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	10/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 2 Residents (R) (R1 and R17) of 4 sampled residents.A grievance filed on 9/2/25 by R1's Power of Attorney for Healthcare (POAHC) indicated R1's iPad was missing. The allegation of misappropriation was not reported to law enforcement or the State Agency (SA).A grievance filed on 9/24/25 by R17's POAHC indicated R17's watch was missing. The allegation of misappropriation was not reported to law enforcement or the SA. Findings includeThe facility's Abuse, Neglect and Exploitation policy and procedure, dated 1/5/24, indicates: . A. The facility will have written procedures to assist staff in identifying the different type of abuse - [NAME]/verbal, sexual abuse, physical abuse and the deprivation by an individual of goods and services. B. Possible indicators of abuse include but are not limited to: .4. Report of theft of resident property, or missing resident property .VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and all other agencies (e.g., law enforcement when applicable) within specified timeframes: A. Immediately, but not later than 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury; b. No later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .1.From 10/7/25 to 10/8/25, Surveyor reviewed R1's medical record. R1 had diagnoses including malignant neoplasm of the bladder, secondary neoplasm of the bone and toxic encephalopathy. R1's most recent Minimum Data Set (MDS) assessment, dated 9/25/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated POAHC (POAHC-V).On 10/7/25, Surveyor reviewed a grievance form, dated 9/2/25, that indicated R1 reported a missing iPad. The grievance indicated the iPad was not listed on R1's inventory sheet, however, R1's family may have brought in the iPad. The grievance did not indicate the facility reported the potential allegation of misappropriation to law enforcement or the SA.On 10/7/25 at 9:45 AM, Surveyor interviewed R1 who indicated R1's iPad was stolen. R1 reported the stolen iPad to a nurse but could not recall when or to whom. R1's medical record indicated a Nurse Practitioner (NP) documented that R1 was upset on 9/4/25 that R1's iPad was stolen.On 10/7/25 at 11:45 AM, Surveyor interviewed POAHC-V who indicated R1 had the iPad the day R1 left for the hospital, however, the iPad was missing when R1 returned. POAHC-V spoke with Social Worker (SW)-H three times and was told SW-H couldn't do anything since the iPad wasn't added to R1's inventory sheet. POAHC-V indicated the iPad cost between 600 and 700 hundred dollars. On 10/8/25 at 10:35 AM, Surveyor interviewed SW-H who verified a grievance form for R1's missing iPad was received on 9/2/25. SW-H verified that R1 reported the missing iPad on 9/2/25 and SW-H had multiple phone calls with POAHC-V regarding the missing iPad. SW-H verified the allegation of misappropriation was not reported to law enforcement or the SA. On 10/8/25 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A did not believe R1's missing iPad was an allegation of misappropriation since the iPad was not on R1's inventory list and staff did not recall seeing the iPad. NHA-A indicated NHA-A did not believe R1 had an iPad in the facility. 2. From 10/7/25 to 10/8/25, Surveyor reviewed R17's medical record. R17 had diagnoses including dementia and neurocognitive disorder with Lewy bodies. R17's most recent MDS assessment, dated 8/4/25, had a BIMS score of 1 out of 15 which indicated R17 had severe cognitive impairment. R17 had an activated POAHC (POAHC-U).On 10/7/25, Surveyor reviewed a grievance filed on 9/24/25 by POAHC-U that indicated R17's watch was missing. The facility offered to reimburse the watch, however, POAHC-U declined and indicated the watch had sentimental value. The grievance investigation did not indicate the facility reported the allegation of misappropriation to law enforcement or the SA.On 10/8/25 at 10:00 AM, Surveyor interviewed POAHC-U who indicated R17 went to the hospital and returned with R17's watch. After R17 passed at the facility, POAHC-U went through R17's belongings and indicated R17's watch was missing. POAHC-U reported the missing watch to Grievance Officer (GO)-I on 9/24/25. POAHC-U indicated the facility could not find R17's watch and offered to reimburse POAHC-U. POAHC-U declined reimbursement and indicated the watch had sentimental value. On 10/8/25 at 11:00 AM, Surveyor interviewed GO-I who verified the facility received a grievance on 9/24/25 that indicated R17's watch was missing. GO-I indicated R17 passed away approximately 2 weeks prior to receipt of the grievance. GO-I notified POAHC-U that housekeeping and

