STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525165	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritan Nursing and Rehab	531 E Washington St West Bend, WI 53095

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure effective pain management was provided for 1 resident (R) (R2) of 1 sampled resident. R2 was not assessed or provided pain medication during the night (NOC) shift of 3/11/25 into 3/12/25. Findings include: The facility's Pain Management Guidelines policy, dated 2/24/25, indicates: .Based on the comprehensive assessment of a resident, the facility must ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management .Strategies for the prevention and management of pain may include but are not limited to: Assessing the potential for pain, recognizing the onset, presence, and duration of pain, and assessing the characteristics of the pain .Expressions of pain may be verbal or nonverbal and are subjective . On 4/23/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, anxiety disorder, and failure to thrive. R2's Minimum Data Set (MDS) assessment, dated 3/17/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 was not cognitively impaired. R2 was responsible for R2's healthcare decisions. Surveyor reviewed a Concern/Comment Report, dated 3/12/25, that indicated R2 reported to staff that R2 did not receive pain medication the previous night. Surveyor reviewed R2's Medication Administration Record (MAR) which contained the following orders and administered doses: ~ Hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg) Give 1 tablet by mouth every 6 hours as needed for pain. The first dose was administered on 3/12/25 at 10:30 AM for pain at a level 9 out of 10 (10 being the worst pain). ~ Acetaminophen oral tablet 500 mg Give 1 tablet by mouth every 4 hours as needed for pain. The first dose was administered on 3/21/25 at 6:25 AM for pain at a level 3 out of 10. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's medical record contained a note, dated 3/11/25 at 3:04 PM, that indicated R2 had not had pain and did not hurt at any time in the last five days. No indicators of pain were present at that time. (No other pain assessments were noted in R2's medical record until hydrocodone/acetaminophen was administered as indicated above.) On 4/23/25, Surveyor reviewed R2's Treatment Administration Record (TAR) which contained the following order: ~ Pain assessment for 3 days every shift until 3/13/25 at (11:50 PM). The order contained nurses' initials on all shifts except for the night (NOC) shift of 3/11/25 into 3/12/25. On 4/23/25 at 4:51 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R2's medical record indicated R2 was not assessed for pain and did not receive pain medication on the NOC shift of 3/11/25 into 3/12/25.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 3 residents (R) (R9, R1 and R3) of 9 sampled residents. R9 had an order for Tresiba (long-acting insulin) and self-administered the medication. R9 did not have a physician order to self-administer Tresiba or a self-administration of medication assessment that indicated R9 could self-administer Tresiba. In addition, 444 units of R9's Tresiba were unaccounted for and allegedly borrowed from other residents' supplies for administration. R1's medical record indicated R1 did not receive multiple doses of medication, including controlled substances and pain medication. In addition, R1 did not receive Rosuvastatin on 4/23/25 and had to request the medication from Registered Nurse (RN)-G. R3's medical record indicated R3 did not receive an injection as ordered. Findings include: The facility's Administering Medications policy, revised 12/2024, indicates: Medications shall be administered in a safe and timely manner, and as prescribed .3. Medications must be administered in accordance with the orders, including any required time frame .13. Insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident .18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered, the dose, the route of administration site (if applicable), any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed, and the signature and title of the person administering the drug 23. Medications ordered for a particular resident may not be administered to another resident .24. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely . 1. On 4/23/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including left lower leg fracture, diabetes mellitus, and end-stage renal disease which required dialysis. R9's Minimum Data Set (MDS) assessment, dated 1/20/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R9 was not cognitively impaired. R9 was responsible for R9's healthcare decisions. R9's Medication Administration Record (MAR) contained the following order and information: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Tresiba flextouch subcutaneous solution pen-injector 100 units/milliliter (ml) (Insulin degludec (generic name for Tresiba)) Inject 18 units subcutaneously one time a day for diabetes. R9's 9:00 AM dose on 4/6/25 was marked 09 which indicated other/see nurse note. A medication administration note, dated 4/6/25 at 8:14 AM, indicated R9's 18 units of Tresiba were not administered because there was no supply in the facility. The note indicated R9's Tresiba was ordered from the pharmacy by the charge Registered Nurse (RN) who notified R9's physician. On 4/23/25 at 11:53 AM, Surveyor interviewed agency RN-C via phone. RN-C verified RN-C entered the above note in R9's medical record. RN-C indicated RN-C received a text message from the charge RN to borrow Tresiba from another resident to administer to R9 on 4/6/25. RN-C refused to do so and entered the above note in R9's medical record. RN-C indicated RN-C observed an unidentified nurse borrow Tresiba from another resident for R9 on 4/7/25. RN-C indicated the nurse asked RN-C, We still don't have Tresiba? to which RN-C told the nurse RN-C was not able to administer Tresiba on 4/6/25. RN-C indicated the nurse stated, I'm just gonna borrow. On 4/23/25, Surveyor reviewed an email from the pharmacy to Director of Nursing (DON)-B, dated 4/23/25, that indicated the pharmacy sent one 3 ml pen of Tresiba with each dispensing on 2/11/25 and 3/13/25. On 4/23/25 at 12:15 AM, Surveyor and RN-D observed R9's Tresiba pen in the medication cart. The Tresiba pen had an open date of 4/10/25 and a dispensed (from pharmacy) date of 4/9/25. RN-D verified R9's Tresiba pen had 50 units left. On 4/23/25, Surveyor reviewed R9's MARs which indicated the following: ~ From 2/11/25 to 3/19/25, R9 received 20 units of Tresiba daily which was totaled 36 doses. (R9 refused the 3/2/25 dose.) ~ From 3/20/25 to 4/9/25, R9 received 18 units of Tresiba daily which totaled 20 doses. (The 4/6/25 dose was not signed out and the open date on the current pen was 4/10/25.) ~ Each Tresiba pen strength was 100 units per ml and contained 3 ml which totaled 300 units per pen. On 4/23/25, Surveyor calculated the following based on the above information: ~ 22 units x 36 doses (2 units are wasted with each dose to prime needle) = 792 units ~ 20 units x 20 doses (2 units are wasted with each dose to prime needle) = 400 units ~ 792 + 400 = 1192 - 600 (total of two pens delivered from pharmacy) = 592 units unaccounted for doses allegedly administered as indicated in R9's MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 1:20 PM, Surveyor interviewed Pharmacy Manager (PM)-E via phone. PM-E indicated R9's Tresiba was on a refill by demand schedule meaning the facility needs to alert the pharmacy when the medication is running low to obtain a refill. PM-E was unsure if R9 brought Tresiba with R9 when R9 was admitted to the facility. PM-E indicated one Tresiba pen was considered a supply of approximately 13 doses. Following a discussion of the above mathematical calculations by Surveyor, PM-E verified the calculations. PM-E indicated R9's physician order for Tresiba to be administered daily and one pen provided approximately 13 doses (therefore 13 days) worth of medication. PM-E indicated there was approximately one month between facility requests for refills on R9's Tresiba. On 4/23/25, Surveyor reviewed R9's medical record which did not indicate R9 brought medications to the facility. On 4/23/25 at 1:39 PM, Surveyor interviewed DON-B who indicated Tresiba was not kept in the facility's contingency supply. DON-B indicated R9 was admitted to the facility from the hospital and medications were not sent with R9. DON-B indicated R9's medical record indicated the facility received a 200 unit/ml Tresiba pen from pharmacy on 1/14/25. R9 had an admission order for Tresiba 28 units daily before the order was changed based on R9's blood sugar results. DON-B indicated the facility