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	04/20/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure the resident environment was free of abuse for 2 residents (R) (R1 and R10) of 10 sampled residents.On 2/15/26, Certified Nursing Assistant (CNA)-J observed R1 crying and R6's hand in R1's shirt touching R1's breast. The facility did not implement preventative safety measures to ensure the safety of R1. In addition, the facility did not complete thorough behavior monitoring and behavior tracking for R6. On 2/11/26, CNA-N observed R10 in R9's room touching R9's private area inside R9's upper thigh. The facility did not complete thorough behavior monitoring and behavior tracking for R10 and did not develop a care plan to address the fact that R10 appeared to target and fixate on R9.The facility's failure to prevent cognitively impaired residents from being sexually abused by residents with a history of inappropriate sexual behavior led to a finding of immediate jeopardy that began on 2/11/26. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 4/1/26 at 3:55 PM. The immediate jeopardy was removed on 4/14/26. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 1/5/24, indicates: .The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse .Prevention of Abuse, Neglect and Exploitation: .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict .Investigation of Alleged Abuse, Neglect and Exploitation: .B. Written procedures for investigations include: .6. Providing complete and thorough documentation of the investigation. 1. From 3/30/26 to 4/1/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, depression, anxiety, and encephalopathy. R6's Minimum Data Set (MDS) assessment, dated 12/11/25, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R6 had severely impaired cognition. The MDS assessment also indicated R6 had verbal behavior toward others (threatening others, screaming at others, cursing at others) on 1 to 3 days during the observation period and physical behavior toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) on 1 to 3 days during the observation period. R6 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. According to an interview with CNA-J on 3/31/26 at 10:31 AM, R6 had inappropriately grabbed CNA-J in the past.R6's behavior care plan, initiated 9/9/24, indicated R6 had a history of inappropriately grabbing staff during cares. The care plan included an intervention, initiated 2/25/25, for cares in pairs due to sexually inappropriate behavior toward staff. No safety interventions were added to the care plan following the incident on 2/15/26.From 3/30/26 to 4/1/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety, and depression. R1's MDS assessment, dated 12/10/25, indicated R1 was rarely to never understood with short-term and long-term memory issues and severely impaired cognition. The MDS assessment indicated R1 wandered on 1 to 3 days during the observation period. R1 had an activated POAHC to assist with healthcare decisions.R1's behavior care plan, initiated 3/16/25, indicated R1 had a history of hallucinations, agitation with staff during cares, wandering the (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unit and into other rooms, taking others' belongings, striking out, refusing cares, crawling out of bed, and crying unprovoked. The care plan included the following interventions:~ Encourage R1 to remain outside of arm's length of other residents (dated 9/14/25).~ Provide a calm and safe environment to allow R1 to express feelings as needed (dated 3/16/25).~ Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed (dated 3/16/25). R1's plan of care was not updated with preventative safety measures following the 2/15/26 incident and did not include a care plan for past trauma.On 3/31/26, Surveyor reviewed the facility's investigation, dated 2/15/26, which included a written and signed statement (dated 2/15/26) from CNA-J that indicated on 2/15/26 at approximately 6:20 PM, R1 was crying and R6 grabbed R1's hand to comfort R1. Two minutes later, CNA-J observed R6's hand in R1's shirt and grabbing R1's right breast. R1 and R6 were separated. When CNA-J asked what R6 was doing, R6 indicated R6 was trying to comfort R1. R6 made sexual comments about CNA-J when CNA-J took R6 back to R6's room. CNA-J stated R1 was still in tears but calmed down a little when given a stuffed animal.On 3/31/26 at 10:31 AM, Surveyor interviewed CNA-J who indicated CNA-J was in the dining room after supper on 2/15/26 and observed R1 crying. R6 appeared to be comforting R1. CNA-J turned back around after removing meal trays and observed R6's hand in R1's shirt. When CNA-J intervened, CNA-J had to remove R6's hand from R1's right breast. CNA-J brought R6 back to R6's room and assisted R6 to bed. CNA-J stated the incident was reported to nursing staff. CNA-J was aware R1 and R6 were placed on 1:1 supervision. CNA-J was unsure if other preventative safety measures were implemented as a result of the incident. CNA-J confirmed CNA-J was positive about what CNA-J observed because CNA-J had to physically remove R6's hand from R1's right breast. On 3/31/26 at 9:29 AM, Surveyor interviewed R1's activated POAHC (POAHC-K) who stated POAHC-K was contacted by a nurse in mid-February who stated staff observed a resident with a hand in R1's shirt near R1's breast. The nurse stated the residents were separated and the facility would report the incident to the State Agency. POAHC-K stated R1 has had increased behaviors with unconsolable crying and wandering since the incident. POAHC-K stated R1 became more emotional at times when R1 had a urinary tract infection (UTI). POAHC-K stated R1 had a history of sexual assault from when R1 was a young adult. POAHC-K indicated R1 could have been retraumatized by the incident on 2/15/26 which could be a contributing factor to R1's increased behaviors.On 3/30/26 at 12:14 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-S who indicated POAHC-K mentioned that R1 had past trauma but did not provide specifics and LPN-S did not inquire further. LPN-S verified R1 wanders in and out of other residents' rooms and staff intervene and redirect R1. On 3/30/26 at 12:55 PM, Surveyor interviewed Unit Manager (UM)-T who stated staff have to watch R6 due to R6's sexually inappropriate behavior toward