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview and record review, the facility did not ensure allegations of misappropriation were thoroughly investigated for 2 Residents (R) (R1 and R17) of 4 sampled residents.R1 and R1's Power of Attorney for Healthcare (POAHC) notified the facility that R1's iPad was missing. The facility did not thoroughly investigate the allegation of misappropriation.R17's POAHC notified the facility that R17's watch was missing. The facility did not thoroughly investigate the allegation of misappropriation. Findings include:The facility's Abuse, Neglect and Exploitation policy and procedure, dated 1/5/24, indicates: V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation; 3. Investigating different types of alleged allegations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; 6. Providing complete and thorough documentation of the investigation.1.From 10/7/25 to 10/8/25, Surveyor reviewed R1's medical record. R1 had diagnoses including malignant neoplasm of the bladder, secondary neoplasm of the bone and toxic encephalopathy. R1's most recent Minimum Data Set (MDS) assessment, dated 9/25/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated POAHC (POAHC-V).On 10/7/25, Surveyor reviewed a grievance form, dated 9/2/25, that indicated R1 reported a missing iPad. The grievance indicated the iPad was not listed on R1's inventory sheet, however, R1's family may have brought in the iPad. On 10/7/25 at 9:45 AM, Surveyor interviewed R1 who indicated R1's iPad was stolen. R1 told a nurse about the stolen iPad but could not recall when or to whom. R1's medical record indicated a Nurse Practitioner documented on 9/4/25 that R1 was upset that R1's iPad was stolen.On 10/7/25 at 11:45 AM, Surveyor interviewed POAHC-V who indicated R1 had the iPad the day R1 left for the hospital. When R1 returned from the hospital, the iPad was missing. POAHC-V spoke with Social Worker (SW)-H three times and was told SW-H couldn't do anything since the iPad wasn't added to R1's inventory sheet. POAHC-V indicated the iPad cost approximately 600 to 700 hundred dollars.On 10/8/25 at 10:35 AM, Surveyor interviewed SW-H who verified a grievance was received on 9/2/25 that indicated R1 reported R1's iPad missing. SW-H indicated the grievance was brought to the daily standup meeting and each department was instructed to ask staff if they had seen the iPad or had any information. SW-H verified the facility did not have documentation to verify that R1, other residents, or staff were interviewed about the missing iPad or other potential missing property.On 10/8/25 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated managers were asked about R1's missing iPad at morning meeting. NHA-A verified the facility did not have documentation to verify that R1, other residents, or staff were interviewed. NHA-A confirmed staff interviews should have been completed but did not feel residents needed to be interviewed.2. From 10/7/25 to 10/8/25, Surveyor reviewed R17's medical record. R17 had diagnoses including dementia and neurocognitive disorder with Lewy bodies. R17's most recent MDS assessment, dated 8/4/25, had a BIMS score of 1 out of 15 which indicated R17 had severe cognitive impairment. R17 had an activated POAHC (POAHC-U).On 10/7/25, Surveyor reviewed a grievance filed on 9/24/25 by POAHC-U that indicated R17's watch was missing. The facility offered to reimburse the watch, however, POAHC-U declined and indicated the watch had sentimental value.On 10/8/25 at 10:00 AM, Surveyor interviewed POAHC-U who indicated R17 went to the hospital and returned with R17's watch. R17 passed away at the facility. POAHC-U indicated after going through R17's personal belongings, POAHC-U noticed that R17's watch was missing and reported the missing watch to Grievance Officer (GO)-I on 9/24/25. POAHC-U indicated the facility could not find R17's watch and offered reimbursement. POAHC-U declined reimbursement and indicated the watch had sentimental value. On 10/8/25 at 11:00 AM, Surveyor interviewed GO-I who verified a grievance was received on 9/24/25 that indicated R17's watch was missing. GO-I indicated R17 passed away approximately 2 weeks prior to receiving the grievance. GO-I notified POAHC-U that housekeeping and nursing staff looked for the watch but couldn't find it. GO-I offered to reimburse POAHC-U, however, POAHC-U declined and was more concerned about the sentimental value. GO-I verified the facility did not have documentation that other residents and staff were interviewed about the missing watch or other