received a Tresiba pen from the pharmacy when R9's order changed on 1/31/25 to 100 units/ml. Surveyor calculated with DON-B the following information: ~ From 2/2/25 to 2/10/25, R9 received 17 units of Tresiba daily which totaled 8 doses. (The 2/1/25 dose was not signed out and R9 refused 2/3/35 dose.) ~ 19 units x 8 doses = 152 units ~ 300 units (total in one pen) - 152 units = 148 units ~ 592 units (from above calculations) - 148 units = 444 units unaccounted for and allegedly administered as indicated in R9's MAR. DON-B verified nurses should not borrow medication from other residents. When asked how DON-B accounted for the discrepancy, DON-B indicated R9 did not want anyone to give R9 injections. DON-B indicated R9 dialed R9's own dose on the pen and self-administered the medication. When asked if a nurse verified the dose R9 prepared, DON-B did not think so. DON-B verified R9's medical record did not contain a physician order or self-administration of medication assessment for R9 to self-administer Tresiba. In addition, R9 did not have a care plan for self-administration of medication. 47248 2. On 4/23/25, Surveyor reviewed R1's medical record. R1 had diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary embolus, edema, venous thrombosis and embolism, wedge compression fracture of unspecified thoracic vertebra subsequent encounter for fracture with routine healing, iron deficiency, borderline personality disorder, and major depressive disorder. R1's MDS assessment, dated 1/25/24, had a BIMS score of 15 out of 15 which indicated R1 was not cognitively impaired. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 5:17 AM, Surveyor interviewed R1 whose call light was activated. R1 indicated R1 was missing an AM medication. R1 showed Surveyor a medication cup and indicated R1 knew R1's medications and Rosuvastatin (used to lower bad cholesterol levels and fats in the blood) was missing. R1 indicated R1 expressed concerns about missed medications in the past but the issue has continued. RN-G then answered R1's call light and R1 indicated Rosuvastatin was missing from the medication cup. RN-G indicated RN-G thought Rosuvastatin was in the cup. Surveyor observed R1 show RN-G the cup and asked RN-G to check the back of the blister pack to ensure the medication was not stuck to the back of the paper. RN-G left R1's room and returned a short time later with Rosuvastatin which was stuck to the back of the paper on the blister pack. R1 indicated R1 frequently has to request medications that were not administered at the right time. R1 stated in February (2025), R1 was not administered medications at night, including gabapentin and pain medication and knew R1 was not the only resident who was not administered medication. R1 fears residents who cannot speak for themselves or do not know their medications do not receive all of their medications. R1 indicated R1 has severe pain and requires medication to be comfortable and maintain independence and happiness. R1 indicated AM and PM shift staff are better than NOC shift staff at administering medication. On 4/23/25 at 5:50 AM, Surveyor interviewed RN-G who works the NOC shift and administers medication. RN-G indicated RN-G has never missed a medication before and thought the medication was in the cup. RN-G indicated after RN-G was alerted by R1 that Rosuvastatin was not administered, RN-G found the medication still attached to the paper on the back of the blister pack. On 4/23/25, Surveyor reviewed R1's February 2025 MAR and noted the following medications were not documented as administered for the administration time of 10:00 PM/11:00: ~ 2/6/25: APAP extra strength oral 500 milligram (mg) tablet (an analgesic medication used to treat pain). ~ 2/16/25: APAP extra strength oral 500 mg tablet and hydromorphone HCl 2 mg (an opioid medication used to treat pain). ~ 2/26/25: Ferrous sulfate 325 mg tablet (an iron supplement used to treat and prevent iron deficiency); APAP extra strength oral 500 mg tablet; Gabapentin 100 mg x 2 (an anticonvulsant medication used to treat pain) and one 300 mg tablet to equal 500 mg; and lidocaine (an anesthetic medication used to treat pain). R1's medical record did not contain progress notes that indicated if the medication was administered, refused, or unavailable. For the administration time of 6:00 PM: ~ 2/26/25: Ropinirole HCl oral tablet 3 