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	09/26/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observation, record review and staff interviews, the facility did not ensure 1 out of 1 residents (R27) reviewed for the use of a physical restraint, conducted a comprehensive assessment and developed a plan of care for the continued use of the physical restraint. R27 has an abdominal binder in place at all times which cannot be removed easily by R27 and restricts R27's freedom of movement or normal access to her body. The facility did not provide evidence that the use of the abdominal restraint is the least restrictive alternative and did not ensure that it was used for the least amount of time and did not document on-going re-evaluation of the need for the abdominal binder. Findings include: R27 was originally admitted to the facility on [DATE] with diagnosis that included Spastic Quadriplegic Cerebral Palsy (CP), Developmental Disorder of speech and language, severe intellectual disabilities, and Dysphasia. R27 has a gastronomy tube (g-tube) in place to assist in meeting nutritional needs because R27 does not receive anything by mouth due to diagnosis of dysphagia. Surveyor conducted a review of the Physician Orders for R27. On 3/9/23 and order was received to, please order abdominal binder for patient to be worn at times of increased agitation so she does not pull her g-tube out . On 4/17/24 a physician order was received for R27, to have abdominal binder in place at all times. Every shift for prevention of G tube removal Check skin integrity under binder Q shift. Behavior Note dated 4/18/24 at 9:33 a.m. documents that R27 rests in bed during her feedings. R27 is NPO (nothing by mouth) and sometimes pulls out her tube; abdominal binders are ordered. On 5/24/24, Nurse Practitioner conducted a monthly follow-up visit and documented that R27 was seen up in wheelchair. Non-verbal, offers no information. She appears comfortable. No obvious signs of hunger or thirst. Care discussed with nursing who reports she has been doing well recently. Historically she frequently self removes her G tube though staff notes she has not removed in > (greater than) 1 month. no other concerns noted. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/2024 at 9:36 p.m., Nursing note documents that R27 removed/pulled out g-tube while hooked up to feeding, abd (abdominal) binder was previously in place. Writer replaced g tube, no issues. Placement verified; air injected and heard with auscultation. Surveyor conducted a review of the most recent annual MDS (Minimum Data Set), dated 7/17/24. The following was noted: (R27) is severely impaired in cognitive skills for daily decision making. Section P0100 Physical Restraints-does not document that any restraints are being used for R27. On 9/24/24 at 7:42 a.m., Surveyor observed that R27 had the abdominal binder in place during the medication pass. 09/25/24 08:03 AM Surveyor conducted an interview with Nursing Home Administrator (NHA)-A regarding R27's use of the abdominal binder. NHA-A stated that they did not conduct a restraint assessment as they don't consider it a restraint because it does not restrict R27's movement. NHA-A stated that they have a physician order for the use and do document on it weekly for the behavior note for specialized services. Surveyor stated that the abdominal binder does restrict access to R27's body and NHA-A stated that it was there to slow down R27's movements. R27 fidgets a lot and it was thought of more as a safety device. NHA-A stated that they can complete a restraint assessment if needed. Surveyor also clarified that the use of the abdominal binder is not on the plan of care for R27. On 09/25/24 at 02:42 PM Surveyor requested to review the facility's policy on restraint use. NHA-A stated the facility does not have a policy and procedure regarding the use of restraints. 09/26/24 08:32 AM the facility provided Surveyor with a copy of R27's plan of care that documents R27 has potential for skin breakdown/pressure ulcer due to need for assist with mobility, contractures, Quadriplegic spastic CP, bladder and bowel incontinence. Malnutrition, g-tube, history of ulcers. Interventions include: Abdominal binder in place to maintain g-tube placement. Date initiated 4/17/24. It was noted that there was no where else in the plan of care that documented why the abdominal binder was in use, how long the abdominal binder should be used and alternative interventions that had previously been used that may have been less restrictive. As of the time of exit on 9/26/24, no additional information was provided as to why the facility did not comprehensively assess the use of the physical restraint (abdominal binder) and then develop a plan of care based on the outcome of the assessment for its continued use.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 2.) R35 was admitted to the facility on [DATE] from the hospital with a primary diagnosis of alcohol dependence with alcohol-induced persisting dementia; and other diagnoses which include, in part, encounter for palliative care, epilepsy, and anxiety disorder. R35's quarterly Minimum Data Set (MDS) with an assessment reference date of 9/9/24 indicated R35 had a Brief Interview for Mental Status score of 13 (fully intact memory). R35 makes self understood and understands others. No behaviors were noted during the look back period. R35's upper extremity has an impairment on one side, the lower extremities have no impairment. R35 is always continent of bowel and bladder. R35 has the following care plan for falls: The resident is Moderate risk for falls r/t Deconditioning, Gait/balance problems, Dementia, Hx falls. Date Initiated: 05/01/2023 Revision on: 07/24/2023 Goal: o Risk of falls/falls with injury will be minimized Date Initiated: 05/01/2023 Revision on: 09/03/2024 Target Date: 12/08/2024 Interventions: o Anticipate and meet The resident's needs. Date Initiated: 05/01/2023 o Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 05/01/2023 o Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 05/01/2023 o Ensure that the resident is wearing appropriate footwear, or non-skid socks when ambulating, transferring or mobilizing in w/c. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 05/01/2023 Revision on: 09/10/2024 o Fall mat on both sides of bed. Date Initiated: 09/10/2024 o Follow facility fall protocol. Date Initiated: 05/01/2023 o Offer toileting upon rising, before/after meals, at bedtime, and PRN. Date Initiated: 09/11/2024 o The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach. Date Initiated: 05/01/2023 Revision on: 05/04/2023 On 09/23/24, at 11:31 AM, Surveyor reviewed a progress note made by the Nurse Practitioner (NP)-Y on 09/10/2024, at 03:45 PM for the date of service. Seen today for nursing concern of new left sided weakness and falls. Patient seen today laying in bed post fall. Hospice nurse at bedside who reported patient unable to talk, increased anxiety, and urinary retention. Foley placed per hospice protocol with immediate return of 500cc clear yellow urine. Patient alert but disoriented at time of visit. Able to verbalize needs at this time. Denies pain. Complains of constipation and left sided weakness. verbalizes my left side isn't working. Per hospice RN, his sx seem a bit improved at time of visit than her last assessment. Discussed likely secondary to TIA. Hospice nurse at bedside, updated brother and family on change of condition who wish to continue comfort measures only. no plans for ER eval. continue hospice. On 09/26/24, at 12:05 PM, Surveyor reviewed a late entry progress note made by the Hospice Registered Nurse (RN)-N effective 9/10/24 at 13:40, created 9/26/24: Resident had multiple falls, 0615 unwitnessed, 0745 witnessed, 1005 unwitnessed, and 1140 witnessed. 