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff, resident, and resident representative interview, and record review, the facility did not ensure 3 Residents (R) (R2, R8, and R11) of 17 sampled residents received care and treatment in accordance with physician orders. R2's edema assessments and weights were not completed as ordered to monitor for fluid retention. In addition, R2's thrombo-embolic deterrent (TED) hose and tubular support bandages (Tubigrips) were not applied as ordered. R8 and R11's Tubigrip stockings were not removed at night as ordered. Findings include:The facility's Care Plans - Comprehensive policy, dated 2010, indicates: . 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; .4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem area and their causes .The facility did not have a written policy for TED hose/Tubigrip stocking application and removal and used medical orders for application. The facility's Weight Monitoring Guideline policy, dated 2019, indicates: Residents will be weighed; documentation will be recorded .Upon admission and re-admission: Hospital weight should be verified and compared to facility admission and/or re-admission weight. Daily for three days .As specified by the physician or mid-level practitioner. 1.From 10/7/25 to 10/8/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including left total knee arthroplasty, osteoarthritis left knee, cellulitis left lower limb, and diabetes. R2's Minimum Data Set (MDS) assessment, dated 9/24/25, 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.R2's hospital record indicated R2 experienced lower extremity edema during R2's hospital stay which was negative for deep vein thrombosis (DVT) (otherwise known as blood clot) and managed with bumetanide (a diuretic medication). R2 was prescribed apixaban (an anticoagulant medication) for DVT prophylaxis. R2's admission assessment indicated R2 had 1+ (a mild degree of swelling characterized by a shallow indentation that quickly disappears when pressure is released) bilateral leg edema.A care plan, initiated 9/18/25, indicated R2 had impaired circulation related to congestive heart failure (CHF) and contained the following interventions: Monitor edema of bilateral lower extremities (BLE). Communicate changes to practitioner.A care plan, initiated 9/18/25, indicated R2 had CHF and contained the following interventions: Monitor/document/report as needed (PRN) any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath on exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue increased heart rate (tachycardia), lethargy, and disorientation.Surveyor reviewed R2's cardiovascular/skin/edema assessment findings and noted the following:~ On 9/19/25, there was no assessment.~ 9/20/25, 9/21/25, and 9/22/25 Daily Skilled Assessments did not include assessments for cardiovascular/skin/edema.~ A 9/22/25 Advanced Practice Nurse Prescriber (APNP) note indicated R2 had BLE 1+ edema and TED hose in place.~ A 9/22/25 assessment at 8:24 PM did not include an assessment for cardiovascular/skin/edema.~ A 9/23/25 Daily Skilled Assessment at 11:14 AM indicated R2 had BLE 3+ edema and TED hose in place.~ A 9/24/25 APNP assessment at 10:30 AM indicated R2 had LLE 2+ edema, warm and perfused, with no weight gain. R2 expressed concern about the edema. The plan was to continue R2's diuretic regimen and monitor fluid status. R2 had TED hose in place.~ A 9/24/25 progress note at 8:55 PM indicated R2 complained of LLE pain. R2's leg was red, swollen, and tender. R2 expressed pain when staff pressed on area. The physician was updated. ~ A 9/24/25 progress note at 11:00 PM indicated R2 transferred to the emergency room (ER) due to increased LLE redness, swelling, and pain. An ultrasound of the LLE was ordered along with bloodwork.R2 also had the following orders: ~ Daily weights x 3 days every shift until 9/21/25 (initiated 9/18/25).~ Daily weight due to water retention-CHF every day shift (initiated 9/21/25).Staff did not obtain R2's weights as ordered on 9/19/25 and 9/24/25. R2 had the following orders for TED hose and Tubigrips:~ TED hose knee-high - place on in the morning and remove in the evening (initiated 9/21/25).~ Double layer Tubigrips on in the AM and remove at bedtime. Change weekly with shower and PRN. Wash in sink with soap and water. Hand dry. Every morning and at bedtime (initiated 9/22/25) Surveyor noted R2 was admitted to the facility from the hospital on 9/18/25 with TED hose in place;

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident representative interview, and record review, the facility did not ensure adequate assistance and supervision to prevent falls was provided for 1 Resident (R) (R4) of 7 sampled residents.R4 had left-sided hemiparesis (paralysis on one side of the body) because of a cerebrovascular accident (CVA) and required assistance for bed mobility. On 8/26/25 at approximately 8:00 AM, R4 rolled out of bed while Registered Nurse (RN)-C was providing care and sustained an orbital floor blowout fracture with herniated extraconal fat (a trauma-induced break in the thin bone separating the eye socket from the sinuses, allowing fat from around the eye to bulge into the sinus cavity). The facility's fall investigation indicated