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	07/29/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary care and services to prevent pressure injuries from developing and/or promote healing for 4 residents (R) (R2, R7, R14, and R15) of 4 sampled residents. R2 had a pressure injury on the sacrum and deep tissue damage to the right heel. R2's June 2025 Treatment Administration Record (TAR) contained orders for staff to monitor R2's bilateral feet wounds, offer changes of position during the day, apply zinc cream to the sacrum, encourage R2 to wear soft boots at all times, ensure sheep skin is in place at the foot of R2's bed, and good change of position with toileting schedules. The orders were not consistently completed.R7 had a pressure injury on the sacrum. R7's June 2025 Medication Administration Record (MAR) and TAR) contained orders for staff to reposition R7 every 2 hours, encourage change of position every 1-2 hours, and apply silver sulfadiazine (wound cream) to R7's coccyx. The orders were not consistently completed. R14 had pressure injuries on the right foot and sacrum. R14's July 2025 MAR and TAR contained orders for Arginaid powder (wound nutrition supplement), liquid protein (wound nutrition supplement), skin prep, and wound cleanse/wash/dressing. The orders were not consistently completed. R15 had deep tissue injuries of the left foot and left buttock. R15's July 2025 MAR and TAR contained orders for skin prep and offloading left buttock with good side-to-side repositioning. The orders were not consistently completed.Findings include:The facility's Pressure Injury/Skin Integrity policy, dated 10/21/24, indicates: It is the policy of this facility to enable nursing staff to manage wounds and select appropriate interventions .Based on the comprehensive assessment of a resident, this facility will ensure: A resident receives care consistent with professional standards of practice to prevent pressure injuries and does not develop pressure injuries .A resident with a pressure injury receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing .The goal for wound care is to prevent or manage the cause, provide a moist wound healing environment, avoid further trauma, protect surrounding skin .Interventions should be documented in the resident's electronic medical record (EMR) .Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services .Repositioning and/or off-loading .Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin. The frequency of documentation shall be determined based on the resident's individual needs .Wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment.1.On 7/29/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including pathological fracture, subsequent encounter for fracture with routine healing, pain, abnormalities of gait and mobility, unsteadiness on feet, and localized edema. R2's Minimum Data Set (MDS) assessment, dated 5/5/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2's MDS assessment, dated 8/16/23, indicated R2 had a stage 3 pressure injury upon admission. R2 made R2's own healthcare decisions and was discharged to the hospital on 6/20/25. R2's medical record indicated R2 had pressure-induced deep tissue damage to the right heel (dated 10/25/24). A skin/wound note, dated 5/8/25, indicated R2's previous stage 3 sacral pressure injury had reopened and measured 3.0 centimeters (cm) x 2.0 x 0.1 cm. R2 indicated the area was painful. Frequent change of position was offered. Surveyor noted the following orders were not documented as completed on R2's June 2025 TAR:~ Monitor bilateral feet for new or worsening wounds. Chart per progress note and update provider if concerns noted at bedtime (HS) (ordered 12/27/24). The order was not documented as completed on 6/9/25, 6/10/25, and 6/15/25.~ Offer to get resident up during the day for change of position. Chart refusals and interventions that occurred, two times a day (ordered 5/29/25). The order was not documented as completed on 6/10/25 (PM) and 6/15/25 (PM). ~ Sacrum treatment, apply skin prep followed by zinc 20% cream every morning and at bedtime, chart assessment per progress note (ordered 5/29/25). The order was not documented as completed on 6/9/25 (HS) and 6/10/25 (HS). ~ Encourage resident to wear soft boots at all times, every shit (ordered 10/24/24). The order was not documented as completed on 6/10/25 (PM) and 6/15/25 (PM).~ Good change of position with toileting schedule, every shift for open area (ordered 11/20/24). The order was not documented as completed on 6/10/25 (PM) and 6/15/25 (PM).~ Sheep skin to base of foot of bed, check placement due to injuries to feet, every shift (ordered 8/5/24). The order was not documented as completed on 6/10/25 (PM) and 6/15/25 (PM). 2. On 7/29/25, Surveyor reviewed R7's medical record. R7 was admitted