0615 fall resident had abrasions to face and bilateral knees. Hospice visited resident and performed assessment. Hospice RN notified family of multiple falls. Hospice RN gave order to insert foley catheter. Foley catheter inserted with Hospice RN. Foley catheter patent and draining clear, yellow urine. NP notified of above falls and new onset of left sided weakness and assessment completed by NP. Order obtained to discontinue neurological checks and obtain VS Q shift x 48 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24, at 02:00 PM, Surveyor reviewed form Fall Data Collection Tool provided by the Facility and the fall information in the electronic medical record for the fall investigations on 9/10/2024 when R35 fell and was found on the floor at 6:15am, 7:45am, 10:10am and 11am. When R35 fell at 6:15am they were found by the bed and no call light was on. R35 was last checked at 5:30am per the report, resident states they fell at 4:00am and reports hitting head. R35 was found lying on ground on the right side, states did hit head and there were red marks on head and knees. On 09/25/24, at 10:22 AM, Surveyor interviewed RN-N about R35 hitting head and neurological checks not being completed. Per RN-N they initiated them but got an order from NP-W to do vitals instead. On 09/25/24, at 12:50 PM, Surveyor interviewed Nurse Supervisor RN-F who stated that they discontinued the neurological checks since R35 is on hospice. They got an order from NP-W to do vitals each shift for 48 hours. RN-F thinks because R35 is hospice, just wants comfort and staff not in room so much for neurological checks. Surveyor notes the order from NP-Y for Check VS Q shift x 48 hours d/t multiple falls on 9/10/2024 was entered into the electronic medical record at 1:33pm, R35 was found on the floor at 6:15am when the initial neurological check was done. Several hours passed before the order was obtained hence neurological checks should have been completed until that point. On 09/25/24, at 01:23 PM, Surveyor spoke with Nursing Home Administrator-A, Regional Consultant-C and RN-F and shared the concern that R35 was found at 6:15am with red marks on head and neurological checks were not completed until the NP order was received. No additional information was provided. On 09/26/24, at 09:11 AM, RN-F followed up with Surveyor that Facility did the first 15 minute check, not sure why stopped. 3.) R66 was admitted to the facility on [DATE] from the hospital with a primary diagnosis of encounter for surgical aftercare following surgery on the digestive system; and other diagnoses which include, in part, non-st elevation myocardial infarction, difficulty in walking, dysphagia, and muscle weakness. Surveyor reviewed the fall information provided by Facility for R66. On 8/5/2024, R66 had an unwitnessed fall and neurological checks were initiated. Surveyor looked at the handwritten form and compared it to the assessments documented in the electronic health record and notes that four of the scheduled checks were not completed (6:15am, 6:30am, 7:30am and 8:00am). On 8/17/2024, R66 had an unwitnessed fall and neurological checks were initiated. Surveyor looked at the handwritten form and compared it to the assessments documented in the electronic health record and notes that three of the scheduled checks were not completed (Q8: PM, NOC and PM, numbers 3, 4 and 6). On 8/22/2024, R66 had an unwitnessed fall and neurological checks were initiated. Surveyor looked at the handwritten form and compared it to the assessments documented in the electronic health record and notes that four of the scheduled checks were not completed (9:45am, 1:45pm, for Q8: AM and PM, numbers 3 and 4). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/24, at 11:25 AM, Surveyor spoke with Nursing Home Administrator-A and Regional Consultant-C regarding concern that R66 had some scheduled neurological checks not completed according to schedule. No additional information was provided. 49435 Based on interview, and record review the facility did not ensure each resident received neurological checks following unwitnessed falls as indicated in facility policy for adequate supervision and assistance devices to prevent accidents for 3 (R10, R35, and R66) of 5 residents reviewed. *R10 had an unwitnessed fall on 11/25/2023 and did not have neurological checks completed as scheduled per the facility policy. *R35 had several unwitnessed falls on 9/10/2024 and did not have neurological checks completed as scheduled per the facility policy. *R66 had unwitnessed falls on 8/5/2024, 8/17/2024 and 8/22/2024. R66 did not have neurological checks completed as scheduled per the facility policy. Findings include: The facility policy entitled, Neurological Observation, with a review date of 6/13/2023, documents, in part: Licensed nurse will monitor and record an individual's Neurological status as indicated . Neurological observation is to be done per the following Neurological Check Schedule, unless otherwise specified by a physician order: At the time of event. Every 15 minutes x4. [Every] 30 minutes x4. [Every] 1-hour x4. [Every] 4 hours x4. Then every shift up to 72 hours . Notify the provider of any changes in neurological status . 1.) R10 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and Hemiparesis affecting Left side following a stroke, Cerebral edema, Dementia, Depression, Anxiety, Osteoporosis, Muscle weakness, and Presence of Left artificial Knee Joint. R10's Admission Minimum Data Set (MDS) assessment, dated 11/22/2023, documents R10 has a Brief Interview for Mental Status (BIMS) score of 14, indicating that R10 is cognitively intact. R10 requires substantial/maximal assistance for transfers. R10's Care Area Assessment (CAA) for falls dated 11/22/2023, documents . [R10] has balance issues with transitions due to hemiplegia [status post stroke]. [R10] is [wheelchair] bound. [R10] needs assist with all mobility. [R10] continues at risk [related to] weakness, hemiplegia [status post stroke], anti-depressant use, dementia, depression, anxiety, [Osteoporosis], [Osteoarthritis], and chronic pain syndrome. R10's fall risk assessment dated [DATE], documents a fall risk score of 10, indicating that R10 is at a high risk for falls. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's At risk for falls care plan includes, in part, the following interventions initiated on 11/20/23: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure that the resident is wearing appropriate footwear shoes, or non-skid socks when transferring or mobilizing in [wheelchair]. Follow facility fall protocol. R10's ADL (activities of daily living) care plan includes, in part, the following intervention initiated on 11/20/23: 2 [assist] sit-to-stand transfers. R10's progress note, dated 11/25/2023 at 8:46 AM, documents, in part: [R10] had an unwitnessed fall at [6 AM] . [Vital Signs within normal limits]. Neuro-check initiated per protocol . Surveyor reviewed R10's Neuro-checks starting on 11/25/2023. Surveyor noted that staff completed an initial evaluation, every 15 minutes x4 evaluations, and every 30 minutes x4 evaluations per the facility policy. Staff did not complete 2 of 4, every 1-hour evaluations. Staff did not complete 3 out of the 4, every 4-hour evaluations. Staff did not complete 5 out of the 9, every 8-hour evaluations. Surveyor noted that staff missed a total of 10 out of 26 opportunities to complete R10's neuro-checks. On 9/26/24 at 7:53 AM, Surveyor interviewed Registered Nurse (RN)-N. Surveyor asked what is expected of staff if a resident has an unwitnessed fall. RN-N stated that the staff member who finds the resident should stay with the resident and get another staff member to get help and alert the nurse. Staff will do vitals and start neuro checks. The RN will assess the resident and determine if it is safe to move the resident. The nurse will notify the doctor, power-of-attorney if applicable, hospice if applicable, and other family members if applicable. RN-N stated that witness statements are then filled out and a nurse's note is entered. Surveyor asked what the neuro-check policy is for an unwitnessed fall. RN-N stated an initial evaluation, every 15 minutes x4, every 30 minutes x4, every hour x4, every 4 hours x4 and every 8 hours for 3 days. Surveyor asked if all the neuro-checks should be completed. RN-N stated yes. On 9/26/2024 at 7:35 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-B. Surveyor informed ADON-B that according to R10's electronic medical record (EMR), there were multiple gaps in documentation of R10's neuro-check after R10's fall on 11/25/2023. ADON-B indicated that staff could do neuro-check in the computer, but they are typically done on paper and the paper documentation is scanned into the EMR. Surveyor asked if R10 had a paper copy of the completed neuro-checks scanned into the EMR. ADON-B stated that the paper copy was not scanned into R10's EMR.