the fall occurred because R4 was not positioned appropriately in bed and rolled out of bed when RN-C turned away to get a brief. R4 was transferred to the hospital on 8/26/25 and returned to the facility the same day. R4 had an episode of vomiting that was reported by facility staff to Hospice staff on 8/27/25. Hospice notes also indicated R4 experienced intermittent confusion and swallowing concerns. The facility did not ensure thorough post-fall monitoring was completed and did not update a physician regarding R4's change of condition. R4 passed away at the facility on 8/30/25. The Medical Examiner's report indicated R4's cause of death was a concussion in the setting of Parkinsonism with R4's right orbital fracture and history of CVA listed as significant conditions. The facility's failure to adequately assist and supervise a resident with left-sided hemiparesis who rolled out of bed, sustained an orbital fracture, and passed away four days later created a finding of immediate jeopardy that began on 8/26/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 10/9/25 at 10:15 AM. The immediate jeopardy was removed on 10/12/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Findings include:The facility's Fall Evaluation Safety Guideline policy, dated 11/28/17, indicates: Any failure to maintain an appropriate lying, sitting, or standing position resulting in a resident's sudden, unintentional relocation either to the ground or into contact with another object below the resident's starting point defines a fall .The intent of this guideline is to ensure the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through: 1) Identification of hazards and risks; 2) Evaluation; 3) Implementation; 4) Monitoring; 5) Analysis. The facility's Falls Investigation Guideline, dated 12/20/22, indicates: .4) If the fall involved a resident hitting their head and/or neck, initiate neurological evaluation .9) Document relevant post-fall clinical findings such as, but not limited to, vital signs, neurological checks, pain, swelling, bruising, alterations in skin integrity, range of motion, decreased mobility, and change in level of consciousness in the resident's record. It is also desirable to note the absence of such significant findings to demonstrate that the patient is being monitored appropriately .11) Monitor the resident and observe for changes for a minimum of 72 hours. From 10/7/25 to 10/8/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including Parkinsonism, history of CVA with left-sided hemiparesis, and stage 4 pressure ulcer of the sacral region. R4's Minimum Data Set (MDS) assessment, dated 8/15/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R4 had intact cognition. R4 was responsible for R4's healthcare decisions. (A Significant Change MDS assessment, dated 5/15/25, indicated R4 required partial to moderate assistance for rolling left to right.) A fall report, dated 8/26/25, indicated at approximately 8:00 AM, RN-C provided wound care for R4 who was in bed on a pressure-reducing air mattress. R4's brief was soiled, and RN-C began incontinence care. When RN-C rolled R4 on the left side (away from RN-C and toward the wall), R4 hit R4's head on the wall. RN-C rolled R4 on the right side (toward RN-C) to examine R4's head. RN-C then turned away to get a brief and R4 rolled out of bed. R4 hit R4's head on the metal bed frame and landed on the floor. The report indicated R4's bed was locked, and the air mattress was properly inflated. R4 was transferred to the Emergency Department (ED) for evaluation. An ED Encounter note, dated 8/26/25, indicated R4 was in bed situated against the wall when RN-C began wound care. When RN-C turned R4 onto R4's left side, R4 hit R4's head on the wall. R4 stated RN-C turned R4 on the right side to evaluate R4's head and then R4 rolled off the bed and onto the floor. R4 stated R4 fell approximately 3 feet. R4 had an abrasion above the right eyebrow with significant bruising and tenderness along the inferior orbital bones. A computed tomography (CT) scan showed a new acute right orbital floor blowout fracture with herniated extraconal fat and minimal presumed swelling of the non-herniated inferior rectus muscle. An X-ray of the right hip was completed and indicated

