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	02/25/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to 72 of 73 residents residing in the facility (1 resident was fed via tube). The microwave in the main kitchen was not in a clean condition. Staff did not test the water temperature of the sanitizing solution in the sanitizer buckets or test the sanitization level in the three-compartment sink per manufacturer's recommendations. Staff did not complete appropriate hand hygiene and safe food handling practices while serving food. Findings include: On 2/23/26 at 10:21 AM, Surveyor completed an initial tour of the kitchen with Food Services Director (FSD)-L and Dietary Manager (DM)-M who stated the facility follows the Wisconsin Food Code. Microwave Cleanliness: The Wisconsin Food Code documents at 4-602.12 Cooking and Baking Equipment: (A) The food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours .(B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. During an initial tour of the kitchen that began at 10:21 AM on 2/23/26, Surveyor and DM-M observed the microwave in the main kitchen and noted dried food debris on the interior ceiling of the microwave. DM-M stated the microwave should be cleaned daily. Sanitizing Solution: The Wisconsin Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure .(K) Employees are properly sanitizing cleaned multi-use equipment and utensils before they are reused through routine monitoring of solution temperature and exposure time for hot water sanitizing and chemical concentration, pH, temperature, and exposure time for chemical sanitizing. The Wisconsin Food Code documents at 4-501.116, Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. Hydrion QT-40 test strips: Product directions state the test solution should be between 65 and 75 degreess Fahrenheit (F). On 2/25/26 at 7:45 AM, Surveyor toured the facility's off-site kitchen. Surveyor reviewed logs that contained parts per million (PPM) for the sanitizing solution in the sanitizing buckets and three-compartment sinks. The logs did not include temperature monitoring. On 2/25/26 at 7:45 AM, Surveyor interviewed FSD-L who verified the facility uses Hydrion QT-40 strips to test the sanitizing solution. FSD-L stated staff test the water temperature by placing a hand in the water to ensure it appears to be room temperature. FSD-L stated staff do not use a thermometer to ensure the water temperature meets the manufacturer's recommendations. Hand Hygiene: The Wisconsin Food Code documents at Chapter 2 Personal Cleanliness 2-301.14 When to Wash: Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling service animals or aquatic animals as specified in 2-403.11 (B); (D) Except as specified in 2-401.11 (B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food; (H) Before putting on gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. The facility's undated Hand Washing policy states hand washing should occur .After touching bare human body parts other than clean hands and clean, exposed portions of arms .After handling soiled equipment or utensils .During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before donning gloves for working with food; After engaging in other activities that contaminate the hands. On 2/24/26 at 11:00 AM, Surveyor observed lunch and tray line service. During tray line service, Surveyor observed Dietary Aide (DA)-N change gloves five times without completing hand hygiene. DA-N touched toasted garlic bread and noodles with gloved hands, and touched utensils, countertops, and meal slips without completing hand hygiene. Surveyor also observed DA-O open cooler doors with gloved hands and grab ready-to-eat food, including cheese, lettuce, and bacon, and put the ready-to-eat food on residents' plates. DA-O did not change gloves or complete hand hygiene. Surveyor observed DA-O repeat the process two more times. On 2/24/26 at 11:31 AM, Surveyor interviewed FSD-L and DM-M who stated it is ideal for staff to use tongs when working with ready-to-eat food; however, staff can touch ready-to-eat food with gloved hands provided they complete appropriate hand hygiene. FSD-L stated staff should complete hand hygiene prior to donning gloves and between glove changes. FSD-L stated glove should be changed if they are contaminated, visibly soiled, or between tasks.