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on the comprehensive assessment of a resident, the facility must ensure that residents receive care, consistent with professional standards of practice, to prevent pressure injuries and do not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 3 (R24) residents reviewed for pressure injuries. R24 had a Controlled Ankle Movement (CAM) boot applied for an ankle fracture. The facility did not implement interventions to remove the boot and assess her skin. R24 developed unstageable pressure injuries to her left heel and top of foot. Findings include: R24 admitted to the facility on [DATE] and has diagnoses that include End Stage Renal Disease, dependence on renal dialysis, Peripheral Vascular Disease (PVD), absence of left leg below knee, osteomyelitis, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Atherosclerotic Heart Disease, chronic Congestive Heart Failure, Atrial Fibrillation, Osteoporosis. The facility Pressure Injury Prevention and Managing Skin Integrity Policy and Procedure reviewed 8/10/23 documents (in part) . . I. Policy: Prevention measures are put in place to reduce the occurrence of pressure injuries. II. Procedure: 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. When indicated, a referral to additional resources (ie Wound Care Specialist, Registered Dietician, 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 5. Risk for pressure ulcer development (Braden Scale). 3. Skin checks a. Skin check will be done upon admission, readmission or as clinically indicated. b. 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. R24's Braden score dated 7/9/23 documented a score of 15, at risk for pressure injuries. R24 had a previous unstageable pressure injury with osteomyelitis to her right heel dating back to 2022. R24's Quarterly Minimum Data Set (MDS) dated [DATE] documents bed mobility and transfer as extensive 1 person assist. R24's Care Plan documents: Potential for skin breakdown/pressure ulcer development r/t (related to) need for assist with mobility, HTN (Hypertension), HLD (Hyperlipidemia) PRN (as needed) narcotic, Anemia, anti-platelet use, wound healing needs, anxiety/depression with psychotropic medication, PVD, Lymphedema and incontinence - initiated 10/17/22, revised 8/7/24. Use of CAM boot was added as revision on 10/11/23. Interventions include: Educate the resident/family caregivers as to causes of skin breakdown; including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning - 10/17/22. Follow facility policies/protocols for the prevention/treatment of skin breakdown - 10/17/22. Monitor/document/report PRN any changes in skin status; appearance, color, wound healing, s/sx (signs or symptoms) of infection, wound size (length x width x depth), stage - 10/17/22. RestQ mattress - 6/2/23. Bilateral heel boots at all times as resident tolerates, or float heels while in bed - 11/9/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Staff to assist with turning and repositioning - 4/1/24. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes - 4/1/24 The resident requires a pressure relieving/reducing device on bed/chair - 10/17/22. Surveyor noted no revisions to the care plan regarding removal of the CAM boot or increased monitoring of R24's skin underneath the boot. On 9/24/24 at 1:55 PM, Surveyor asked Consultant-C for information regarding R24's left heel pressure injury, and when it was identified. Consultant-C advised Surveyor the facility began utilizing new program in April and will have to do some research. Consultant returned and advised Surveyor she determined R24's left heel pressure injury goes back to October 2023 and advised Surveyor where to locate documentation in the electronic health record. Surveyor asked for documentation of the initial comprehensive assessment and measurements when the pressure injury was identified and asked if she had knowledge of how the pressure injury developed. Consultant-C stated: I want to say it was from her boot (Consultant-C looked at Nursing Home Administrator (NHA)-A), right? NHA-A stated: I believe so. Surveyor was unable to locate information regarding R24's CAM boot and asked the facility for information; when it was applied and why. After much record review and multiple discussions with the facility, Surveyor was provided an Orthopedics consult dated 9/19/23 which documented: Patient presents to orthopedics with left ankle fracture. Xrays repeated today and show fracture in similar position as previous images. Discussed non-operative treatment with pt (patient). Use tubigrip and elevate as much as possible for swelling/pain. CAM boot in place at all times except for hygiene and icing. On 9/24/24 at 2:30 PM, Consultant-C advised Surveyor the Wound Advance Practice Nurse Practitioner (APNP) and facility wound nurse do wound rounds together and document, therefore some entries are by the APNP and some are by the wound nurse. Consultant-C advised Surveyor documentation confirms the left heel pressure injury was identified on 10/11/23. Surveyor review of R24's progress notes noted the first documentation regarding R24's left heel pressure injury on 10/11/23 which documented: 10/11/23 Wound Care Follow up APNP. Wound assessed and noted to have new area to dorsal aspect of left foot with ruptured blister, skin intact. Treatment plan discussed with treatment nurse and patient. Left heel unstageable Pressure injury Measuring 3.9 cm (centimeters) x 4 cm with 100% eschar, no drainage, periulcer skin intact blanchable redness. Status: Stable. Plan: Betadine daily. Stage 2 pressure injury to left dorsal foot, blister Measuring 3 cm x 4 cm, 100% epithelial, blister flush to skin without fluid. Scant serous drainage, peri ulcer skin with blanchable redness. 10/25/23 Wound Care Follow up APNP. Left heel unstageable pressure injury measuring 4.5 cm x 3.9 cm with 100% eschar, no drainage, peri skin intact blanchable redness. Status: Stable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage 2 pressure injury to left dorsal foot measuring 3 cm x 4 cm, 100% eschar, periulcer skin with blanchable redness. Status: Stable. Surveyor noted the wound documentation on 10/25/23 incorrectly documented the left dorsal foot pressure injury as a stage 2 with 100% eschar, it should have been staged unstageable. Review of R24's October, 2023 Treatment Administration Record (TAR) documented: Left Heel: Skin prep daily in the evening for DPTI (Deep Tissue Injury) - Start Date 10/5/23 which was signed out as completed. Surveyor noted documentation indicated the pressure injury was present as early as 10/5/23 and not identified on 10/11/23 as previously reported by Consultant-C. On 9/24/24 at 3:00 PM, during the daily exit meeting, the facility was notified that documentation revealed evidence R24's left heel pressure injury was present as early as 10/5/23 as evidenced by documentation and treatment implemented on the TAR. Surveyor asked for documentation of a comprehensive assessment and measurements of the pressure injury prior to those completed on 10/11/23. On 9/24/24 at 3:45 PM, Surveyor was provided an orthopedic consult dated 10/3/23 which documented: Patient seen in orthopedics clinic. Developing pressure ulcer to L (left) heel. Skin irritation noted to anterior ankle. Old boot removed. Placed heel-bo pad to heel and wrapped with ace wrap. Fit patient for larger size boot with extra padding to protect skin. Staff should examine skin and provide wound care at least Once daily. Frequently reposition to take pressure off heel. OK to remove boot at rest to prevent ulcer to heel. OK to open/remove boot for icing. NWB (Non-Weight Bearing) LLE (Left Lower Extremity). Surveyor was provided the facility 24 hour board documentation for 10/5/23 which documented R24's left heel Deep Tissue Injury (DTI) to include measurements 3 x 4.3. Consultant-C pointed out there was writing at the bottom of the page, which Consultant-C explained indicates someone must have done an audit, but noted nothing was documented for R24. The facility also provided a text message communication between the facility and the Wound APNP which read: Wed, [DATE]:00 PM (R24) just returned. Her right heel is resolved, left heel has DPTI. Can I use skin prep to left heel? She has a broken left ankle in a cam boot. Surveyor noted there was no evidence the facility completed comprehensive assessment of R24's left heel pressure injury when identified by ortho on 10/3/23. A comprehensive assessment was not completed until she was seen by the Wound APNP on 10/11/23 which documented the left heel unstageable pressure injury and left dorsal foot stage 2 pressure injury. On 9/25/24 at 10:19 AM, Surveyor spoke with Consultant-C. Surveyor asked if R24's care plan was revised to include increased monitoring of the skin under the boot. Consultant-C stated: I hope so. Surveyor noted R24 was issued a CAM boot on 9/19/23. No revisions were made to the care plan to include the CAM boot. The boot was ordered to be worn at all times except for hygiene and icing. The care plan was not revised to include increased monitoring of R24's skin under the boot. R24 was determined to be at risk for pressure injuries and had an actual pressure injury to her right heel dating back to 2022. The facility continued with only weekly skin checks. The most recent skin check on 9/29/23 included no documentation of abnormalities. (continued on next page)