staff. UM-T was aware of an incident in which R6 had a hand in R1's shirt and indicated it was why R6 was placed on 1:1 supervision. UM-T was not involved in the investigation or follow-up. UM-T stated UM-T spoke with POAHC-K who stated R1 had a history of being sexually molested which could explain R1's frequent crying after the incident with R6. UM-T was unsure when POAHC-K provided the information and stated Social Services Designee (SSD)-G might know. UM-T confirmed R1 wanders the halls and goes into other residents' rooms on occasion. UM-T stated R1 is tearful almost every day. On 3/30/26 at 1:04 PM, Surveyor interviewed SSD-G who indicated R1 becomes tearful at times, has a history of being argumentative with other residents, and goes in and out of other residents' rooms. SSD-G verified R6 had inappropriate sexual behavior toward staff. SSD-G was unaware of inappropriate sexual behavior toward other residents aside from the 2/15/26 incident with R1. SSD-G denied awareness of past trauma for R1. R6's behavior tracking (monitoring for yelling/screaming at staff, refusal of care, grabbing at staff) indicated documentation was to be completed every shift. Documentation indicated the following:~ January 2026: R6 had 3 documented occurrences of sexually inappropriate behavior and 6 documented occurrences of grabbing. Of the 93 total entries for behavior tracking, 25 entries (approximately 27%) were missing or incomplete.~ February 2026: R6 had no (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented occurrences of sexually inappropriate behavior or grabbing. Of the 84 total entries for behavior tracking, 71 entries (approximately 85%) were missing or incomplete. ~ March 2026: R6 had 1 documented occurrence of sexually inappropriate behavior and 2 documented occurrences of grabbing. Of the 90 total entries for behavior tracking, 67 entries (approximately 74%) were missing or incomplete. Progress notes in R6's medical record, dated 2/15/26, 2/17/26, and 2/18/26, indicated R6 was on 1:1 supervision. R6's medical record did not include 1:1 documentation for 2/16/26 or documentation indicating when 1:1 supervision was discontinued. On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, Director of Nursing (DON)-B, Regional Nurse Consultant (RNC)-F, and RNC-L. NHA-A stated staff notify NHA-A or DON-B when incidents occur. NHA-A and DON-B are responsible for completing the investigation with the assistance of regional nurses. When asked what safety measures were implemented to protect residents, RNC-L stated within 48 hours of the incident, RNC-L assessed R6 who was completely dependent on staff for care and mobility; therefore, R6 was removed from 1:1 supervision. RNC-L stated the facility rearranged seating in the dining room and encouraged male residents to sit with other males and female residents to sit with other females. RNC-F stated R1 gets tearful when R1 has a UTI and was prescribed a course of antibiotics. When asked about documentation for 1:1 supervision, RNC-L stated the facility's schedule specifies which staff are to provide 1:1 supervision. RNC-L acknowledged the schedule does not indicate which resident the 1:1 staff is for. When Surveyor asked about behavior monitoring/tracking and pointed out the missing entries for R6, an explanation was not provided.From 3/30/26 to 4/1/26, Surveyor made several inquiries regarding care plan updates. The facility could not provide evidence that preventative safety measures were implemented and added to R6 and R1's care plans following the 2/15/26 incident. The facility's 2/15/26 investigation did not include preventative safety measures for R1's frequent tearfulness, wandering, or intrusive behaviors. The investigation also did not include safety measures to protect other residents from R6's sexually inappropriate behavior.2. From 3/30/26 to 4/1/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including vascular dementia with behavioral disturbance, bipolar disorder, anxiety disorder, depression, and history of traumatic brain injury. R10's MDS assessment, dated 3/18/26, had a BIMS score of 4 out of 15 which indicated R10's cognition was severely impaired. R10 had an activated POAHC to assist with healthcare decisions. A behavioral psych note, dated 1/24/26, indicated R10 had a history of hypersexual behaviors.R10's care plan did not include a history of inappropriate sexual behavior prior to the incident below on 2/11/26. A progress note in R10's medical record, dated 2/11/26, stated a CNA reported that R10 entered another resident's room (R9) and appeared to touch R9's pubic area and thigh over R9's clothing. R10 was removed from the room and placed in the common area for 1:1 monitoring. Labs were ordered and R10 was started on paroxetine (an antidepressant medication) 20 milligrams (mg) daily for hypersexual behavior.From 3/30/26 to 4/1/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including dementia, depression, anxiety, and Wernicke's encephalopathy (a life-threatening acute neurological emergency caused by severe thiamine deficiency that includes confusion, eye abnormalities, and an unsteady/uncoordinated gait.) R9's MDS assessment, dated 2/7/26, had a BIMS score of 3 out of 15 which indicated R9's cognition was severely impaired. R9 had an activated POAHC to assist with healthcare decisions. R9 passed away on 3/26/26. On 4/1/26 at 11:26 AM, Surveyor interviewed CNA-N who indicated CNA-N retrieved a lift outside R9's room on 2/11/26 and observed R10 in the room. CNA-N stated R9 was in a wheelchair facing the TV and R10 was in a wheelchair facing R9 on R9's right side. CNA-N stated CNA-N observed R10 touch R9's private area inside the thigh. CNA-N removed R10 from the room and reported the incident to the nurse. CNA-N stated R10 was placed on 1:1 supervision and moved to a different unit. CNA-N stated R10 had a history of sexually touching R10's self in front of others and being verbally and physically inappropriate with female staff. CNA-A did not observe the behavior with any other residents. CNA-N stated R10 had a history of targeting R9 and CNA-N redirected R10 away from R9 in the past. (Of note: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R10's care plan did not include R10's history of targeting R9.)On 4/1/26 at 12:06 PM, Surveyor interviewed LPN-O who was