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, and resident representative interview and record review, the facility did not ensure 5 residents (R) (R11, R36, R13, R39, and R80) of 6 sampled residents received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, name and address (mailing and email) with telephone number of the office of the state long-term care Ombudsman plus notification of discharge/transfer to the Ombudsman. In addition, the facility did not ensure residents received written information on the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility.R11 was transferred to the hospital on 1/24/26. R11 was not provided with a written bed hold or transfer notice. R36 was transferred to the hospital on 1/27/26. R36 was not provided with a written bed hold or transfer notice. R13 was transferred to the hospital on 1/16/26. R13's representative was not provided with a written bed hold or transfer notice.R39 was transferred to the hospital on [DATE]. R39 was not provided with a written bed hold or transfer notice.R80 was transferred to the hospital on [DATE] and 12/1/25. R80 was not provided with written bed hold or transfer notices.Findings include: The facility's undated Individual Bed Hold policy and procedure indicates: The individual, Guardian, and/or individual representative will be informed upon admission and/or hospital/therapeutic leave of their bed hold options at the facility .B. Upon transfer to the hospital and/or therapeutic leave: 1. The individual will be informed and receive a copy of the bed hold procedure and letter. 2. Options will be given for a decision to be made regarding bed hold status. 3. If the individual is unable to make their preference known, the designee will contact the Guardian and/or individual representative to determine preference. 4. The response will be documented. 5. A Life Coach or designee will contact the individual representative on the next working day to ensure the representative understands the bed hold and return to facility information. The facility's undated Individual Transfer and Discharge policy and procedure indicates: .A. Acceptable conditions for transfer or discharge from the facility: 1. Upon the request or with the informed consent of the individual or Guardian .3. If the individual requires care other than that which the facility is licensed to provide or does not provide. 4. For medical reasons as ordered by a physician. 5. In case of a medical emergency .B. Notice: 1. The individual, the individual's physician, Guardian, relative, or other individual representative will receive a written notice including the reason for the transfer .2. The notice shall contain the name, address, and telephone number of the Board on Aging and Long-Term Care . 1. From 2/23/26 to 2/25/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had a diagnosis of congestive heart failure. R11's Minimum Data Set (MDS) assessment, dated 12/6/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's healthcare decisions. R11's medical record indicated R11 was transferred to the hospital on 1/24/26 due to vomiting. R11's medical record did not contain a written bed hold or transfer notice. On 2/23/26 at 1:12 PM, Surveyor interviewed R11 who indicated R11 did not feel well and vomited. R11 went to the hospital and was not sure if R11 received a written bed hold or transfer notice. (See interview under example 2.) (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. From 2/23/26 to 2/25/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had a diagnosis of congestive heart failure. R36's MDS assessment, dated 2/19/26, had a BIMS score of 15 out of 15 which indicated R36 had intact cognition. R36 was responsible for R36's healthcare decisions. R36's medical record indicated R36 was transferred to the hospital on 1/27/26 due to a urinary tract infection (UTI) and pneumonia. R36's medical record did not contain a written bed hold or transfer notice. On 2/24/26 at 4:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Regional Nurse Consultant (RNC)-C regarding the facility's bed hold policy and transfer notices. NHA-A and RNC-C indicated the facility did not have bed hold or transfer notices for R11 and R36. NHA-A and RNC-C indicated it was an area the facility needed to work on and confirmed written bed hold and transfer notices should have been provided. 3. From 2/23/26 to 2/25/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, diabetes, and chronic kidney disease. R13's most recent MDS assessment, dated 1/6/26, had a BIMS score of 0 out of 10 which indicated R13 had severe cognitive impairment. R13 had a Power of Attorney ((POA)-H) who was responsible for R13's healthcare decisions. R13's medical record indicated R13 was transferred to the hospital on 1/16/26 after a fall. R13's medical record did not contain a written bed hold or transfer notice. On 2/23/26 at 11:03 AM, Surveyor interviewed POA-H who did not recall if POA-H was given a written bed hold or transfer notice for R13's hospital transfer. (See interview under example 4.) 