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	525543	A. Building B. Wing	09/26/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	R24 was followed by the facility wound nurse and Wound APNP weekly and subsequently seen by an outside wound clinic. Treatment was adjusted accordingly and completed as ordered. Despite this, R24's wounds failed to heal, and subsequent testing was completed. 12/28/23 Radiology report: Critical lower limb ischemia. Left - mild stenoses of the proximal and distal superficial femoral artery. Multifocal high grade 70-80 percent stenoses of the above knee popliteal artery. There is three vessel runoff, but there are also high grade stenoses of the tibioperoneal trunk and proximal anterior tibial artery. 2/28/24 Peripheral intervention - Critical limb ischemia. Diagnosis: PVD. LLE angiogram, lower extremity nonhealing wounds. Chronic renal insufficiency on dialysis who has had wounds on her left foot that have not healed. She had abnormal noninvasive studies showering severe disease in her left SFA (Superficial Femoral Artery) anterior tib, tibioperoneal trunk. 7/11/24 LLE angiography: The left SFA shows that there has about a 20% proximal lesion over the course of 1 centimeter. The left popliteal has a 10% mild stenosis and a 30-40% stenosis at the joint in the P2 section, this is over the course of about 2 cm. The anterior dorsalis pedis does not feed the pedal loop. The Tibioperoneal trunk has a 30% proximal lesion over the course of 1-2 cm. Conclusion: Severe single-vessel below the knee stenosis. The SFA has mild proximal disease. The popliteal artery has mild to moderate disease. The anterior tibial has severe proximal disease. The dorsalis pedis does not feed the pedal loop. The tibioperoneal trunk has mild proximal disease. The posterior tib has an irregular course but no focal stenosis, peroneal artery is normal. Hospital Medicine Progress note dated 7/18/24 documents: Chronic LLE foot ulcer. Boot in September of last year that caused some irritation and subsequent ulcerations to the top of her left foot. These have now been present for several months without healing. She has a history of prior vascular disease with prior stenting. On 9/25/24 at 12:09 PM, Surveyor advised Consultant-C of concern R24 was issued a CAM boot to be worn at all times. The care plan was not revised to include increased monitoring of R24's skin under the boot. R24 developed unstageable pressure injuries on her left foot. Consultant reported she is aware of the concern. On 9/26/24 at 7:59 AM, Surveyor spoke with Consultant-C and advised of the following concerns: R24 was determined to be at risk for pressure injuries and had an actual pressure injury to her right heel dating back to 2022. The facility continued with only weekly skin checks. R24 was issued a CAM boot on 9/19/23. The boot was ordered to be worn at all times except for hygiene and icing. No revisions were made to the care plan to include the CAM boot and the care plan was not revised to include increased monitoring of R24's skin under the boot. R24 developed unstageable pressure injuries to her left foot, which were identified by ortho on 10/3/23. A comprehensive assessment of the pressure injuries was not completed until she was seen by the APNP on 10/11/23. In addition, the 10/25/23 assessment of R24's dorsal foot pressure injury was incorrect. Documentation indicated it was stage 2 with 100% eschar was present, which would indicate the pressure injury was unstageable. Consultant-C stated: I know, I understand the concern. I just want you to know we did a complete skin sweep last night for any/all residents with any type of boots, splints, or binders - everything was in place and no areas were found.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview, and record review the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 (R10 and R222) of 5 residents reviewed. *R10 had an unwitnessed fall on 11/25/2023 and did not have neurological checks completed as scheduled per the facility policy. R10's Fall Risk Care Plan was not updated after R10's fall on 11/25/2023. On 1/19/2024, R10 was transferred by Certified Nursing Assistant (CNA)-W with a Sara Steady (an assistive device used for transferring residents). CNA-W did not have assistance from another staff member when R10's care plan documented 2 assist should be used with transferring R10. R10 fell from the Sara Steady and fractured R10's left tibia. R10 was hospitalized from 1/19/2024 through 1/22/2024 and required a Closed reduction of R10's left leg while under sedation. *R222 had a fall on 6/6/2024 that the facility did not thoroughly investigate. Findings include: The facility policy entitled, Falls, with a review date of 6/13/2023, documents, in part: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls . Licensed nurse completes electronic documentation of the Fall Incident Report. The care plan will be updated with an identified intervention. Registered Nurse reviews and completes the fall assessment and interventions. Fall follow-up assessments completed as indicated . The Interdisciplinary Team (IDT) will review Fall incident report and utilize root cause analysis to make further recommendations. Director of Nursing (or designee) and Executive Director to review and sign Fall incident Report. Quality Assurance and Process Improvement Committee reviews facility fall incidents and trends . The facility policy entitled, Safe Individual Handling Program, with a review date of 6/13/2023, documents, in part: . Transfer Assessment-Individuals will be assessed according to ability per transfer and movement objective criteria. Nursing will perform this assessment in collaboration with therapy as applicable. Once the assessment is completed, the appropriate transfer status will be determined. Care Plan-Individual specific transfer status will be addressed on the Care Plan to include specific equipment type if applicable. All staff to transfer according to the Care Plan unless it is determined by the Registered Nurse (RN)/ Licensed Practical Nurse (LPN)/ Certified Nursing Assistant (CNA) at the time that the transfer is not a safe transfer for either the individual or the staff member . Employee Training-Employees will be trained upon hire and when deemed appropriate. Training to include: Safe Individual Handling Policy Overview . Proper transfer techniques using the equipment with return demonstration . The facility policy entitled, Neurological Observation, with a review date of 6/13/2023, documents, in part: Licensed nurse will monitor and record an individual's Neurological status as indicated . Neurological observation is to be done per the following Neurological Check Schedule, unless otherwise specified by a physician order: At the time of event. Every 15 minutes x4. [Every] 30 minutes x4. [Every] 1-hour x4. [Every] 4 hours x4. Then every shift up to 72 hours . Notify the provider of any changes in neurological status . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1.) R10 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and Hemiparesis affecting Left side following a stroke, Cerebral edema, Dementia, Depression, Anxiety, Osteoporosis, Muscle weakness, and Presence of Left artificial Knee Joint. R10's Admission Minimum Data Set (MDS) assessment, dated 11/22/2023, documents R10 has a Brief Interview for Mental Status (BIMS) score of 14, indicating that R10 is cognitively intact. R10 requires substantial/maximal assistance for transfers. R10's Care Area Assessment (CAA) for falls dated 11/22/2023, documents . [R10] has balance issues with transitions due to hemiplegia [status post stroke]. [R10] is [wheelchair] bound. [R10] needs assist with all mobility. [R10] continues at risk [related to] weakness, hemiplegia [status post stroke], anti-depressant use, dementia, depression, anxiety, [Osteoporosis], [Osteoarthritis], and chronic pain syndrome. R10's fall risk assessment dated [DATE], documents a fall risk score of 10, indicating that R10 is at a high risk for falls. R10's At risk for falls care plan includes, in part, the following interventions initiated on 11/20/23: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure that the resident is wearing appropriate footwear shoes, or non-skid socks when transferring or mobilizing in [wheelchair]. Follow facility fall protocol. R10's ADL (activities of daily living) care plan includes, in part, the following intervention initiated on 11/20/23: 2 [assist] sit-to-stand transfers. R10's progress note, dated 11/25/2023 at 8:46 AM, documents, in part: [R10] had an unwitnessed fall at [6 AM] . [Vital Signs within normal limits]. Neuro-check initiated per protocol . Surveyor reviewed R10's 11/25/23 fall investigation completed by the facility. R10 