CNA H self-transfer R3 and R1 in and out of bed. When we saw this CNA F and I went to Nurse Supervisor I to let her know that CNA H was self transferring. Before she started to transfer R3, CNA F asked her if she needed help with her and she said No, I got it. And closed the door. I was working with another resident when all of a sudden I heard R3 screaming Help me, and Oww. So I ran over to see her in bed and CNA H was unhooking her from the hoyer.Nurse Supervisor I's Witness Statement, dated 4/9/26, includes: On Saturday April 4th, I had been working. when 2 staff members had approached me about some issues that happened with CNA FAI. The first incident happened when one of the staff heard R3 scream/yell loudly from her room. She had gone into her room to find R3 was in the lift and sling and was sitting on bed leaning to the left side. CNA H was asked if she needed any help and CNA H had stated no that she was ok now. I had gone to talk to CNA H after hearing the report of the one person transfer. I had reminded CNA H to stick to her assignment, to follow resident care plans, and to use proper procedure for transfers. Later staff noted R1 in the lunchroom sobbing and had asked her what was wrong. She too had been very roughly handled by CNA H. Her cares had been done poorly and she too had also been transferred alone with a hoyer.(It is important to note R3 is heard screaming, Help me, and Oww. behind her closed bedroom door. The facility failed to investigate this incident thoroughly by interviewing R3 and other residents who CNA H cared for during this shift and by completing skin assessments on non-interviewable residents.)On (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/1/26 at 12:30 PM NHA A (Nursing Home Acting Administrator) indicates she did not include R3 in this report as an affected person and she should have. NHA A indicated hearing a resident screaming behind a closed door and/or yelling, Help Me, and Oww, would make her suspicious of abuse. NHA A indicated she should have interviewed R3 as part of the investigation. NHA A indicated she is unsure how many residents were affected because she did not interview other residents and did not complete skin assessments on non-interviewable residents. NHA A indicated staff get annual abuse training, but there was no house wide abuse training offered after this incident. NHA A indicated she did not follow the facility's abuse policy and procedure but should have. NHA A indicated she has not had the proper training to be an Administrator and was put in the role to act as Administrator until INHA C (Interim Nursing Home Administrator) takes her last test.On 7/1/26 at 1:39 PM INHA C and DON B (Director of Nursing) indicated if staff hear a resident screaming, Help me, and Oww, they should intervene immediately and stay with the resident until they know the resident is safe. DON B indicated staff should have removed CNA H from the room and took over cares with R3. INHA C and DON B indicated this is a second allegation of abuse against CNA H and the facility should have conducted a thorough investigation and educated staff on the abuse policy and procedure after this incident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility did not ensure the resident environment remains as free of accidents/hazards as is possible for 2 of 3 sampled residents (R1, R3) reviewed for accidents/hazards.CNA H (Certified Nursing Assistant) transferred R1 and R3 alone using a hoyer lift, while the facility policy is to have 2 staff when using the hoyer lift.Evidenced by:Facility policy titled Full Body Lift, undated, includes: . At all times full body lifts are two staff transfers.CNA D's Witness Statement, dated 4/5/26, includes:. Upon arrival I observed R1 is on the phone talking with her daughter; visibly upset and crying. CNA E was also present in the room. After ending the call, R1 explained the situation regarding an incident involving CNA H, R1 reported that CNA H used a hoyer lift with an incorrect sling size and applied the sling improperly. She also stated that during care, CNA H accidentally tipped over a bedpan containing urine and feces onto the bed. Although CNA H cleaned the bed afterward, R1 reported that her back was not cleaned following the incident, which caused her significant upset, distress, and frustrated.CNA E's Witness Statement, dated 4/5/26, includes: . when getting ready to transfer R1, CNA H did not put the straps on to the lift and R1 had to tell CNA H to do it.Med Tech G's Witness Statement, dated 4/5/26, includes: Yesterday on 4/4/26 when I was in the dining room for lunch, I was informed about CNA H that she transferred R3 by herself and R3 was screaming and crying about it. I told the other aides they needed to report it. I was also informed about her transferring R1 by herself and R1 was very upset and did not feel safe with CNA H. I didn't actually see any of it happen, but was told by R1, R3, and staff.CNA E's Witness Statement, dated 4/5/26, includes: I saw CNA H self-transfer R3 and R1 in and out of bed. When we saw this CNA F and I went to Nurse Supervisor I to let her know that CNA H was self-transferring. Before she started to transfer R3, CNA F asked her if she needed help with her and she said No, I got it. And closed the door. I was working with another resident when all of a sudden I heard R3 screaming Help me, and Oww. So I ran over to see her in bed and CNA H was unhooking her from the hoyer.CNA F's Witness Statement, dated 4/4/26, includes: On Saturday, April 4, I heard R3 screaming at the time CNA FAI was putting her to bed by herself. I asked if she needed help and CNA H responded, No. She also transferred R1 by herself. I did report it to Nurse Supervisor I.Nurse Supervisor I's Witness Statement, dated 4/9/26, includes: On Saturday April 4th, I had been working. when 2 staff members had approached me about some issues that happened with CNA H. The first incident happened when one of the staff heard R3 scream/yell loudly from her room. She had gone into her room to find R3 was in the lift and sling and was sitting on bed leaning to the left side. CNA H was asked if she needed any help and CNA H had stated no that she was ok now. I had gone to talk to CNA H after hearing the report of the one person transfer. I had reminded CNA H to stick to her assignment, to follow resident care plans, and to use proper procedure for transfers. Later staff noted R1 in the lunchroom sobbing and had asked her what was wrong. She too had been very roughly handled by CNA H. Her cares had been done poorly and she too had also been transferred alone with a hoyer.On 7/1/26 at 1:39 PM INHA C (Interim Nursing Home Administrator) and DON B (Director of Nursing) indicated all hoyer lift transfers are to be done with 2 staff assisting. INHA C and DON B indicated they should have educated all staff who use the lifts after CNA H (Certified Nursing Assistant) was found to be hoyer transferring R1 and R3 alone. DON B indicated staff should intervene if they observe another staff member using a hoyer lift alone.