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	08/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 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 observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 8 residents (R) (R2, R4, R10, R9, R5, R6, R7, and R8) of 10 sampled residents.On 8/12/25, R2 was administered sevelamer. R2 did not have an order for the medication. On 7/31/25 and 8/1/25, multiple medications for R2 were administered late or not in accordance with physician orders.On 8/4/25, 8/20/25, 8/21/25, and 8/22/25, multiple medications for R4 were not administered in accordance with physician orders. In addition, R4's AM medications were not administered timely on 8/25/25.On 8/25/25, R10's ropinirole was not administered in accordance with the physician order.On 8/25/25, R9's Protonix and potassium chloride were not administered in accordance with physician orders.On 8/25/25, R5, R6, R7, and R8's AM medications were not administered timely.Findings include:The facility's Administering Medications policy, dated 5/2025, 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 frames. 4. Medications must be administered within one hour of their prescribed time, unless otherwise specified .6. The individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: .b. Checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel .The facility's Adverse Consequences and Medication Errors policy, dated 4/2014, indicates: Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate 5. A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician orders .15. The following information is documented in an incident report and in the resident's clinical record: a. Factual description of the error or adverse consequence. b. Name of physician and time notified. c. Physician's subsequent orders. d. Resident's condition for 24 to 72 hours or as directed .1.On 8/25/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including osteoarthritis of right shoulder, joint replacement of right shoulder, and epilepsy. R2's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2 was responsible for R2's healthcare decisions. Surveyor reviewed a medication error report for R2, dated 8/12/25, that indicated R2 received sevelamer (a medication used to control high blood phosphate levels in those with chronic kidney disease) that was intended for another resident when R2 was mistaken for another resident who looked like R2. R2's physician and family were notified and R2 was monitored for adverse effects. On 8/26/25 at 10:54 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated an agency staff reviewed the resident's photograph for identification before administering sevelamer, however, the resident looked similar to R2 and staff administered the medication to R2. DON-B indicated staff education was in the process but had not been completed. R2's medical record indicated R2 was admitted to the facility on [DATE] at 2:23 PM and had the following physician orders, dated 7/31/25:~ Amlodipine besylate 5 milligrams (mg) give 1 tablet by mouth in morning~ Atorvastatin calcium 80 mg give 1 tablet by mouth at bedtime ~ Clopidogrel bisulfate 75 mg give 1 tablet by mouth in morning~ Cyanocobalamin oral 1000 micrograms (mcg) give 1 tablet by mouth in morning~ Docusate sodium 100 mg give 1 capsule by mouth in morning~ Fexofenadine HCL180 mg give 1 tablet by mouth in morning~ Polyvinyl alcohol 1.4% instill 1 drop in both eyes in morning~ Potassium gluconate 595 mg give 1 tablet by mouth in morning~ Selenium 200 mcg give 1 capsule by mouth in morning~ Tamsulosin HCL 0.4 mg give 1 capsule by mouth in morning~ Levetiracetam 1000 mg give tablet by mouth two times daily ~ Phenytoin sodium 100 mg give 1 capsule by mouth three times daily~ Sucralfate 1 gram (gm) give 1 tablet by mouth before meals~ Gabapentin 600 mg give 1.5 tablets by mouth four times dailyOn 8/26/25, Surveyor reviewed a Medication (Administration) Audit Report for R2 for 7/31/25 through 8/13/25 that indicated the following:~ On 7/31/25, R2's atorvastatin and gabapentin were not administered because the medications were unavailable.~ On 7/31/25, R2's levetiracetam, phenytoin, and sucralfate were administered late. ~ On 8/1/25, R2's cyanocobalamin, fexofenadine, polyvinyl eye drops, potassium, and selenium were not administered because the medications were unavailable.~ On 8/1/25, R2's amlodipine, clopidogrel, docusate sodium, tamsulosin, phenytoin, and gabapentin were administrated late. On 8/26/25 at 10:54 AM, Surveyor interviewed DON-B and Regional Registered Nurse (RRN)-F. DON-B started at the facility 6 weeks prior and indicated this was the first time