4. From 2/23/26 to 2/25/26, Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] and had diagnoses including pneumonia, depression, and anxiety. R39's most recent MDS assessment, dated 1/13/26, had a BIMS score of 8 out of 10 which indicated R39 had moderate cognitive impairment. R39 was responsible for R39's healthcare decisions. R39 was transferred to the hospital on [DATE] for a gastrointestinal (GI) bleed. R39's medical record did not contain a written bed hold or transfer notice. On 2/24/26 at 8:04 AM, Surveyor interviewed R39 who did not recall if R39 received a written bed hold or transfer notice. On 2/24/26 at 4:20 PM, Surveyor interviewed NHA-A and RNC-C regarding the facility's bed hold policy and transfer notices. NHA-A and RNC-C indicated it was an area the facility needed to work on and confirmed written bed hold and transfer notices should have been provided. 5. From 2/23/26 to 2/25/26, Surveyor reviewed R80's medical record. R80 was admitted to the facility on [DATE] and had diagnoses including pleural effusion and pulmonary embolism. R80's MDS assessment, dated 10/7/25, had a BIMS score of 6 out of 15 which indicated R80 had severely impaired cognition. R80 had a Power of Attorney for Healthcare (POAHC) who assisted R80 with healthcare decisions. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R80's medical record indicated R80 was hospitalized twice while in the facility. The first hospitalization was from 10/22/25 to 11/2/25 and the second hospitalization started on 12/1/25. R80 did not return to the facility. R80's medical record did not include written bed hold or transfer notices. On 2/25/26 at 12:17 PM, Surveyor interviewed NHA-A who confirmed the facility did not have a written bed hold or transfer notice for either of R80's hospitalizations. NHA-A acknowledged the facility's previous process for bed hold and transfer notices was insufficient and did not follow regulations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored in accordance with the facility's policy. Three of 6 medication carts were observed unlocked and unattended. In addition, 2 of 6 medication carts and 1 of 2 medication storage rooms contained expired medication and medical supplies. This practice had the potential to affect more than 4 of the 73 residents residing in the facility. Medication carts on the 400 and 200 wings were unlocked and unattended. Medication carts and the medication storage room on the 200 and 400 wings contained expired medication and medical supplies. Findings include: The facility's Medication Storage policy, dated 5/2018, indicates: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication .B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medication (such as medication aides) are permitted to access medication. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory .Expiration Dating (beyond-use dating): .C. Certain medication or package types, such as intravenous (IV) solutions, multiple dose injectable vials .once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency . Medication Carts: On 2/24/24 at 8:32 AM, Surveyor observed a medication cart that was unlocked and unattended on the 400 wing. The front of the medication cart faced the hallway while Nurse Extern (NE)-I was in a resident's room. On 2/24/26 at 8:36 AM, Surveyor interviewed NE-I who verified medication carts should be locked when unattended. On 2/24/26 at 9:14 AM, Surveyor noted the 400 and 500 wing medication cart was unlocked and licensed staff were not in the area. A Certified Nursing Assistant and Housekeeping staff were in the nurses' station. On 2/24/26 at 10:37 AM, Surveyor noted the 100, 200, and 300 wing medication cart was unlocked in the nursing station and licensed staff were not present. Surveyor observed a resident roaming the area in a wheelchair. On 2/24/26 at 9:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who stated the medication cart was only left open when LPN-D was in the area. LPN-D verified LPN-D left the desk for a brief period to attend to a resident. LPN-D verified medication carts should be locked when unattended. On 2/25/26 at 1:16 PM, Surveyor interviewed Director of Nursing (DON)-B who stated medication carts should be locked at all times when not in sight of licensed staff. Expired and Unlabeled Medication and Supplies: On 2/24/26 at 2:11 PM, Surveyor observed 1 of 2 medication treatment carts and 1 of 2 medication storage rooms and noted the following: 400 Wing Registered Nurse (RN) Medication/Treatment Cart: ~ An open vial of insulin for R3 without an open or use-by date ~ A tube of Desenex for R52 with an expiration date of 12/2025 ~ Three DermaView adhesive dressings with expiration dates of 10/2019 On 2/24/26 at 2:16 PM, Surveyor interviewed RN-J who verified the undated and expired medications/dressings in the medication/treatment cart. RN-J indicated staff should label insulin vials with an open/use-by date when the vial is opened. 