aware R10 was sexually inappropriate with staff and was aware of an incident between R10 and R9. LPN-O denied witnessing R10 be inappropriate with other residents but stated R10 hyper fixated on R9 and gravitated toward and tried to enter R9's room. LPN-O stated R10 often had to be redirected away from R9. LPN-O stated since R9 passed away, R10 had not focused on any other residents. LPN-O confirmed R10 remained on 1:1 supervision because R10 continued to be sexually inappropriate with female staff. On 4/1/26 at 12:17 PM, Surveyor interviewed CNA-P who often worked with R10 and confirmed R10 was sexually inappropriate toward female staff. CNA-P stated R10 was particularly drawn to R9 and often tried to go in R9's room. Staff redirected R10. CNA-P was not aware of R10 being sexually inappropriate with any other residents. On 4/1/26, Surveyor reviewed the facility's investigation which included the following: ~ A written statement from CNA-Q stated on 2/11/26 at approximately 9:45 AM, CNA-Q was walking down the hall and observed R10 trying to enter R9's room. CNA-Q redirected R10 to the dining room.~ A written statement from CNA-R stated on 2/11/26, CNA-R observed R10 exit R9's room. CNA-Q did not observe any inappropriate behavior. The investigation contained 8 additional staff interviews in which 5 staff members indicated they saw R10 go into other residents' rooms. R10 had an order for valproic acid (a mood stabilizer) 10 milliliters (ml) twice daily for hypersexual behaviors. R10's behavior tracking (monitor for sexual inappropriate verbal or physical touch and increased wandering) every shift indicated the following:~ January 2026: R10 had 4 documented occurrences of wandering and no documented occurrences of inappropriate sexual behavior. Of the 93 total entries for behavior tracking, 37 entries (approximately 40%) were missing or incomplete.~ February 2026: R10 had no documented occurrences of wandering and 2 documented occurrences of inappropriate sexual behavior. Of the 84 total entries for behavior tracking, 66 entries (approximately 79%) were missing or incomplete.~ March 2026: R10 had 4 documented occurrences of wandering and 7 documented occurrences of inappropriate sexual behavior. Of the 90 total entries for behavior tracking, 69 entries (approximately 77%) were missing or incomplete.On 3/31/26 at 2:40 PM, Surveyor interviewed DON-B and RNC-F. DON-B provided staff education on 1:1 companion care following the 2/11/26 incident. DON-B stated R10 remained on 1:1 supervision and was seen by behavioral health. RNC-F stated RNC-F interviewed CNA-N who originally reported that CNA-N observed R10 touch R9 inappropriately. RNC-F stated CNA-N recanted the statement and indicated CNA-N did not know for sure what CNA-N saw. Surveyor reported to RNC-F that CNA-N confirmed with Surveyor that CNA-N saw R10 touch R9 inappropriately. Although R9 had not expressed signs of trauma from being inappropriately touched, using the reasonable person concept it is likely that a reasonable person who is in a vulnerable position would feel extreme fear, anxiety, and distress when violated sexually and when safety needs are not met.The failure to supervise a resident with a history of wandering, targeting other residents, and being verbally and physically sexually inappropriate, created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The immediate jeopardy was removed on 4/14/26, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan: 1. Implemented 1:1 supervision (companion care) for R1, R6, and R10.2. Provided staff education on notification and reporting allegations of abuse, recognizing and managing behaviors, and companion care, including how to redirect/intervene for the safety of residents and those around them.3. Reviewed/revised behavior monitoring for R1, R6, and R10, including changes in condition, companion care, and monthly behavior meetings to address needs.4. Reviewed/revised care plans for R1, R6, and R10 and scheduled care conferences to further address needs.5. Implemented audits to be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement policies and procedures for 1 of 8 sampled staff to prevent abuse, neglect, misappropriation, and exploitation of residents. The facility did not ensure a thorough background check was completed for Licensed Practical Nurse (LPN)-H. Findings include: The facility's Abuse, Neglect, and Exploitation policy, dated 1/5/24, indicates: .The components of the facility's abuse prohibition plan are discussed herein: 1. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation. Responsibility of performance of compliance checks on contracted temporary staff will be established via contractual agreement .3. The facility will maintain documentation of proof that the screening occurred .On 3/30/26, Surveyor reviewed a sample of employees for background check compliance, including LPN-H. LPN-H was hired by the facility on 8/28/25. Background check information provided by the facility on 3/30/26 revealed LPN-H's Department of Justice (DOJ) and Governmental Findings reports were completed on 3/30/26. On 3/30/26 at 12:39 PM, Surveyor interviewed Director of Human Resources (DHR)-I who indicated LPN-H's DOJ and Governmental Findings reports were completed on 3/30/26 because the facility did not have either document on file. DHR-I indicated audits were being done to ensure all background checks were completed. On 3/30/26 at 1:46 PM, Surveyor interviewed NHA (Nursing Home Administrator)-A who verified LPN-H's background check information did not contain DOJ and Governmental Findings reports prior to 3/30/26. NHA-A indicated DOJ and Governmental Findings reports should be obtained for all staff prior to hire as part of the facility's background check process.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure allegations of abuse were reported to the State Agency (SA) for 6 residents (R) (R6, R1, R10, R9, R7, and R8) of 9 sampled residents. On 2/15/26, Certified Nursing Assistant (CNA)-J observed R6 touching R1's breast. The facility did not report the allegation of abuse to the SA. On 2/11/26, CNA-N observed R10 touching R9's pubic area and thigh. The facility did not report the allegation of abuse to the SA. On 9/14/25, staff observed R1 and R7 in a verbal dispute. R1 stated R1 hit R7 and showed staff R1's reddened left palm. The facility did not report the allegation of abuse to the SA.On 12/23/25, staff observed R8 punch R1 in the arm after R1 grabbed R8's walker. The facility did not report the allegation of abuse to the SA. On 3/6/26, R1 struck and threw a glass of orange juice at R9. The facility did not report the allegation of abuse to the SA. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 1/5/24, indicates: .The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse. 2. The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse to the State Agency (SA) and other officials in accordance with state law.VII. Reporting/Response.1. Reporting of all alleged violations to the Administrator, SA, Adult Protective Services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Between 3/30/26 and 4/1/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, depression, anxiety, and encephalopathy. R6's Minimum Data Set (MDS) assessment, dated 12/11/25, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R6 had severely impaired cognition. R6 had an activated Power of Attorney for Healthcare (POAHC). Between 3/30/26 and 4/1/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety, and depression. R1's MDS assessment, dated 12/10/25, indicated R1 was rarely to never understood with short-term and long-term memory issues and severely impaired cognition. R1 had an activated POAHC.On 3/31/26, Surveyor reviewed an investigation that included a written and signed statement, dated 2/15/26, from CNA-J that indicated on 2/15/26 at approximately 6:20 PM, R1 was crying and R6 grabbed R1's hand to comfort R1. Approximately two minutes later, CNA-J observed R6's hand in R1's shirt and grabbing R1's right breast. R6 and R1 were separated. When CNA-J asked what R6 was doing, R6 stated R6 was trying to comfort R1. R6 made sexual comments about CNA-J when CNA-J took R6 back to R6's room. CNA-J indicated R1 was in tears but calmed down a bit when given a stuffed animal. On 3/31/26 at 10:31 AM, Surveyor interviewed CNA-J who confirmed the events from the written statement and stated CNA-J was positive about what CNA-J observed because CNA-J had to physically remove R6's hand from R1's right breast.On 3/31/26 at 12:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse Consultant (RNC)-F, RNC-L, and [NAME] President of Clinical Operations (VPCO)-V. After RNC-F indicated the facility did not report the incident because CNA-J recanted CNA-J's original statement, Surveyor informed the group that CNA-J confirmed the incident with Surveyor. NHA-A stated staff notify either NHA-A or DON-B when an incident occurs. NHA-A and the regional nurses review the incident and determine whether or not to report it to the SA. NHA-A and DON-B are responsible for reporting incidents of abuse. NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V confirmed the allegation of sexual abuse that occurred on 2/15/26 was not reported to the SA. 2. Between 3/30/26 and 4/1/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses including vascular dementia with behavioral disturbance, bipolar disorder, anxiety disorder, depression, and history of traumatic brain injury. R10's MDS assessment, dated 3/18/26, had a BIMS score of 4 out of 15 which indicated R10 had severely impaired cognition. R10 had an activated POAHC. Between 3/30/26 and 4/1/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including dementia, depression, anxiety, and Wernicke's encephalopathy (an acute neurologicl emergency caused by a severe deficiency of thiamine leading to brain damage in the thalamus and brainstem; symptoms includes confusion and loss of coordination). R9's MDS assessment, dated 2/7/26, had a BIMS score of 3 out of 15 which indicated R9's cognition was severely impaired. R9 had an activated POAHC and passed away on 3/26/26. A progress note in R10's medical record, dated 2/11/26, indicated a CNA reported that R10 entered (R9's) room and appeared to touch (R9's) pubic area and thigh over the clothing. R10 was moved to the common area for 1:1 monitoring. On 4/1/26 at 11:26 AM, Surveyor interviewed CNA-N who indicated CNA-N retrieved a lift outside R9's room on 2/11/26 and observed R10 in R9's room. R9 was in a wheelchair facing the TV. R10 was in a wheelchair facing R9 on R9's right side. CNA-N stated CNA-N observed R10 touch R9's private area inside the thigh. CNA-N removed R10 from the room and reported the incident to the nurse. CNA-N stated CNA-N was 100% sure that CNA-N saw R10 touch R9 inappropriately. On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. When RNC-F indicated the facility did not report the incident to the SA because CNA-N recanted CNA-N's original statement, Surveyor informed the group that CNA-N confirmed the event with Surveyor. NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V confirmed the incident on 2/11/26 was not reported to the SA. 3. Between 3/30/26 and 4/1/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of dementia. R7's MDS assessment, dated 11/3/25, had a BIMS score of 6 out of 15 which indicated R7 had severely impaired cognition. R7 had an activated POAHC. An incident report, dated 9/14/25, stated R1 and R7 had a verbal dispute and were separated. R1 stated R1 hit R7 and showed staff R1's reddened left palm. The report indicated R1's red palm could be due to R1 self-propelling a wheelchair. The report indicated R1 had increased agitation and started rambling. R7 could not provide an account of the incident.On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. NHA-A stated NHA-A was not employed by the facility on 9/14/25 and was not familiar with the incident. DON-B, RNC-F, RNC-L, and VPCO-V confirmed the incident on 9/14/25 was not reported to the SA.4. Between 3/30/26 and 4/1/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had a diagnosis of dementia with behavioral disturbance. R8's MDS assessment, dated 2/4/26, had a BIMS score of 5 out of 15 which indicated R8 had severely impaired cognition. R8 had an activated POAHC. A progres note in R1's medical record, dated 12/23/25, indicated R1 aggressively grabbed (R8's) walker and (R8) punched R1 in the arm. An incident report, dated 12/23/25, indicated R1 was self-propelling a wheelchair in the hallway and came upon R8 using a wheeled walker. When R1 grabbed R8's walker, R8 made a punching motion toward