was attempting to sit at the edge of the bed without assistance. R10 then slid out of bed onto the floor onto R10's buttock. R10 did not obtain an injury due to this fall. The fall investigation documented a new intervention: wheelchair to be left at bedside with brakes locked to help prevent future falls. Surveyor reviewed R10's care plan. This new intervention was not added to R10's care plan. On 9/26/2024 at 7:35 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-B. Surveyor asked if R10's care plan had an intervention added after R10's fall on 11/25/2023. ADON-B stated that the care plan was not updated. ADON-B stated that it is an expectation that an intervention should have been added to R10's care plan after the 11/25/2023 fall. On 1/19/2024, R10 had another fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R10's late entry progress note, dated 1/19/2024 at 8:56 PM, documents, in part: CNA came to the writer to report [resident] is on the floor. [Writer] entered the room to observed that the [NAME] steady lift was in front/between the [resident] and [wheelchair] was by the bed (back of [wheelchair] facing bed) and the brakes were on . [R10's] [left] leg contracted with knee/thigh is bent away from body and when touching/trying to straight leg [resident] yelling in pain but when not touched/moved [resident] was not in pain . The fall was witnessed by CNA who was moving [resident] from toilet to [resident's] [wheelchair] . CNA was putting [resident] in [NAME] steady lift and when trying to put the 2 seats down so [resident] can sit, [resident] was impatient and when CNA tried to move the 2 seats together [resident] was on the floor and a cracking noise was heard and CNA called for help. After writer assessed [resident], to which [resident] was placed into bed with 4 staff members with Hoyer lift . R10's progress note, dated 1/19/2024 at 8:24 PM, documents: [7:41 PM]- [Resident's sister/Power of attorney] was called informed of [R10's] fall and going to [emergency room]. [8:24 PM]- received the copy of the result of the x-ray of the [left] leg. [8:39 PM]-911 was called. [8:44 PM]- EMS (emergency medical services) here and was given report. [8:51 PM]-[R10] on stretcher with EMS and have left the facility. R10 was taken to the ER and was hospitalized from 1/19/24 until 1/22/24. R10's Hospital Discharge Summary dated 1/22/2024 documents: Brought in by EMS from nursing home for left leg pain. Patient is non-ambulatory, and injury likely happened while transferring. She was found to have a left knee proximal tibia periprosthetic fracture, prosthetic dislocation. She underwent closed reduction under sedation 1/20/24. Surveyor reviewed R10's fall investigation completed by the facility. CNA-W's undated witness statement documents: Was getting resident off the toilet while using the [NAME] Steady. After washing her bottom and putting the brief and [R10's] pants on, [R10] was ready to go to [R10's] chair. While [R10] was standing, I pulled the [NAME] Steady out of the bathroom while [R10] was standing on it. [R10] started to go down slowly, went behind [R10] to help ease [R10] to the ground. Realized I didn't put the seat down for [R10] to sit. Never used or seen a [NAME] Steady before. Did ask and only got told how to use it. Surveyor notes CNA-W was unavailable for interview. On 9/25/24 at 9:39 AM, Surveyor interviewed, CNA-X. CNA-X stated that CNA-X was not in the room when the fall occurred but was working at the time of R10's fall. CNA-X stated that CNA-W told CNA-X that CNA-W forgot to put the seat to the Sara Steady down during R10's transfer and that is why R10 fell . Surveyor asked what R10's transfer status was at the time of the fall. CNA-X stated that R10 required 2 assist with the Sara Steady. Surveyor asked if CNA-W asked CNA-X for help. CNA-X stated CNA-X was not asked to help transfer R10. CNA-X stated that they work as a team, and they were doing the best they could. Surveyor asked if CNA-X was trained to use the Sara Steady. CNA-X stated that CNA-X was trained, and that CNA-X had trained CNA-W on how to use the Sara Steady days before the fall occurred. CNA-X stated that the fall was a complete accident. On 9/25/24 at 2:01 PM, Surveyor interviewed Physical Therapist (PT)-V. Surveyor asked what R10's transfer status was prior to R10's fall on 1/1/9/2024. PT-V stated that PT-V recommended using the Sara Steady with 2 assists for all transfers. PT-V stated that PT-V always recommends 2 assist when using the Sara Steady. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Included in R10's fall investigation was the following time line completed by ADON-B on 1/22/2024: 1045: Obtained written statement from [CNA-W]. 1047: [CNA-W] didn't know how to find Kardex in [EMR]. [CNA-W] did state she had log in. When writer had [CNA-W] log into [EMR], [CNA-W] did not have access to [facility], only had access to [assisted living facility]. Writer changed location to ALL and then [facility] but there was no access for [CNA-W] to see [facility]. [CNA-W] stated [CNA-W] did message [Scheduler-G] on Saturday to request access. 1054: Spoke with [CNA-X] and [CNA-W]. [CNA-X] stated [CNA-X] did show [CNA-W] how to use the Sara Steady. [CNA-W] then stated she did not remember this. 1055: Had [CNA-X] demonstrate use of Sara Steady and no concerns noted. 1056: [CNA-W] reenacted transfer. [CNA-W] showed writer unlocking breaks after [R10] stood. Pulling Sara Steady back out of the bathroom and letting [R10] know that there was a bump in the threshold. When [CNA-W] had the Sara Steady over the threshold, [CNA-W] stopped the machine. [CNA-W] said [R10] started to sit at this time and [CNA-W] realized [CNA-W] had not put the paddles in place. [CNA-W] went around the machine and assisted [R10] to the ground. Then went to get help. 1123: Writer called [name of staff] who created a ticket to expand [CNA-W] access [in EMR] . On 9/25/2024 at 10:45 AM, Surveyor interviewed ADON-B. Surveyor asked about R10's fall on 1/19/2024. ADON-B stated that through the investigation, ADON-B recognized that R10's transfer was not completed as care-planned. Surveyor asked what R10's transfer status was prior to R10's fall on 1/19/2024. ADON-B stated they would get back to Surveyor. Surveyor asked when staff are trained on the Sara Steady and lifts. ADON-B stated that staff are trained on Sara Steady and lifts during orientation. In addition, staff are trained on who to go to with any questions. On 9/26/24 at 7:35 AM, ADON-B returned to Surveyor. ADON-B stated that the facility identified errors in R10's transfer. R10 should have been assisted by 2 staff members and staff should have put the seat of the Sara Steady down. ADON-B indicated that CNA-W had been trained on how to use the Sara Steady during orientation, the week prior to R10's fall on 1/19/2024. ADON-B stated that ADON-B educated CNA-W about how to get into the CNA Kardex/Care plan the week prior to R10's fall on 1/19/2024. ADON-B stated that the Sara Steady was removed from the floor until all staff members were re-trained. Surveyor reviewed the Facility QAPI (Quality Assurance and Performance Improvement) Meeting notes dated 1/22/2024 which documents, in part: . Identified concern: Staff used the Sara Steady incorrectly by not putting the butt paddles down to prevent a fall and did not follow the care plan. What we did: What corrective action will be accomplished for those residents found to have been affected by the deficient practice. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~Resident will be reassessed for transfers upon return. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. ~All other residents using Sara Steady were assessed for appropriateness and to ensure not care planned for 2 person assist. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. ~Staff member that did the transfer was re-educated and asked to re-enact how she used the lift and following the care plan. ~All CNA staff were re-educated before working next shift on use of Sara Steady and following the care plan. How do you plan to monitor performance to make sure that solution is sustained. ~Audits of those using a Sara Steady transfer will be audited for 4 weeks then frequency determined. When will this be completed. ~1/22/2024. This plan was discussed, developed, and reviewed by the QAPI team (Sign below including Medical Director). Surveyor reviewed the weekly audit outlined in the QAPI plan. For each week of the audit, the following was documented: No patients currently using the Sara Steady. On 9/26/24 at 10:53 AM, Surveyor notified Nursing Home Administrator (NHA)-A of the concerns regarding R10's fall. R10 was transferred with one assist when the care plan indicated that R10 should be transferred with 2 assist. CNA-W did not use the Sara Steady properly and did not put the seat down while transferring R10. NHA-A stated that the facility recognized the issues regarding R10's fall and developed a QAPI plan. NHA-A indicated that this fall should qualify as past-non-compliance. Surveyor explained that because there was non-compliance related to falls after R10's fall, that this accident does not qualify for past-non-compliance. No further information was provided. 