400 Wing Medication Technician (MT) Medication Cart: ~ Albuterol inhalers for R70 with expiration dates of 2/2025 and 12/2025~ Nine Aspercreme lidocaine patches for R56 with expiration dates of 12/2025 400/500 Wing Medication Storage Room: ~ Two oxygen tubings dated 11/2025~ One container of Clorox wipes with an expiration date of 8/2021~ One box of adhesive remover with an expiration date of 2/2025~ Four bottles of lubricant with expiration dates of 9/2024~ One bottle of Hibiclens antiseptic skin cleanser with an expiration date of 1/2026~ One 14 French catheter with an expiration date of 2/1/26~ Thirteen COVID-19 tests with expiration dates of 10/2025~ Twenty COVID-19 tests with expiration dates of 1/2023 On 2/24/26 at 2:26 PM, Surveyor (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interviewed MT-K who verified the above findings and indicated inhalers are good for 30 days post opening. On 2/25/26 at 1:16 PM, Surveyor interviewed DON-B who stated staff should monitor medication carts and storage rooms to ensure expired medications and supplies are removed timely. DON-B verified staff should label an insulin vial with an open and use-by date when the vial is opened.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not incorporate recommendations from a Pre-admission Screening and Resident Review (PASRR) Level II and PASRR evaluation report into the plan of care for 1 resident (R) (R68) of 5 sampled residents . R68's PASRR Level II Screen indicated R68 required specialized services. A PASRR evaluation stated staff should focus on sensory stimulation activities, socialization, and recreational opportunities to benefit R68's social development. An activities note for R68 indicated R68 should be provided with fidget objects and sensory items. On 2/23/26, 2/24/26, and 2/25/26, R68 was observed in R68's room with the lights down and blinds closed. R68 did not have any sensory stimulation objects and was not invited to any activities during that time period.Findings include:From 2/23/26 to 2/25/26, Surveyor reviewed R68's medical record. R68 was admitted to the facility on [DATE] and had diagnoses including spastic quadriplegia cerebral palsy, epilepsy, severe intellectual disability, cachexia, and weakness. R68's most recent Minimum Data Set (MDS) assessment, dated 2/13/26, indicated R68 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs), including transfers, bed mobility, and hygiene.A care plan, revised 2/14/26, indicated R68 had the potential for decreased socialization due to health status and needed specialized services. The goal was to fill leisure time with watching TV, listening to music, people watching, participating in games as able, enjoying objects such as crinkly books, and being around animals as able. The care plan contained the following interventions: Sensory 1:1 visits as able; Assist with obtaining in-room leisure items such as music and safe sensory objects; Invite to music/social events, sensory programs, games (especially tossing games), and religious programs as able; Offer in-room entertainment, music activities, spiritual activities, and pet visits as able.R68's most recent PASRR Level II assessment, dated 7/17/25, indicated R68 required specialized services for a developmental disorder of speech and language and severe intellectual disabilities. The focus of specialized services was to maintain or improve R68's current level of functioning and indicated opportunities for sensory stimulation, socialization, and leisure should be continued. The Qualified Intellectual Disability Professional (QIDP) indicated staff should focus on sensory stimulation activities, socialization, and recreational opportunities to aide in R68's social development and vocational skills.A behavior note, dated 12/18/25, indicated R68 was alert and enjoyed independently manipulating leisure objects, passively participated in and observed activities around R68, and was at times playful and interactive and threw things. The note indicated R68 enjoyed observing the environment by the nurses' station.A care conference note, dated 1/12/26, indicated R68 enjoyed manipulating smaller toys while in a wheelchair. R68 was non-verbal, seemed to be up and out of bed less, and participated passively in activities. The note indicated staff would continue to bring R68 to activities.A life enrichment quarterly note, dated 1/14/26, indicated R68 spent most of the day in bed with stimulation fidgets and the TV on and had 1:1 