R1. The report indicated neither R1 or R8 were interviewable due to dementia. On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. NHA-A stated NHA-A was not employed by the facility on 12/23/25 and was not familiar with the incident. DON-B, RNC-F, RNC-L, and VPCO-V confirmed the incident on 12/23/25 was not reported to the SA. 5. An incident note, dated 3/6/26, indicated R1 was attempting to get on the elevator when (R9) invaded R1's personal space. R1 threw a glass of orange juice in (R9's) direction. R9 could not recall the incident. A progress note in R1's medical record, dated 3/6/26, indicated R1 attempted to enter the elevator independently. During the incident, R1 struck (R9) and threw orange juice at (R9). R1 also attempted to hit staff. R1 cried excessively and appeared emotionally distressed. Staff intervened and redirected R1. A follow-up note to the 3/6/26 progress note, dated 3/10/26, indicated R1 appeared to strike (R9) during the interaction but no contact was made. On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V confirmed the incident on 3/6/26 was not reported to the SA.

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	525165	A. Building B. Wing	04/20/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and and record review, the facility did not ensure allegations of abuse were thoroughly and accurately investigated for 6 residents (R) (R6, R1, R9, R10, R7, and R8) of 9 sampled residents. On 2/15/26, Certified Nursing Assistant (CNA)-J observed R6 touching R1's breast. The facility did not ensure the allegation of abuse was thoroughly and accurately investigated. In addition, the facility did not ensure ongoing behavior monitoring was thoroughly completed. On 2/11/26, CNA-N observed R10 touching R9's pubic area and thigh. The facility did not ensure the allegation of abuse was thoroughly and accurately investigated. In addition, the facility did not ensure ongoing behavior monitoring was thoroughly completed. On 9/14/25, staff observed R1 and R7 in a verbal dispute. R1 told staff R1 hit R7 and showed staff R1's reddened palm. The facility did not ensure the allegation of abuse was thoroughly investigated or ensure safety interventions to prevent recurrence were appropriate. On 12/23/25, staff observed R8 punch R1 in the arm after R1 grabbed R8's walker. The facility did not ensure the allegation of abuse was thoroughly investigated or ensure safety interventions to prevent recurrence were appropriate. On 3/6/26, R1 attempted to enter the elevator, threw a glass of juice at R9, and appeared to strike R9. The facility did notensure the allegation of abuse was thoroughly investigated or ensure ongoing behavior monitoring was completed. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 1/5/24, indicates: .The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse .V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when allegations 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 .3. Identifying and interviewing all persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; and 6. Providing complete and thorough documentation of the investigation. 1. Between 3/30/26 and 4/1/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, depression, anxiety, and encephalopathy. R6's Minimum Data Set (MDS) assessment, dated 12/11/25, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R6 had severely impaired cognition. R6 had an activated Power of Attorney for Healthcare (POAHC). Between 3/30/26 and 4/1/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety, and depression. R1's MDS assessment, dated 12/10/25, indicated R1 was rarely to never understood and had short-term and long-term memory issues with severely impaired cognition. R1 had an activated POAHC. On 3/31/26, Surveyor reviewed an investigation that included a written and signed statement, dated 2/15/26, from CNA-J. The statement indicated CNA-J was in the dining room on 2/15/26 at approximately 6:20 PM and observed R1 crying. R6 grabbed R1's hand to comfort R1. Two minutes later, CNA-J observed R6's hand in R1's and shirt grabbing R1's right breast. R1 and R6 were separated. When CNA-J asked what R6 was doing, R6 indicated R6 was trying to comfort R1. R6 made sexual comments about CNA-J when CNA-J took R6 to R6's room. CNA-J indicated R1 was in tears but calmed down a bit when given a stuffed animal. On 3/31/26 at 10:31 AM, Surveyor interviewed CNA-J who confirmed the incident in CNA-J's written statement and stated CNA-J was positive about what CNA-J observed because CNA-J had to physically remove R6's hand from R1's right breast. An incident report for R1, dated 2/15/26, indicated R1 was tearful in the common area which was usual behavior for R1 since R1 tended get emotional while looking for dad. R1 had a history of chronic urinary tract infections (UTIs). R1's family indicated R1 gets more tearful when R1 has a UTI. The incident report indicated a peer (R6) held R1's hand to comfort R1. A few minutes later, (CNA-J) told the nurse it appeared (R6's) hand made contact (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with R1's upper right extremity. An incident report for R6, dated 2/15/26, indicated staff saw R6 sitting by (R1) attempting to console (R1). R6 tapped (R1) on the arm to stop (R1) from crying. On 3/31/26 at 12:26 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-F who completed the incident reports for R1 and R6. RNC-F stated RNC-F was not originally notified of the incident but assisted with the investigation. When asked why the incident reports did not match CNA-J's witness statement, RNC-F stated CNA-J recanted the original statement and told RNC-F that CNA-J did not actually see any contact. When Surveyor stated CNA-J told Surveyor that CNA-J was certain of the contact because CNA-J had to remove R6's hand from R1's breast, RNC-F did not provide a definitive response regarding why the incident reports did not match the witness statement. R6's behavior care plan, initiated 9/9/24, indicated R6 had history of inappropriately grabbing staff during cares. The care plan included an intervention, initiated 2/25/25, for cares in pairs due to sexually inappropriate behavior toward staff. R6's care plan did not include updated safety interventions following the 2/15/26 incident. R1's behavior care plan, initiated 3/16/25, indicated