49011 2.) R222 was admitted to the facility on [DATE] from the hospital with a primary diagnosis of encounter for surgical aftercare following surgery on the digestive system; and other diagnoses which include, in part, pneumonitis, muscle weakness, and polyneuropathy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R222's discharge Minimum Data Set (MDS) with an assessment reference date of 6/27/24 indicated R222 had a Brief Interview for Mental Status score of 13 (fully intact memory). R222 is able to make decisions for themselves. R222's MDS showed that no behaviors were noted. For toileting R222 requires supervision or touching assistance, is occasionally incontinent of bladder and always continent bowel. The MDS noted one fall since admission. On 09/26/24, at 08:21 AM, Surveyor reviewed R222's care plan and noted the following: R222 is at risk for falls r/t (related to) weakness post hospitalization for Ileocecal mass with resection and Aspiration Pneumonia with hypoxic respiratory failure, need for assist with mobility, Neuropathy, HTN (hypertension), OA (open area), Hyperthyroidism, balance concerns, and translocation. Date Initiated: 05/30/2024 R222 had a goal of: Risk of falls/falls with injury will be minimized Date Initiated: 05/30/2024 Target Date: 08/26/2024. Interventions include: o Be sure The resident's call light is within reach and encourage the resident to use it for assistance Date Initiated: 05/30/2024 o Encourage resident to use call light when feeling weak and/or during the night. Date Initiated: 06/06/2024 o Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility Date Initiated: 05/30/2024 o Ensure that The resident is wearing appropriate footwear when ambulating, transferring or mobilizing in w/c. Date Initiated: 05/30/2024 Revision on: 06/28/2024 o Follow facility fall protocol. Date Initiated: 05/30/2024 o PT/OT evaluate and treat as ordered or PRN. Date Initiated: 05/30/2024 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	o The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Personal items within reach Date Initiated: 05/30/2024 R222's activities of daily living care plan notes the following pertinent interventions: o TOILET USE: 1A Date Initiated: 05/30/2024 o TRANSFER/AMB (ambulation): Up ad lib in room and hall with FWW post cares during waking hours Date Initiated: 05/30/2024 On 09/24/24, at 12:50 PM, Surveyor reviewed a progress note written on 6/6/2024, at 06:11am, At 0605am Pt sent to (name of hospital) (sic) Ambulance for unwitnessed fall and c/o (complaints of) neck pain. Surveyor requested fall investigation information from the Facility and reviewed it. There was a Witness Statement Form completed by Licensed Practical Nurse (LPN)-M CNA found (R222) on floor. (R222) laying face down facing side bed. C/O neck and lt (left) knee pain. Night Staff stated (R222's) independent we don't check her, (R222) stated this was at about midnight, found her at 0535. On 09/25/24, at 07:44 AM, Surveyor interviewed LPN-M and asked about the fall. LPN-M remembers hearing about it but was not at the Facility at midnight. Surveyor reminded LPN-M that they wrote a statement as resident was sent out at 5:35am when they were there. LPN-M states they wrote down what staff told them. On 09/25/24, at 12:58 PM, Surveyor interviewed Nurse Supervisor (NS)-F who stated that is what was reported to them, that the day shift certified nursing assistant found R222 laying on stomach. R222 had been getting up to go to the bathroom and fell . Surveyor asked how long the resident was on the floor before being discovered. NS-F was not sure how long R222 laid on the floor. NS-F stated that rounding is done on a schedule. Night shift should have checked on R222. NS-F stated that night shift should do rounds at least twice during the shift. After this fall the action taken by NS-F was that they verbally talked to night shift about rounding and peeking on residents. On 09/25/24, at 02:20 PM, Surveyor spoke with LPN-M again to see if anything was remembered about the fall. LPN-M stated being 90 percent certain R222's door was open so staff should have seen the resident. LPN-M remembers R222 did not tell staff not to check on them. On 09/25/24, at 03:13 PM, NS-F followed up with Surveyor that in conclusion they don't know how long R222 was on the floor. NS-F states that on the 24-hour board for 6/5/24 it is written that R222 is up ad lib and check on at night, fall happened then that night and education was done on 7/2/2024. (continued on next page)

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	09/26/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor was given the written education staff were to read and sign off on. The education was staff should be checking and changing resident throughout their shift and PRN, ex: beginning, middle, and end of shift. If a resident is sleeping, please wake up resident to offer a check and change (unless a resident specifically doesn't want to be woken up, ex: on NOC shift and have a sign on door). If resident refuses at time of offer, re-approach at a different time, or ask the resident around which time would work better. If resident still refusing, let your floor nurse know so it can be documented accordingly. On 09/26/24, at 08:02 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who wrote statement that they found R222 on the floor. CNA-J remembers hearing R222 yelling so walked into room and found R222 laying on stomach on the floor by bed. R222 did not say how long there. CNA went and got nurse, did notice R222 had rug burn on knee. On 09/26/24, at 09:17 AM, CNA-J followed up with Surveyor and stated that the door was shut, R222 liked the door shut. Surveyor asked if that meant R222 should not have been checked on to which CNA-J responded R222 should have been checked on a couple times at night. Surveyor reviewed the form Fall Data Collection Tool. Many lines were left blank. For instance, Time of Fall, Last time resident had a wellness check, Last time resident was toileted were all not completed. Surveyor notes there was no documentation provided as to when R222 had last been checked on. There was no documentation as to whether door was open or shut. On 09/26/24, at 09:24 AM, Surveyor interviewed CNA-I who was working the unit on the night of the fall. CNA-I states had checked on R222 between 1:30-2am. R222 had been pressing light all night and CNA-I was going in each time light was pressed. Between 2:00-5:30am they were answering call lights and busy, but at 2:00am R222 was asleep in bed. CNA-I stated they sat with R222 till emergency medical services arrived and that R222 stated had been on floor awhile, had been on floor since midnight and was in pain. A new Witness Statement Form was provided to the Surveyor dated 9/26/2024, at 9:19am, written by NS-F as a verbal over the phone interview of CNA-I. Writer called (CNA-I) who was working on 6/6 when (R222) fell . (CNA-I) reports resident was on her call light a few times that night. Resident was checked on at these times. Last toilet check was at 1:30-2am due to doing rounds/answering lights. CNA did peek head into resident's room frequently. On 09/26/24, at 11:02 AM, Surveyor interviewed Occupational Therapist (OT)-U who reviewed therapy notes and stated that from 5/30/24 to 6/4/24, R222 was a stand by assist, per the notes on 6/5/24 and 6/6/24 cannot be sure, but starting 6/7/24 R222 was switched to up at lib with walker. On 09/26/24, at 11:25 AM, Surveyor spoke with Nursing Home Administrator-A and Regional Consultant-C regarding fall concerns for R222 as there was a lack of thorough investigation. The last time R222 was checked on was not documented, so how long on floor cannot be determined. No additional information was provided.