visits from staff as able. When up, R68 spent time sitting among peers with fidget objects and sensory items. R86 participated in live music and entertainment when able. The note indicated R68 participates in music and church when up.On 2/23/26 at 10:34 AM, 11:44 AM, 1:02 PM, and 2:55 PM, Surveyor observed R68 in bed with the door half closed, the lights turned down, and the blinds closed. Surveyor observed sensory objects on a shelf in R68's room but none in R68's hands. R68's TV was on the facility's informational channel with no sound.Surveyor reviewed the facility's Activity Calendar for 2/23/26 and noted the following scheduled activities: 9:30 AM Exercise; 10:00 AM Sit and be fit; 10:15 AM Card club, coffee, and social group; 11:15 AM Activity talk; 1:15 PM Music videos; 1:30 PM Banana bread and coffee; 2:00 PM Dice; 3:30 PM Mail pass; 4:45 PM Old time radio show; 7:00 PM Antique roadshow. Surveyor did not observe R68 go to any activities. R68's medical record did not indicate R68 was invited to any activities.On 2/24/26 at 9:20 AM, (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observed R68 in bed with the door open, the curtain drawn, the lights turned down, and the blinds closed. R68 did not have any sensory objects. R68's TV was on the facility's informational channel.On 2/24/26 from 10:03 AM to 1:24 PM (a continuous observation for 3 hours and 21 minutes), Surveyor observed R68 in bed with the lights turned down and the blinds closed. R68 did not have any sensory objects. R68's TV was on the facility's informational channel. Surveyor noted several staff walked past R68's room during that time but did not enter R68's room.On 2/24/26 at 1:44 PM, Surveyor observed Certified Nursing Assistant (CNA)-F provide incontinence care for R68. CNA-F did not interact with R68 aside from providing care. CNA-F left R68's room without providing R68 with any sensory items.On 2/24/26 at 2:10 PM, Surveyor observed R68 in bed with the lights turned down and the blinds closed. R68 did not have any sensory objects. R68's TV was on the facility's informational channel.On 2/24/26 at 1:44 PM, Surveyor interviewed CNA-F who stated staff get R68 up depending on the day. CNA-F indicated R68 had not been getting out of bed recently due to having loose stools.On 2/24/26, Surveyor reviewed the facility's activity calendar for 2/24/26 and noted the following scheduled activities: 9:15 AM Daily chronicles and current events; 9:45 AM Greet your neighbor; 10:00 AM Chips and salsa; 10:30 AM Dice; 1:15 PM Music videos; 1:30 PM Happy hour/birthday party; 3:00 PM Cards; 3:30 PM Mail pass; 7:00 PM Bucks basketball.Surveyor did not observe R68 participate in any activities. R68's medical record did not indicate R68 was invited to any activities.On 2/25/26 at 8:47 AM, Surveyor observed R68 in bed fidgeting with the bed sheet and pulling it over R68's face. R68 did not have any sensory items. R68's TV was on the facility's informational channel.On 2/25/26 at 9:02 AM, Surveyor interviewed CNA-Q who stated staff use a lift to get R68 out of bed. CNA-Q was not sure when R68 had last gotten out of bed.On 2/25/26 at 10:02 AM, Surveyor observed R68 in bed. A fidget toy was on the floor next to the bed. The lights were turned down and the blinds were closed. R68 did not have any other sensory items. R68's TV was on the facility's informational channel.On 2/25/26, Surveyor reviewed the facility's activity calendar and noted the following scheduled activities: 9:45 AM Music videos; 10:00 AM [NAME] basketball/monopoly exercises; 10:30 AM Bocce ball; 11:15 AM Activity talk; 1:15 PM Trivia; and 1:30 PM Beanbag fishing. Surveyor did not observe R68 go to any activities. R68's medical record did not indicate R68 was invited to any activities. On 2/25/26 at 12:04 PM, Surveyor interviewed Life Enrichment Assistant (LEA)-P who stated staff typically invite/bring R68 to activities, even to passively participate, when R68 is in R68's wheelchair. LEA-P stated nursing staff are responsible for getting R68 into the wheelchair. LEA-P reviewed R68's activity attendance for the last 6 months and indicated R68 had attended only 12 activities. LEA-P verified R68 did not attend any activities from 2/23/26 to 2/25/26.On 2/25/26 at 11:20 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding R68's specialized services. NHA-A verified staff should get R68 out of bed to provide opportunities for socialization and confirmed staff should be provide R68 with sensory items throughout the day when R68 is in bed.