R1 had a history of hallucinations, agitation with staff during cares, wandering the unit and into other rooms, taking others' belongings, striking out, refusing cares, and crawling out of bed. The care plan also indicated R1 had a history of crying unprovoked. R1's care plan was not updated to include preventative safety measures following the 2/15/26 incident. R6's behavior symptoms charting (monitoring for yelling/screaming at staff, refusal of care, grabbing at staff), indicated the following: ~ February 2026: R6 had no documented occurrences of sexually inappropriate behavior and no documented occurrences of grabbing. Of the 84 total entries for behavior tracking, 71 entries (approximately 85%) were missing or incomplete. ~ March 2026: R6 had 1 documented occurrence of sexually inappropriate behavior and 2 documented occurrences of grabbing. Of the 90 total entries for behavior tracking, 67 entries (approximately 74%) were missing or incomplete. Progress notes in R6's medical record, dated 2/15/26, 2/17/26, and 2/18/26, indicated R6 was on 1:1 supervision. R6's medical record did not include 1:1 documentation for 2/16/26 or documentation indicating when 1:1 supervision was discontined. R1's behavior symptoms charting indicated the following: ~ February 2026: R1 had 4 documented occurrences of frequent crying and no documented occurrences of wandering. Of the 84 total entries for behavior tracking, 62 entries (approximately 74%) were missing or incomplete. ~ March 2026: R1 had 4 documented occurrences of frequent crying and no documented occurrences of wandering. Of the 93 total entries for behavior tracking, 77 entries (approximately 83%) were missing or incomplete. A note included in the incident report for R6, dated 2/18/26 and completed by RNC-L, indicated R6 had poor dexterity, needed assistance to feed self, and had difficulty holding onto items. The note indicated staff were unsure if R6 truly touched (R1). On 3/31/26 at 12:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, RNC-F, RNC-L, and [NAME] President of Clinical Operation (VPCO)-V. NHA-A stated staff notify either NHA-A or DON-B when incidents occur. NHA-A and DON-B are responsible for completing the investigation with assistance from the regional nurses. When Surveyor asked what safety measures were implemented to protect residents following the incident on 2/15/26, RNC-L stated within 48 hours of the incident, RNC-L assessed R6 who was completely dependent on staff for care and mobility. R6 was removed from 1:1 supervision. RNC-L stated the facility also rearranged seating in the dining room. Male residents were encouraged to sit with male residents and female residents were encouraged to sit with female residents. RNC-F indicated R1 gets tearful when R1 has a UTI and stated R1 started a course of antibiotics. When Surveyor asked for documentation that 1:1 supervision was provided, RNC-L stated the facility's schedule specifies staff who are assigned 1:1 supervision for residents. RNC-L acknowledged the schedule doesn't specify which resident the 1:1 supervision is for. An explanation was not provided regarding the missing behavior monitoring and tracking entries. On 4/1/26 at 12:20 PM, Surveyor observed lunch in the dining room and observed R6 raise R6's hand to R6's face on 3 occasions. R6 did not appear to have difficulty with arm motion. Between 3/30/26 and 4/1/26, Surveyor asked about care plan updates several times. The facility did not provide evidence (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that preventative safety measures were implemented and added to R6 and R1's care plans following the 2/15/26 incident. 2. Between 3/30/26 and 4/1/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including vascular dementia with behavioral disturbance, bipolar disorder, anxiety disorder, depression, and history of traumatic brain injury. R10's MDS assessment, dated 3/18/26, had a BIMS score of 4 out of 15 which indicated R10's cognition was severely impaired. R10 had an activated POAHC. Between 3/30/26 and 4/1/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including dementia, depression, anxiety, and Wernicke's encephalopathy (an acute neurological emergency caused by a severe deficiency of thiamine leading to brain damage in the thalamus and brainstem; symptoms include confusion and loss of coordination.) R9's MDS assessment, dated 2/7/26, had a BIMS score of 3 out of 15 which indicated R9's cognition was severely impaired. R9 had an activated POAHC and passed away on 3/26/26. A progress note in R10's medical record, dated 2/11/26, indicated a CNA reported that R10 entered (R9's) room and appeared to touch (R9's) pubic area and thigh over R9's clothing. R10 was moved to the common area for 1:1 monitoring. On 4/1/26 at 11:26 AM, Surveyor interviewed CNA-N who stated CNA-N observed R10 in R9's room when CNA-N retrieved a lift from outside R9's room on 2/11/26. CNA-N stated R9 was in a wheelchair facing the TV. R10 was in a wheelchair facing R9 on R9's right side. CNA-N stated CNA-N observed R10 touch R9's private area inside the thigh. CNA-N removed R10 from the room and reported the incident to the nurse. CNA-N stated CNA-N was 100% sure CNA-N saw R10 touch R9 inappropriately. An incident report for R10, dated 2/11/26, indicated a CNA reported to the nurse that R10 entered (R9's) room. R10 was taken to the nurses' station and placed on companion care. An incident report for R9, dated 2/11/26, indicated a CNA reported to the nurse that (R10) was found in R9's room. (R10) was immediately removed from the room. R10's medical record indicated R10 should be monitored for sexually inappropriate verbal or physical touch and increased wandering every shift. R10's behavior tracking indicated the following: ~ February 2026: R1 had no documented occurrences of wandering and 2 documented occurrences of inappropriate sexual behavior. Of the 84 total entries for behavior tracking, 66 entries (approximately 79%) were missing or incomplete. ~ March 2026: R1 had 4 documented occurrences of wandering and 7 documented occurrences of inappropriate sexual behavior. Of the 93 total entries for behavior tracking, 72 entries (approximately 77%) were missing or incomplete. On 3/31/26 at 2:40 PM, Surveyor interviewed DON-B and RNC-F. DON-B provided documentation of staff education on 1:1 companion care following the 2/11/26 incident. DON-B stated R10 remains on 1:1 supervision and is seen by behavioral health. DON-B stated supporting evidence of 1:1 supervision is reflected on the nursing schedules which indicate which staff are assigned to companion care. Surveyor noted the facility's schedules indicated several staff were assigned to companion care. When asked how the facility determines which staff are assigned to which residents, DON-B did not respond. RNC-F stated RNC-F interviewed CNA-N who originally reported that CNA-N witnessed R10 touch R9 inappropriately. RNC-F stated CNA-N recanted the statement and indicated CNA-N did not know for sure what CNA-N saw. Surveyor informed RNC-F that CNA-N confirmed with Surveyor that CNA-N saw R10 touch R9 inappropriately. 