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interviews and record review the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice, including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility for 1 of 1 (R24) residents reviewed for dialysis. The facility did not implement interventions to assess and document care of R24's Arteriorvenous (AV) fistula including auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow. Findings include: R24 admitted to the facility on [DATE] and has diagnoses that include End Stage Renal Disease, dependence on renal dialysis, Peripheral Vascular Disease, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Atherosclerotic Heart Disease, Chronic Congestive Heart Failure and Atrial Fibrillation. The facility Dialysis Policy and Procedure reviewed 7/13/21 documents (in part) . . Policy: The care for a individual receiving dialysis will be coordinated and communicated between the Skilled Nursing Facility (SNF) staff and the relevant dialysis staff. Procedure: A. An individual care plan will be developed/revised in the SNF in collaboration with information provided by the relevant dialysis facility. Individual record will reflect up to, and including: 1. Identification of individualized risk factors and potential complications related to dialysis; 3. Medical status including status of comorbid conditions, frequency of vital signs, weights, and monitoring fluids as ordered. B. Individual record will reflect the coordination and collaboration with the relevant dialysis facility including exchange of pertinent information before, during, and post dialysis including emergency protocol contact information. R24's care plan focus area initiated 10/17/22 documents: Needs dialysis r/t (related to) ESRD (End Stage Renal Disease). Fistula LUE (Left Upper Extremity). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions include: Do not draw blood or take B/P (Blood Pressure) in arm with graft. Encourage resident to go for the scheduled dialysis appointments. Monitor labs and report to doctor as needed. Monitor/document/report PRN (As Needed) any s/sx (signs or symptoms) of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: Changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN new/worsening peripheral edema, changes in weight. R24's current (September 2024) Medication Administration Record (MAR) documents: Monitor dialysis site for s/sx of infection or bleeding daily (specify site location) one time a day at 6:00 AM. No blood pressure or lab draws from L (left) arm r/t dialysis fistula every shift. On 9/24/24 at 9:06 AM, R24 reported she receives dialysis three times weekly on Monday, Wednesday and Friday. R24 reported staff really don't look at the access site, the only time it is looked at is when she goes to dialysis. R24 reported she doesn't ask staff to look at it, but she takes the bandage off herself, and if it bleeds, she calls staff and they change it. R24 then reported staff change the bandage once or twice a week. On 9/24/24 at 11:15 AM, Assistant Director of Nursing (ADON)-B advised Surveyor where to find R24's dialysis communication forms in the electronic health record. Surveyor noted a section for staff to complete before dialysis and a section for dialysis center staff to complete after dialysis. Surveyor asked ADON-B what is the expectation when R24 returns from dialysis. ADON-B reported the completed form is scanned in. Surveyor asked if the nurses do an assessment upon R24's return from dialysis. ADON-B stated: No, she's pretty stable. Surveyor where to find documentation staff is assessing R24's AV Fistula. ADON-B stated: You mean like the bruit? Surveyor stated: Yes, checking the bruit and thrill. ADON-B reported she was not sure, and would have to look into it. Surveyor asked if it is the expectation nurses should be assessing R24's fistula bruit/thrill to assure adequate blood flow. ADON-B stated: Yes, I would think daily, but at least after she returns from dialysis. Surveyor located no evidence the facility is assessing R24's AV fistula (pulse, bruit and thrill) to assure adequate blood flow. On 9/25/24 at 3:30 PM, during the daily exit meeting with the facility, Surveyor advised of concern there is no evidence the facility is assessing and monitoring R24's AV Fistula to ensure adequate blood flow. ADON-B reported she is not able to find evidence or documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview, and record review, the Facility did not ensure food was prepared and served in a sanitary manner. -Proper dishwashing rinse cycle temperatures were not obtained on the dish washing machine gauge or the manual gauge that was run though the dishwashing machine. There was no evidence or observations that sanitizing temperature was reached by the dishmachine and the dishmachine was observed to not properly sanitize the dishware through the high temperature cycle. -Cook-R was observed grabbing ready to eat food with gloved hands, after touching non-sanitized food surfaces, and placing the ready to eat food on plates for residents to eat. [NAME] was observed not changing gloves and washing hands after touching non-sanitized food surfaces. This practice has the potential to affect 76 of 76 residents residing in the facility. Findings include: 1.) The Facility Policy and Procedure titled, Manual Dishwashing with no dates, documents: Policy: All flatware, serving dishes, and Cookware will be washed, rinsed, and sanitized after each use. Dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation. Procedure: 1. Prior to use, run the machine until verification of proper temperatures and machine function is made . The Facility Policy and Procedure titled, Recording Dish Machine Temperatures with no dates, documents: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. Procedure: . 2. The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process . 5. Dishwashing staff will be trained to report any problem with dish machine to the food service manager as soon as they occur. 6. The food service manager will promptly assess any dish machine problems and take action immediately to assure sanitation of dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/24 at 09:34 AM, Surveyor observed as dietary staff used the dish machine to clean and sanitize dishes. Surveyor observed the wash and rinse cycle gauge read 160 degrees Fahrenheit each. Surveyor noted that the rinse cycle should read 180 degrees Fahrenheit for sanitation of dishware to occur per the gauges on the dishmachine. Surveyor interviewed Regional Manager (RM)-S about the sanitizing temperatures in the dishmachine. RM-S informed Surveyor that the dishmachine rinse cycle needed to hit 180 degrees on rinse cycle for the surface temp of the dishes. A gauge was put in the dish rack and run through a cycle and it showed 150 degrees on the gauge first time through and 155 degrees when put through in it's own rack a second time. RM-S stopped dish activity and told Surveyor they would work on problem. On 09/25/24 at 10:15 AM, RM-S followed up with Surveyor and informed that the machine was drained and restarted and now is hitting the correct temperature. On 09/25/24 at 10:47 AM, RM-S let Surveyor know that [NAME] was called about the rinse water not heating and that staff needed to turn on and off to reactivate the machine. RM-S informed Surveyor that the dishmachine was needed to keep running as the facility did not have a three compartment sink to use because maintenance took the nozzle off sprayer off the sink. On 09/25/24 at 01:34 PM, Surveyor returned to dish washing area and observed staff cleaning lunch dishes. Per Dietary Aide-Q some dishes just went through, and the dishmachine is now is draining and will be reset. On 09/25/24 at 01:39 PM, Dietary Aide-Q told Surveyor that the rinse cycle reached the correct temperature once today and hasn't gone back since. On 09/25/24 at 01:39 PM, Surveyor observed the dishmachine with Dietary Manager-T as the gauge showed 166 degrees, then 167 degrees as racks were sent through. Staff continued to re-attempt getting machine to temperature and at 01:43 PM and 01:45 PM it was observed to reach 164 degrees Fahrenheit during the rinse cycle. Manager-T left to call RM-S. On 09/25/24 at 03:11 PM, Surveyor returned to the dishwashing area to follow up and Dietary Aide-Q told Surveyor that it still was not up to temperature and showed the picture taken of the one time it did reach temperature. Surveyor notes staff were still running dishes and putting them away upon entrance to the room. On 09/25/24 at 03:22 PM, Surveyor told Assistant Director of Nursing-B, Nursing Home Administrator (NHA)-A, and Regional Consultant-C of the concern with the dish machine not hitting the correct rinse temperature to sanitize dishware and that despite this staff continued to use it to wash and sanitize dishware. On 09/26/24 at 07:25 AM, NHA-A told Surveyor [NAME] was out yesterday and the dishwasher needed some parts and that until those come in and machine is up and running the Facility would be using Styrofoam dishware. 