mg (used to treat Parkinson's disease and restless legs syndrome), tizanidine HCl 2 mg (a muscle relaxant), and hydromorphone HCl 2 mg A progress note, dated 2/11/25, indicated the following: ~ Lidocaine HCl injection solution 1 % Inject 10 ml intramuscularly one time only for muscle pain for 1 day to be administered at bedside by MD for trigger point injections. Noted as not done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Kenalog 40 injection suspension Inject 40 mg intramuscularly one time only for muscle pain for 1 day to be administered at bedside by MD for trigger point injections. Noted as not done. R1's medical record did not indicate why medications were not administered. On 4/23/25, Surveyor reviewed R1's March 2025 MAR and noted the following medications were not indicated as administered for the medication administration time of 10:00 PM/11:00 PM: ~ 3/4/25: Ferrous sulfate 325 mg and APAP 2 tablets 500 mg R1's medical record did not indicate if the medications were administered, refused, or unavailable. On 4/23/25 at 12:09 PM, Surveyor interviewed DON-B who indicated there should be a progress note to indicate why a medication was not administered, if it was refused, or if it was unavailable. DON-B reviewed R1's MAR and could not explain why the medication was not signed out and could not confirm if it was administered, refused, or unavailable. DON-B indicated nursing staff are trained to use code 9 on the MAR when a medication is not administered and to write a progress note. DON-B indicated code 2 indicates the medication was refused. DON-B verified staff did not follow the facility's medication administration policy since the medications were not documented as administered in February or March 2025. 3. On 4/23/25, Surveyor reviewed R3's medical record. R3 had diagnoses including anxiety, depression, cirrhosis of liver, chronic kidney disease stage 3, left knee septic arthritis, severe portal hypertensive gastropathy, severe portal hypertensive duodenopathy, and atrial fibrillation. R3's MDS assessment, dated 2/8/25, had a BIMS score of 11 out of 15 which indicated R3 had moderate cognitive impairment. On 4/23/25 at 8:37 AM, Surveyor interviewed R3 who indicated R3 knew all of R3's medications and frequently had to request missing medications from nursing staff after R3's medications were provided. R3 indicated R3 missed a recent injection and was unsure why. R3 indicated R3 did not trust that nursing staff administered medication as ordered and stated R3 always checks R3's medications to ensure R3 receives the right medications. A progress note, dated 4/7/25, indicated: Epoetin Alfa injection solution 10000 units/ml (used to treat anemia in those with chronic kidney disease): Inject 10000 units subcutaneously once daily every 14 days for thrombocytopenia. Hold if hemoglobin is less than 11. (A medication administration progress note indicated the medication was not administered because a hemoglobin level was obtained.) On 4/23/25 at 12:09 PM, Surveyor interviewed DON-B who reviewed R3's medical record and indicated the missed Epoetin Alfa injection on 4/7/25 indicated a hemoglobin level was not completed. DON-B indicated an order was not obtained for the hemoglobin level. DON-B confirmed the order should have been obtained by nursing staff. DON-B indicated it was a reoccurring order for R3 and could not explain why it was not completed.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47248 Based on observation, staff and resident interview, and record review, the facility did not ensure food preferences were honored for 2 residents (R) (R1 and R3) of 2 sampled residents. R1 was not provided R1's preferred breakfast item of fried eggs and was told by kitchen staff that eggs were not available. R3's meal ticket indicated R3's food preference for breakfast was 3 fried eggs if available. R3 did not receive fried eggs and was told by kitchen staff that eggs were not available. Findings include: 1. On 4/23/25, Surveyor reviewed R1's medical record. R1 had diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary embolus, edema, venous thrombosis and embolism, wedge compression fracture of unspecified thoracic vertebra subsequent encounter for fracture with routine healing, iron deficiency, and borderline personality disorder. R1's Minimum Data Set (MDS) assessment, dated 