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	525543	A. Building B. Wing	02/25/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a comprehensive care plan was developed and implemented for 2 residents (R) (R63 and R12) of 20 sampled residents. R63 had orders for gastrostomy (G)-tube management for seizure rescue medication administration. R63's care plan did not include G-tube care. R12 had an order for the use of continuous oxygen to maintain optimal oxygen saturation rates. R12's care plan did not indicate R12 used continuous oxygen. Findings include: The facility's policy and procedure for Individual Care Plan Conferences, dated 2/21/24, indicates: A written care plan is developed and maintained directing a course of comprehensive care specific to the individual's needs from all appropriate disciplines and the individual's primary care provider . 1. On 2/24/26, Surveyor reviewed R63's medical record. R63 was admitted to the facility on [DATE] and had diagnoses including hemiplegia, Arnold Chiari Syndrome, epilepsy, dysphagia, and depression. R63's Minimum Data Set (MDS) assessment, dated 1/15/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R63 had significant cognitive impairment. R63 had a Guardian for healthcare decisions. R63's medical record indicated R63 had a G-tube to provide rescue medication for seizures and contained the following orders: ~ Exchange Mic-Key button G-tube every 3 months. Size 16 French, 3.5 centimeter (cm) length with 5 milliliter (ml) balloon. Every day shift every 3 months starting on the 14th for 1 day for G-tube (dated 1/14/26) ~ G-tube care: Cleanse skin with gentle soap and water. Pat dry. Apply a thin strip of Silvercel antimicrobial alginate around insertion site. Apply drain sponge over Silvercel in evening, every day (dated 4/11/25) ~ Flush G-tube with 30 cubic centimeters (ccs) free water flush twice daily (dated 4/11/25) R63's care plan did not contain goals or interventions to address maintenance of the G-tube or the potential for impaired skin integrity. On 2/25/26 at 12:27 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated LPN-D followed the Medication Administration Record (MAR) for R63's G-tube orders. LPN-D verified R63's care plan should address G-tube maintenance. On 2/25/26 at 1:06 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff are expected to develop a care plan intervention for skin integrity to address R63's G-tube placement and maintenance. 2. On 2/24/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, dysarthria, hypoxemia, dependence on supplemental oxygen, and epilepsy. R12's MDS assessment, dated 1/28/26, had a BIMS score of 10 out of 15 which indicated R12 had moderate cognitive impairment. R12 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. R12's medical record contained the following oxygen orders: ~ Change humified air canister as needed (dated 2/11/25) ~ Change oxygen tubing - Date tubing every night shift every 7 days (dated 2/11/25) ~ Cleanse top of left ear/crease behind ear with soap and water. Pat dry. Apply non-sting skin prep to area. Ensure foam is intact to nasal cannula to prevent further skin injury two times daily (dated 10/20/25) ~ Oxygen at 1-5 liters per nasal cannula to keep oxygen saturation greater or equal to 90% every shift (dated 5/12/25) R12's care plan did not contain goals or interventions to address R12's dependence on oxygen and potential for airway disturbance. On 2/25/26 at 12:24 PM, Surveyor interviewed Medication Technician (MT)-E who indicated MT-E would ask the nurse or refer to R12's care plan for information regarding oxygen use. On 2/25/26 at 1:04 PM, Surveyor interviewed DON-B who indicated staff should refer to a resident's MAR and Treatment Administration Record (TAR) for oxygen orders and confirmed residents who use oxygen should have a care plan to address airway needs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure timely incontinence care was provided for 1 resident (R) (R68) of 4 sampled residents.R68's care plan indicated R68 should be checked and changed every 2 to 3 hours or as needed. On 2/24/26, staff did not check and change R68 for 3 hours and 21 minutes. R68 was in a brief that had soaked through to a Chux pad underneath R68 and R68's room smelled of urine. Findings include: The facility's undated Activities of Daily Living (ADL) Protocol indicates: Toileting should be offered every 2 to 3 hours and incontinence care should be provided as needed. On 2/24/26, Surveyor reviewed R68's medical record. R68 was admitted to the facility on [DATE] and had diagnoses including spastic quadriplegia cerebral palsy, epilepsy, severe intellectual disability, cachexia, and weakness. R68's most recent Minimum Data Set (MDS) assessment, dated 2/13/26, indicated R68 had severe cognitive impairment, was always incontinent of bladder and bowel, and required staff assistance for incontinence