3. Between 3/30/26 and 4/1/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of dementia. R7's MDS assessment, dated 11/3/25, had a BIMS score of 6 out of 15 which indicated R7 had severely impaired cognition. R7 had an activated POAHC. An incident report for R7, dated 9/14/25, indicated R7 had a verbal dispute with (R1). R7 and (R1) were separated. Nursing assessments were completed with no injuries noted. R7 could not provide an account of the incident. An incident report for R1, dated 9/14/25, indicated R1 had a verbal dispute with (R7). Staff separated R1 and (R7) and stated R1 hit R7. R1 showed staff R1's left palm which was red. The report indicated R1's red palm could be due to self-propelling in a wheelchair. The report indicated R1 had increased agitation and started rambling. The facility's investigation indicated a safety intervention was added to encourage R1 to remain out of arms reach of other residents. (Of note: R1's medical record (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated R1 had severely impaired cognition with short- and long-term memory loss.) On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. NHA-A stated NHA-A was not employed by the facility on 9/14/25 and was not familiar with the incident. When Surveyor asked about preventative safety interventions, the information was not provided. When Surveyor asked about the appropriateness of a reminder for a resident with advanced dementia, NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V did not provide a direct answer. 4. Between 3/30/26 and 4/1/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had a diagnosis of dementia with behavioral disturbance. R8's MDS assessment, dated 2/4/26, had a BIMS score of 5 out of 15 which indicated R8 had severely impaired cognition. R8 had an activated POAHC. A progress note in R1's medical record, dated 12/23/25, indicated R1 aggressively grabbed (R8's) walker and (R8) punched R1 in the arm. An incident report for R1, dated 12/23/25, indicated R1 was self-propelling a wheelchair in the hallway and came upon (R8) who had poor safety awareness and dementia. (R8) was walking with a wheeled walker and invaded R1's personal space. (R8) made a punching gesture toward R1 when R1 grabbed (R8's) walker. R1 then swung at (R8's) hand. R1 could not provide a description of the incident. The root cause of the incident was determined to be behavioral symptoms related to dementia combined with insufficient supervision in a shared common area. The report contained the following corrective actions: ~ Increase supervision in hallways, especially during high traffic times.~ Assess R1 for behavioral triggers and update R1's care plan.~ Provide structured activities or engagement to reduce wandering/approaching behaviors.~ Educate staff on early intervention when residents approach others.~ Consider seating placement adjustments to reduce resident interactions that may lead to conflict.~ Implement individualized behavior management strategies.~ Conduct staff in-services on dementia-related behaviors and de-escalation.~ Evaluate the environment for safety, resident flow, and spacing. R1's care plan did not include updated safety interventions following the incident on 12/23/25. An incident report for R8, dated 12/23/25, indicated R8 was walking down the hallway with a wheeled walker. (R1) approached R8 and grabbed R8's walker. R8 made a pushing motion toward (R1's) hand. R8 was not intervieweable due to dementia and did not recall the incident. R8 was reminded to be aware of and honor personal space. Between 3/30/26 and 4/1/26, Surveyor requested the facility's full investigation for the incident on 12/23/25. Surveyor noted the investigation did not include staff or witness statements, staff education, updated care plans, or behavior management strategies. On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V. NHA-A stated NHA-A was not employed by the facility on 12/23/25 and was not familiar with the incident. Surveyor asked about preventative safety interventions; however, the information was not provided. When Surveyor asked about the appropriateness of education and reminders for residents with advanced dementia, NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V did not provide a direct answer. 5. An incident note for R1, dated 3/6/26, indicated R1 was attempting to get on the elevator when (R9) invaded R1's personal space. R1 threw a glass of orange juice in (R9's) direction. R1 could not give an account of the incident. R1 was placed on 1:1 supervision. A progress note in R1's medical record, dated 3/6/26, indicated R1 attempted to enter the elevator independently. During the incident, R1 struck (R9) and threw orange juice at (R9). R1 also attempted to hit staff. R1 cried excessively and appeared emotionally distressed. Staff intervened and redirected R1. A follow-up note to the 3/6/26 progress note, dated 3/10/26, indicated R1 appeared to strike (R9) during the interaction but no contact was made. Between 3/30/26 and 4/1/26, Surveyor requested the facility's full investigation for the 3/6/26 incident. Surveyor noted the investigation did not include staff or witness statements. Surveyor reviewed R1's behavior tracking for March 2026 which indicated R1 had the following behaviors after 3/25/26: ~ Episodes of frequent crying on 3/26/26 and 3/29/26~ Episodes of frequent crying, yelling/screaming, and wandering on 3/31/26 On 3/31/26 at 12:50 PM, Surveyor interviewed NHA-A, DON-B, RNC-F, RNC-L, and VPCO-V who indicated R1 was placed on 1:1 supervision and tested for a UTI following the incident. 