1/25/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was not cognitively impaired. On 4/23/25 at 5:17 AM, Surveyor interviewed R1 who indicated R1 was not satisfied with most food items and had regularly received fried eggs for breakfast which was R1's preference. R1 indicated Dietary Manager (DM)-H told R1 that the facility could not get shelled eggs because the vendor did not have any available. R1 indicated DM-H talked with R1 on many occasions and attempted to find other foods that R1 liked for breakfast. R1 indicated liquid eggs are not palatable and R1 feels R1 should be able to have fried eggs for breakfast on a daily basis. On 4/23/25 at 7:00 AM, Surveyor toured the kitchen and observed a case of pasteurized eggs, a case of liquid eggs, and a box of hard-boiled eggs in the walk-in cooler. Surveyor noted the box of shelled eggs was labeled Desserts only. Surveyor interviewed Kitchen Manager (KM)-F who indicated the eggs in the walk-in cooler were for special items because the price of eggs was expensive and the facility's budget did not allow the facility to purchase eggs with every order. KM-F thought the case of eggs was delivered by mistake because the facility usually only purchased hard boiled eggs and liquid eggs that were served to residents for breakfast. On 4/23/25 at 8:00 AM, Surveyor observed meal service at the fourth floor steam table. Surveyor noted R1's meal tray contained scrambled eggs with ham, cheese, and peppers. R3's meal ticket indicated 3 fried eggs if available. Surveyor noted the fourth floor steam table had scrambled eggs but no fried eggs. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 8:25 AM, Surveyor interviewed R1 who was eating an omelet scramble, rye toast, and two yogurts. R1 was happy with the rye toast and yogurt and stated, I want real eggs. R1 also stated, I won't stand for it. I don't want these rubbery eggs. R1 indicated R1 spoke with DM-H about the food. R1 indicated DM-H tries, however, R1 was informed real eggs can not be ordered by the facility due to the cost. R1 indicated R1 understands rising costs and but R1 is one person and wants to have fried eggs. R1 stated, I spend all my money here and should be able to eat what I like. 2. On 4/23/25, Surveyor reviewed R3's medical record. R3 had diagnoses including chronic kidney disease stage 3, left knee septic arthritis, erosive distal esophagitis, atrial fibrillation, anxiety, and gastroesophageal reflux disease (GERD). R3's MDS assessment, dated 2/8/25, had a BIMS score of 11 out of 15 which indicated R3 had moderately impaired cognition. On 4/23/25 at 8:45 AM, Surveyor interviewed R3 who had received a breakfast tray. R3 indicated R3 wanted and requested fried eggs for breakfast but had not received them for a long time. R3 indicated the scrambled eggs were egg goulash and disgusting and R3 would not eat them. R3 made a request to DM-H who informed R3 that eggs cannot be ordered due to cost and the eggs are not available. R3 indicated R3 understood the rising costs, however, eggs should be offered. R3 found it hard to believe the facility could not buy eggs. R3 indicated eggs in the form R3 and other residents request should be honored because that is their preference. On 4/23/25 at 12:40 PM, Surveyor interviewed DM-H who indicated the facility orders shelled eggs every week, however, the vendor is unable to provide them. DM-H indicated DM-H spoke with R1 who agreed to an egg scramble or hard boiled eggs. DM-H indicated shelled eggs are in the cooler but are only for specialty items. DM-H indicated the facility serves the skilled nursing and assisted living facilities. DM-H indicated one case of eggs was not enough to serve all residents who request a fried egg. DM-H indicated DM-H already discussed a cooked and frozen fried egg patty with residents and was looking into the possibility of ordering the item. DM-H indicated residents who prefer fried eggs had a recent meal ticket change to if available. DM-H indicated shelled eggs are available but not served per residents' preferences because staff were cooking 50-60 fried eggs between both facilities which was beyond the facility's budget and what their vendor could provide. DM-H indicated DM-H is not allowed to order eggs from another vendor and kitchen staffing does not allow for one cook to spend the amount of time it takes to make fried eggs which are difficult to keep warm for service.