cares. A care plan, revised 2/14/26, indicated R68 had a history of urinary tract infections (UTIs) and should be checked and changed every 2 to 3 hours and as needed. On 2/24/26 at 10:03 AM, Surveyor observed R68 in bed. Surveyor noted a strong urine odor in the room. Surveyor continuously observed R68 from 10:03 AM to 1:24 PM (3 hours and 21 minutes) and noted several staff walked past R68's room but did not enter to see if R68 was incontinent and needed to be changed. On 2/24/26 at 1:24 PM, Surveyor observed Certified Nursing Assistant (CNA)-F enter R68's room and provide incontinence care. CNA-F verified R68 was incontinent of urine and stated urine had soaked into a washable Chux pad beneath R68. CNA-F provided R68 with a clean brief and Chux pad. On 2/24/26 at 1:38 PM, Surveyor interviewed CNA-F who stated CNA-F tries to check and change R68 every two hours, however, it does not happen at times. CNA-F stated CNA-F last checked R68 at approximately 10:00 AM and R68 was dry. CNA-F stated R68 did not routinely use the call light to make R68's needs known. On 2/24/26, Surveyor reviewed R68's CNA charting and noted R68 was provided incontinence care at 8:49 AM. On 2/25/26 at 11:08 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R68 should be checked and changed every two to three hours and should not have been left in a wet brief for over three hours.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure a gastrostomy (G)-tube was flushed as ordered for 1 resident (R) (R63) of sampled 2 residents. R63 had a G-tube to provide rescue medication for seizures. R63 had an order to flush the G-tube for patency. R63's G-tube was not flushed in accordance with the order. Findings include: The facility's General Guidelines for Administering Medication via Enteral Tube policy, dated 5/2018, indicates: The facility assures the safe and effective administration of enteral formula and medication via enteral tubes .D. Enteral tubes are flushed with at least 15 milliliters (ml) of purified or sterile water before administering medication, between each medication, and after all medications have been administered . On 2/24/26, Surveyor reviewed R63's medical record. R63 was admitted to the facility on [DATE] and had diagnoses including hemiplegia, Arnold Chiari Syndrome, epilepsy, dysphagia, and depression. R63's Minimum Data Set (MDS) assessment, dated 1/15/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R63 had severe cognitive impairment. R63 had a Guardian for healthcare decisionsR63's medical record indicated R63 had a G-tube to provide rescue medication for seizures. R63 had the following orders: ~ Exchange Mic-Key button G-tube every 3 months. Size 16 French, 3.5 centimeters (cm) length with 5 milliliter (ml) balloon. Every day shift every 3 months starting on the 14th for 1 day for G-tube (dated 1/14/26) ~ G-tube care: Cleanse skin with gentle soap and water. Pat dry. Apply a thin strip of Silvercel antimicrobial alginate around the insertion site. Apply drain sponge over Silvercel in evening, every day (dated 4/11/25) ~ Flush G-tube with 30 cubic centimeters (ccs) of free water twice daily (dated 4/11/25) R68's Medication Administration Record (MAR) indicated R68's G-tube was not flushed on the 1/25/26, 2/22/26, 2/23/26, and 2/24/26 AM shifts. On 2/25/26 at 1:06 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should provide flushes as ordered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure monitoring interventions for high-risk medications were in place for 1 resident (R) (R7) of 9 sampled residents.R7 was prescribed morphine sulfate (an opioid medication) for pain and gabapentin (an anticonvulsant medication) for nerve pain. Staff did not monitor R7 for adverse reactions or side effects of the high-risk medications.Findings include: The facility's Miscellaneous Special Situations policy, dated May 2018, indicates: Box warning medications - Many medications used by residents in the nursing home may carry a Food and Drug Administration (FDA)-issued box warning. The box warning is a serious type of warning the FDA can require on medication labeling and is important to the health and safety of prescription drug consumers. Nursing facility staff, prescribers, and pharmacists should be familiar with box warnings for any medication used for a nursing home resident and assure the medications are used and monitored appropriately .C. The attending physician should assure and document .2. Ongoing monitoring for any adverse events. 