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 the necessary respiratory care and services for 1 Resident (R) (R1) of 4 sampled residents.R1 received supplemental oxygen. R1 did not have an order for oxygen or a care plan for oxygen therapy. Findings include:On 10/8/25, Surveyor requested the facility's oxygen policy and procedure from Director of Nursing (DON)-B who provided an undated Oxygen Guideline Policy Interpretation and Implementation and Fire Prevention form that addressed oxygen safety and fire prevention. DON-B indicated the facility did not have another oxygen policy. From 10/7/25 to 10/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of the bladder, secondary neoplasm of the bone, toxic encephalopathy, and osteoporosis with current pathological fractures. R1's most recent Minimum Data Set (MDS) assessment, dated 9/25/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Health Care (POAHC).On 10/7/25 at 9:45 AM, Surveyor interviewed R1 and observed an oxygen concentrator at R1's bedside. When Surveyor asked if R1 needed oxygen, R1 indicated R1 didn't know. R1 did not appear short of breath (SOB) during the interview.R1's medical record did not contain an order for oxygen. In addition, R1's care plan did not address oxygen use. Progress notes in R1's medical record indicated R1 required oxygen after a change in respiratory status on 9/13/25. On 10/7/25 at 10:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G who was unsure if R1 used oxygen and indicated oxygen use was not on R1's CNA care plan.On 10/7/25 at 12:21 PM, Surveyor interviewed Registered Nurse (RN)-F who verified R1 had an oxygen concentrator in R1's room but did not have an order for oxygen or a care plan that addressed oxygen use. On 10/7/25 at 1:15 PM, Surveyor interviewed DON-B who verified R1 did not have an order or a care plan for oxygen use. DON-B located an oxygen order from R1's Hospice provider, dated 9/17/25, that indicated: Inhale 1-5 liters per minute (LPM) into the lungs continuous as needed (PRN) for dyspnea. DON-B indicated the order was entered into R'1s medical record during the survey on 10/7/25. On 10/8/25, Surveyor reviewed R1's medical record and noted an order, dated 9/13/25, that indicated: In emergency, apply oxygen at 2 liters/minute per nasal cannula every 4 hours as needed for standing order. Obtain a set of vital signs. Notify physician if continuous oxygen is needed. Surveyor verified with DON-B that the order was entered on 10/7/25.

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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 - 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** Based on staff interview and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 1 Resident (R) (R2) of 4 sampled residents.D-Mannose (a simple sugar related to glucose considered effective for treating carbohydrate-deficient glycoprotein syndrome and can help with digestive issues, low blood sugar and blood clotting disorders), nateglinide (an oral medication used to manage type 2 diabetes), and pregabalin (an anticonvulsant medication) were not administered to R2 in accordance with physician orders. 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 .From 10/7/25 to 10/8/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including left total knee arthroplasty, osteoarthritis left knee, cellulitis left lower limb, and diabetes. R2's Minimum Data Set (MDS) assessment, dated 9/24/25, 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.R2's medical record indicated R2 had the following physician orders:~ D-Mannose oral capsule 500 milligrams (mg) give 1 capsule by mouth in the morning for supplement, dated 9/18/25.~ Nateglinide oral tablet 120 mg give 0.5 tablet by mouth three times daily for diabetes, dated 9/18/25.~ Nateglinide oral tablet 60 mg give 1 tablet by mouth three times daily for diabetes, dated 9/20/25.~ Pregabalin oral capsule 50 mg give 1 capsule by mouth three times daily for nerve pain, dated 9/18/25.Surveyor reviewed a Medication (Administration) Audit Report for R2 for 9/18/25 through 9/25/25 that indicated the following:~ On 9/19/25, R2's D-Mannose was not administered because the medication was unavailable.~ On 9/18/25, R2's 9:00 PM dose of nateglinide was not administered because the medication was unavailable.~ On 9/19/25, R2's 9:00 AM, 2:00 PM, and 9:00 PM doses of nateglinide were not administered because the medication was unavailable.~ On 9/20/25, R2's 9:00 AM dose of nateglinide was not administered because the medication was unavailable.~ On 9/20/25, R2's 12:00 PM and 5:00 PM doses of nateglinide were not administered because the medication was unavailable.~ On 9/21/25, R2's 12:00 PM dose of nateglinide was not administered because the medication was unavailable.~ On 9/18/25, R2's 8:00 PM dose of pregabalin was not administered because the medication was unavailable.~ On 9/19/25, R2's 8:00 AM, 2:00 PM, and 8:00 PM doses of pregabalin were not administered because the medication was unavailable.~ On 9/20/25, R2's 8:00 AM and 2:00 PM doses of pregabalin were not administered because the medication was unavailable. On 10/8/25 at 10:19 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the pharmacy should deliver a medication when it is ordered. DON-B stated if the pharmacy does not deliver a medication, staff should call the pharmacy with a stat (immediate) order to obtain the medication timely.