2.) The Facility Policy and Procedure titled, Hand Washing with no dates, documents: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: Staff will wash hands frequently as needed throughout the day following proper hand washing procedure (and surrogate prosthetic devices washing procedures as appropriate) . Encourage hand washing instead of the use of chemical sanitizing gels or lotions . Procedure: Cleans hands and exposed portions of arms (or surrogate prosthetic devices) immediately before engaging in food preparation including working with exposed food. 1. When to wash hands: . -During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . -Before donning gloves for working with food -After engaging in other activities that contaminate hands . The Facility Policy and Procedure titled, Gloves with no dates, documents: Policy: Plastic gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handler's hands to the food product being served. Bare hand contact with food is prohibited. Procedure: . 2. Staff appropriately use utensils such as gloves, tongs, deli paper and spatulas to prevent food borne illness . 6. Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed . -After handling anything soiled . -Anytime you touch any contaminated surface . 7. Wash hands after removing the gloves. On 09/25/24 at 11:07 AM, Surveyor observed meal service in the kitchen that serves all food to residents. Surveyor observed Cook-R touch the microwave with gloved hands to remove chicken strips on a plate, then touch the chicken strips to cut up wearing the same gloves. On 09/25/24 at 11:18 AM, Surveyor observed Cook-R wiping nose on arm and continue to plate food. On 09/25/24 at 11:23 AM, Surveyor observed Cook-R touch a potato chunk, with the same gloves as started with, to move over for vegetable. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/24 at 11:26 AM, Surveyor observed Cook-R touch a potato chunk again to move over, with the same gloves on. On 09/25/24 at 11:27 AM, Surveyor observed Cook-R take gloves off and go into the walk in cooler. On 09/25/24 at 11:28 AM, Cook-R put on new gloves, no hand washing occurred. On 09/25/24 at 11:33 AM, Surveyor observed Cook-R grab a hamburger bun from a bag and place on plate with same gloves. On 09/25/24 at 11:37 AM, Surveyor observed Cook-R take a hot dog bun out of bag and place onto plate after touching microwave door to put hot dog inside. On 09/25/24 at 11:40 AM, Surveyor observed Cook-R lay a meal ticket, given by staff in dining room, directly onto plate then add food items to plate. On 09/25/24 at 11:41 AM, Surveyor observed Cook-R take gloves off and put new ones one without hand washing. On 09/25/24 at 03:22 PM, Surveyor told Assistant Director of Nursing-B, Nursing Home Administrator-A, and Regional Consultant-C of the concern with the hand hygiene during the lunch time service. No additional information was provided.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure medical records contained documentation related to Pneumococcal immunizations for 1 (R67) of 5 residents reviewed for immunizations. R67's medical record does not contain any documentation as to whether R67 was offered, received, or declined the Pneumococcal immunization. Findings include: The facility policy entitled, Infection Control-Individual Immunizations, with a review date of 9/20/2023, documents, in part: Prophylactic immunizations will be offered to individuals to promote the absence of Health Care Acquired Infections . Upon admission, the organization will verify the individual's immunization status, update Primary Care Provider (PCP) as indicated and administer immunizations as ordered. Individual will be offered immunizations based upon the Center for Disease Control (CDC) recommendations and guidelines and as prescribed by their PCP. Other prophylactic treatments or immunizations will be offered to individuals per medical director recommendations, as indicated . Immunization consent and or refusal shall be documented within the Electronic Medical Record (EMR). R67 was admitted to the facility on [DATE]. R67 is [AGE] years old. R67's physician orders with a start date of 8/9/2024 document: Ok to give Pneumonia vaccination according to the WIR (Wisconsin Immunization Registry) guidelines. Surveyor reviewed R67's electronic medical record and was unable to locate whether R67 was offered, received, or declined the Pneumonia immunization. On 9/26/2024 at 10:10 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-B about individual resident immunizations. ADON-B stated that ADON-B completes a monthly audit of resident immunizations. During the monthly audit, ADON-B will identify residents who are eligible for immunizations. Surveyor asked about R67's immunization record. ADON-B stated R67 does not have an immunization record in R67's EMR and R67 does not have an immunization record on the WIR (Wisconsin Immunization Registry). Surveyor asked if R67 had been offered the pneumonia immunization. ADON-B stated that R67 was not in the facility when ADON-B completed the last immunization audit and R67 has not been offered the immunization. ADON-B stated that the facility has an influenza immunization clinic coming up and R67 has been offered an influenza immunization. Surveyor asked if resident immunizations are addressed on admission. ADON-B stated, not yet, but it is a work in progress. ADON-B stated the facility has hired two new supervisor positions that will start to help with the admission process. Surveyor noted R67 was admitted on [DATE] and did not have his immunization record addressed until after Surveyor brought this to the facilities attention on 9/26/2024. On 9/26/24 at 10:53 AM, Surveyor informed Nursing Home Administrator (NHA)-A that R67's EMR did not document whether R67 was offered, received, or declined the Pneumonia immunization. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why R67's medical record did not contain any documentation as to whether R67 was offered, received, or declined the Pneumococcal immunization.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 1 (R67) of 5 residents reviewed for immunizations. R67's medical record does not contain any documentation as to whether R67 was offered, received, or declined the COVID-19 immunization. Findings include: The facility policy entitled, Infection Control-Individual Immunizations, with a review date of 9/20/2023, documents, in part: Prophylactic immunizations will be offered to individuals to promote the absence of Health Care Acquired Infections . Upon admission, the organization will verify the individual's immunization status, update Primary Care Provider (PCP) as indicated and administer immunizations as ordered. Individual will be offered immunizations based upon the Center for Disease Control (CDC) recommendations and guidelines and as prescribed by their PCP. Other prophylactic treatments or immunizations will be offered to individuals per medical director recommendations, as indicated . Immunization consent and or refusal shall be documented within the Electronic Medical Record (EMR). R67 was admitted to the facility on [DATE]. R67 is [AGE] years old. Surveyor reviewed R67's electronic medical record and was unable to locate whether R67 was offered, received, or declined the COVID-19 immunizations. On 9/26/2024 at 10:10 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-B about individual resident immunizations. ADON-B stated that ADON-B completes a monthly audit of resident immunizations. During the monthly audit, ADON-B will identify residents who are eligible for immunizations. Surveyor asked if COVID-19 was included in the audit. ADON-B indicated that COVID-19 was included in the audit. Surveyor asked about R67's immunization record. ADON-B stated R67 does not have an immunization record in R67's EMR and R67 does not have an immunization record on the WIR (Wisconsin Immunization Registry). Surveyor asked if R67 had been offered the COVID-19 immunization. ADON-B stated that R67 was not in the facility when ADON-B completed the last immunization audit and R67 has not been offered the immunization. Surveyor asked if resident immunizations are addressed on admission. ADON-B stated, not yet, but it is a work in progress. ADON-B stated the facility has hired two new supervisor positions that will start to help with the admission process. Surveyor noted R67 was admitted on [DATE] and did not have his immunization record addressed until after Surveyor brought this to the facilities attention on 9/26/2024. On 9/26/24 at 10:53 AM, Surveyor informed Nursing Home Administrator (NHA)-A that R67's EMR did not document whether R67 was offered, received, or declined the COVID-19 immunization. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why R67's medical record did not document whether R67 was offered, received, or declined the COVID-19 immunization.