3. Evaluation and management of any experienced adverse events .E. Nursing staff must be informed by the attending physician or via in-service or clinical protocol of symptoms, side effects, and special monitoring to monitor and report associated with medications with box warnings.From 2/23/26 to 2/25/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including dementia, fibromyalgia, and osteoarthritis. R7's Minimum Data Set (MDS) assessment, dated 1/24/26, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R7 had severe cognitive impairment. R7 received Hospice services and had an activated Power of Attorney (POA).R7's medical record contained the following orders: ~ Morphine sulfate solution 20 milligrams (mg)/milliliter (ml), give 0.5 ml by mouth every hour as needed for moderate pain/dyspnea.~ Gabapentin capsule 100 mg, give 3 capsules by mouth every morning and at bedtime for pain.R7's plan of care did not contain monitoring interventions for the use of opioid or anticonvulsant medication, including side effects for opioid use of sedation, dizziness, nausea, vomiting, constipation, and respiratory depression or side effects for anticonvulsant use of fatigue, tremors, rash, blurred vision, and weight gain.On 2/24/26 at 1:34 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who reviewed R7's medical record and confirmed R7 did not have monitoring interventions for opioid or anticonvulsant use. LPN-D stated LPN-D updates the provider if there is anything unusual with a resident. LPN-D indicated the facility does not schedule daily monitoring for adverse reactions or side effects.On 2/25/26 at 12:20 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-C who verified R7's plan of care did not contain adverse reaction/side effect monitoring for opioid or anticonvulsant use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R68) of 6 sampled residents.During the provision of incontinence care for R68, Certified Nursing Assistant (CNA)-F did not complete hand hygiene after removing soiled gloves.During the provision of incontinence care for R68, CNA-G did not wear a gown, appropriately change gloves, or complete hand hygiene after removing soiled gloves. Findings include: The facility's Hand Hygiene policy, revised 12/5/24, indicates: Hand hygiene should be completed before moving from work on a soiled body site to a clean body site on the same resident, after contact with bodily fluids, and immediately after glove removal. The facility's Enhanced Barrier Precautions (EBP) policy, revised 2/6/25, indicates: For residents for whom EBP is indicated, a gown and gloves should be worn when completing high-contact resident cares such as dressing, bathing, providing hygiene, changing linens, and changing briefs. On 2/24/26, Surveyor reviewed R68's medical record. R68 was admitted to the facility on [DATE] and had diagnoses including spastic quadraplegic cerebral palsy, epilepsy, severe intellectual disability, cachexia, and weakness. R68's most recent Minimum Data Set (MDS) assessment, dated 2/13/26, indicated R68 had severe cognitive impairment, had a feeding tube, and was always incontinent of bowel and bladder. A care plan, revised 2/14/26, indicated R68 had a history of urinary tract infections (UTIs) and was on EBP related to a feeding tube. On 2/24/26 at 1:34 PM, Surveyor observed CNA-F provide incontinence care for R68 who was incontinent of urine. CNA-F provided care, removed gloves, and donned clean gloves before putting a clean brief on R68 and changing R68's linens. CNA-F did not complete hand hygiene after removing soiled gloves. On 2/24/26 at 2:02 PM, Surveyor interviewed CNA-F who verified CNA-F should have completed hand hygiene after removing soiled gloves and prior to donning clean gloves. On 2/25/26 at 8:47 AM, Surveyor observed CNA-G provide incontinence care for R68 who was incontinent of bowel. CNA-G did not wear a gown during cares. CNA-G provided care, changed R68's linens, touched items in R68's closet, and touched soiled linen carts outside R68's room before removing gloves. CNA-G did not complete hand hygiene prior to touching another resident's wheelchair and wheeling the resident to the nurses' station. CNA-G completed hand hygiene at the nurses' station. On 2/25/26 at 9:14 AM, Surveyor interviewed CNA-G who verified CNA-G should have worn a gown during incontinence care and should have changed gloves and washed hands when moving from dirty to clean areas. On 2/25/26 at 11:20 AM, Surveyor interviewed Director of Nursing (DON)-B and Registered Nurse Consultant (RNC)-C regarding proper infection control practices during cares. DON-B verified staff should complete hand hygiene after removing soiled gloves and should change gloves after completing perineal care for an incontinent resident before doing anything else. RNC-C verified staff should wear gloves and a gown during high-contact cares for residents on EBP.