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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. This practice had the potential to affect more than 4 of the 67 residents residing in the facility.On 8/26/25. the 400 North medication cart was left unlocked and unattended.Findings include:The facility's Storage of Medications policy, dated 4/2007, indicates: .7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others .On 8/26/25 at 9:23 AM, Surveyor observed agency Registered Nurse (RN)-J leave a medication cart unlocked and unattended with an open computer screen on top of the cart that displayed resident information. The medication cart drawers faced the hallway. Surveyor observed one resident self-propel in a wheelchair in the hallway.On 8/26/25 at 9:23 AM, Surveyor interviewed RN-J who verified the medication cart should not be left unlocked and unattended and the computer should be turned off. RN-J indicated RN-J usually locks the cart but forgot when RN-J went to the kitchen to refill a water jug. On 8/26/25 at 10:54 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated medications carts should be locked when unattended.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff and resident interview, and record review, the facility did not ensure food was served at a palatable, safe, and appetizing temperature for 4 residents (R) (R1, R3, R2 and R4) of 6 sampled residents. This practice had the potential to affect more than 4 of the 67 residents residing in the facility.R1 and Anonymous Person (AP)-E (on behalf of R3) indicated hot and cold foods were not always served at palatable temperatures. R2 and R4 indicated the food was not palatable. During the lunch meal on 8/25/25, the facility served food that appeared to be burned. During the lunch meal on 8/26/25, food was not held at a palatable temperature.Findings include:The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501. 19, and except as specified under (B) and (C) of this section, time/temperature control for safety food shall be maintained: (1) At 57 Celsius (C) (135 Fahrenheit (F)) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 degrees C (130 degrees F) or above; or (2) At 5 C (41 F) or less.The temperatures are designed to reduce the risk of foodborne illnesses by ensuring harmful pathogens are destroyed during cooking.On 8/25/25 at 9:58 AM, Surveyor interviewed AP-E who indicated R3 had a soft bite diet, however, the food R3 received was mushy and usually cold. AP-E felt that may be why R3 did not always eat.On 8/25/25 at 12:11 PM, Surveyor observed lunch in the fourth floor dining room. A posted menu indicated the meal was ham steak with baked sweet potato, cauliflower, and fruited gelatin. During lunch, Surveyor observed the following:~ R4 was at a table with 2 other residents. Surveyor observed staff serve R4's meal and heard R4 indicate the sweet potato was burned. R4 declined to eat the sweet potato. Staff took R4's plate and brought R4 an alternate. Surveyor also overheard R4 state to another resident that the food was terrible.~ Surveyor observed 4 other residents' sweet potatoes and noted the potatoes contained a black peel and edges.~ R3 was served ground ham, mashed cauliflower, and cut up sweet potato. R3 ate approximately half of the meal. (Documentation in R3's medical record indicated R3 usually ate between 50-75% of meals.)On 8/25/25 at 2:48 PM, Surveyor interviewed R4 who indicated the food was mediocre and institutional tasting.On 8/26/25 at 10:17 AM, Surveyor interviewed R2 who stated the food was gross and not palatable.On 8/26/25 at 12:05 PM, Surveyor observed lunch in the fourth floor dining room. A posted menu indicated the meal was sweet and sour chicken with steamed rice, steamed broccoli, a mini egg roll, and fruit fluff.On 8/26/25 at 12:55 PM, Surveyor asked Dietary Aide (DA)-C to complete holding temperatures in the steam table. Surveyor observed the following temperatures:~ Steamed rice: 91 F~ Sweet and sour chicken: 87 F~ Broccoli: 77 FSurveyor interviewed DA-C who was not aware of minimum holding temperatures or what steps to take if temperatures were below minimum holding temperatures.On 8/26/25 at 2:23 PM, Surveyor interviewed R1 who stated staff put cold food on the same tray and under the same food cover as hot food which made the cold food warm and gross.On 8/26/25 at 12:59 PM, Surveyor interviewed Food Service Director (FSD)-D who stated hot food should be held at 135 F or higher and cold food at 41 F or lower. FSD-D stated staff take holding temperatures prior to serving. FSD-D stated food should be at minimum holding temperatures at the end of meal service, however, minimum holding temperatures were not routinely monitored at the end of meal service. FSD-D stated staff should notify the kitchen if holding temperatures are not at minimum temperatures prior to serving. FSD-D stated there were concerns that the steam rollers were not holding temperatures and maintenance was notified. FSD-D stated it was recommended that the facility replace the steam rollers.