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 residents (R) (R5 and R7) of 11 residents observed during the provision of care. Staff did not ensure enhanced barrier precautions (EBP) were followed during transfers and cares for R5.Staff did not ensure EBP was followed during catheter care for R7. In addition, staff did not ensure a catheter collection bag was stored properly and a collection bag exchange was completed appropriately. Staff did not ensure medical equipment was sanitized after use and before being placed in storage.Findings includeThe facility's Enhanced Barrier Precautions (EBP) policy, dated 4/1/24, indicates: .3. Implementation of EBP: .b. Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities .4. High-contact resident care activities include: a. dressing, .c. transferring, d. providing hygiene, e. changing linens, f. changing briefs or assisting with toileting, g. device care or use: central lines, urinary catheters, feeding tubes, tracheotomy/ventilator tubes . The facility's Catheter Care policy, revised 2/5/25, indicates: Leg bags may be stored in a clean plastic bag when not in use or as per facility policy. The facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised July 2014, indicates: Durable medical equipment must be cleaned and disinfected before reuse by another resident.1. On 7/29/25 at 5:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-D and CNA-E retrieve a lift and enter R5's room. A sign outside R5's door indicated R5 was on EBP. Surveyor asked permission to observe the transfer and noted CNA-D and CNA-E did not don PPE prior to entering R5's room. Upon entering the room, Surveyor observed dirty towels on the floor to the left of the door. CNA-E picked up the towels and put them in a bag. CNA-D and CNA-E then situated R5 in a sit-to-stand lift. While R5 stood in the lift in accordance with a standing program, CNA-D made R5's bed without donning a gown or gloves. While wearing gloves but not a gown, CNA-E cleaned up supplies used during cares and removed the garbage. After exiting R5's room at 5:57 AM, Surveyor asked CNA-E if PPE was required during cares and transfers for R5. CNA-E stated PPE was only needed for catheter care. On 7/29/25 at 6:02 AM, Surveyor interviewed Registered Nurse (RN)-F who indicated only gloves were needed during a transfer for a resident on EBP. RN-F indicated a gown was needed if the resident was on isolation precautions.2. On 7/29/25 at 8:14 AM, Surveyor observed CNA-H complete cares for R7. A sign outside R7's door indicated R7 was on EBP. While wearing gloves but not a gown, CNA-H removed R7's gown and blankets. When Surveyor asked if PPE should be worn during cares, CNA-H indicated PPE was only needed if emptying catheter or ostomy bags. When R7 asked CNA-H to exchange R7's catheter collection bag for a leg bag before putting on R7's pants, CNA-H donned a gown and retrieved a leg bag from the bathroom. Surveyor noted the bag did not contain a cap which CNA-H confirmed. CNA-H put the leg bag on R7s' bed without a barrier, retrieved a graduated cylinder to empty the collection bag, and knelt on the floor without a barrier while emptying the bag. CNA-H then emptied the cylinder, washed hands, donned clean gloves, and returned to R7's bedside to secure the leg bag. CNA-H disconnected the collection bag and placed the tubing on top of the uncapped bag on R7's bed. CNA-H then connected the leg bag without cleansing either connection port. R7 told CNA-H there were alcohol pads in the bathroom that CNA-H should use. Surveyor then observed the collection bag connection tube fall on the floor and leak urine. CNA-H retrieved alcohol wipes, disconnected the leg bag, and cleansed both connections with an alcohol wipe. CNA-H then hung the collection bag from a rail in the bathroom and wiped urine off the floor with a paper towel. When R7 stated to CNA-H that R7's daughter would bring vinegar to clean the collection bags, R7 indicated R7 did not know where the facility kept vinegar or if it was used to clean the bags. When Surveyor indicated the connection tube of the collection bag had been on the floor, CNA-H went to the bathroom, removed the collection bag from the railing, and put it in the garbage. 3. On 7/29/25 at 5:58 AM, Surveyor observed CNA-D return a sit-to-stand lift to the equipment storage area and walk down the hall away from the lift. When Surveyor asked if lifts should be sanitized after use, CNA-D confirmed lifts should be sanitized after use and retrieved sanitizing wipes. CNA-D returned to sanitize the lift. On 7/29/25 at 8:12 AM, Surveyor observed RN-I obtain a resident's vital signs with a vitals machine. RN-I removed the cuff and oxygen sensor and put them in storage and did not sanitize the machine after use.On 7/29/25 at 8:35 AM, Surveyor interviewed RN-I who indicated vitals machines should be sanitized after use. On 7/29/25 at 1:14 PM, Surveyor interviewed Infection Preventionist (IP)-J who confirmed staff should wear PPE during high-contact cares, including transfers. IP-J also verified staff should put dirty linens in garbage