1:1 supervision was discontinued on 3/25/26 after R1 completed a course of antibiotics and behaviors related to the UTI resolved.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure bathing/showering assistance was provided for 2 residents (R) (R5 and R2) of 5 sampled residents. R5 and R2 did not receive weekly baths/showers as scheduled.Findings includeThe facility's Activities of Daily Living (ADLs) policy, dated 5/7/20, indicates: In accordance with the comprehensive assessment, together with respect for individual resident needs and choices, our facility provides care and services for the following activities: Hygiene: Bathing .1. On 3/30/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including fracture of right lower leg, morbid obesity, and type 2 diabetes. R5's Minimum Data Set (MDS) assessment, dated 3/20/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. On 3/30/26 at 11:00 AM, Surveyor interviewed R5 who indicated the facility does not always complete showers on R5's scheduled day and it had been 3 weeks since R5 had a proper shower.On 3/30/26 at 3:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-U who indicated a resident's bath/shower day should be reflected on CNA daily charting in the resident's medical record. CNA-U indicated documentation includes what was provided and how the resident was assisted. On 3/30/26, the facility provided bathing documentation for R5. The documentation provided was in the CNA task documentation and was called bathing - Section GG charting. The documentation was to be completed every shift. Surveyor reviewed the documentation for R5 and noted charting was not completed every shift. When completed, the documentation indicated NO or a number that identified how R5 was assisted. In addition, the documentation did not identify what was provided (bath/shower/bed bath) or if R5 refused. The documentation indicated R5 did not receive a shower between 2/6/26 and 2/20/26. Surveyor also reviewed the shower documentation in R5's medical record that CNA-U referred to and noted there was no documentation for the previous 30 days.(See interview under example 2)2. On 3/30/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic pain syndrome and obesity. R2's MDS assessment, dated 12/29/25, had BIMS score of 15 out of 15 which indicated R2 had intact cognition. An ADL care plan, initiated 12/24/25, indicated R2 was non-ambulatory and used an EZ stand to transfer with the assistance of 2 staff. On 3/30/26, the facility provided bathing documentation for R2. The documentation provided was in the CNA task documentation and was called bathing - Section GG charting. The documentation was to be completed every shift. Surveyor reviewed the documentation for R2 and noted charting was not completed every shift. When it was completed, the documentation indicated NO or a number that identified how R2 was assisted. The documentation did not indicate what was provided (shower/bath/bed bath) or if R2 refused. The documentation indicated R2 did not receive a bath/shower between 1/18/26 and 1/29/26 or 2/1/26 and 2/20/26. On 3/30/26 at 3:27 PM, Surveyor interviewed Director of Nursing (DON)-B about where CNAs should document showers. When Surveyor explained the documentation provided by the facility versus CNA interviews that indicated shower documentation should be completed in a different section of the resident's medical record that identifies what type of bathing is provided, DON-B stated DON-B would look into it. DON-B indicated the facility added a shower aide when scheduling allowed and resident concerns were down. When Surveyor indicated R5 and R2 had periods of over 7 days where a bath/shower was not provided, DON-B confirmed showers should be provided weekly and refusals should be documented.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure physician orders were followed and treatment was not provided without an order for 1 resident (R) (R4) of 3 sampled residents.R4 had an order for bilateral Tubigrips (elasticized tubular bandages designed to provide firm, sustatined support for general edema). The order was not consistently followed. In addition, R4 had a Kerlix (woven gauze) wrap dressing around R4's lower left leg. R4 did not have an order for the dressing.Findings include:The facility's policy Wound Care Prevention and Program Management policy, dated 11/13/24, indicates: .1. Interventions will be implemented to mitigate the risk for skin breakdown, based on individual risk factors .On 3/30/26,, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes with diabetic chronic kidney disease, congestive heart failure (CHF), venous infusion, polyneuropathy, morbid obesity, peripheral vascular disease (PVD), and venous insufficiency. A care plan, initiated 11/24/25, indicated R4 had impaired circulation related to CHF and venous infusion. R4 had a physician order, dated 12/4/25, for Tubigrips, size per leg measurements. On AM, Off HS (bedtime). Every morning and at bedtime for lymphedema.On 3/30/26 at 12:00 PM, Surveyor interviewed R4 who indicated staff don't always complete R4's leg treatments. On 3/30/26 at 12:21 PM, Surveyor asked Licensed Practical Nurse (LPN)-Y to assist Surveyor with looking at R4's lower legs. When LPN-Y removed a blanket from R4's lower legs, Surveyor observed a loose piece of Kerlix around R4's left upper ankle. LPN-Y verified the Kerlix was dated 3/26/26. LPN-Y removed the bandage and stated it must have loosened and fallen down. R4's medical record did not contain an order for a Kerlix dressing around R4's left lower extremity.On 3/30/26 at 12:35 PM, Surveyor interviewed R4 about R4's order for Tubigrips. R4 stated R4 had not seen the Tubigrips in a while and didn't know where they were. R4 stated staff had not been applying the Tubigrips.On 3/30/26 at 12:37 PM, Surveyor interviewed LPN-Y who indicated R4 did not have an order for a Kerlix dressing and LPN-Y was unsure why Kerlix was used. LPN-Y also indicated LPN-Y did not see Tubigrips in R4's room that morning.On 3/30/26 at 2:38 PM, Surveyor confirmed with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A that R4 should have Tubigrips on. DON-B and NHA-A also confirmed if R4 refused to wear Tubigrips, the refusal should be documented. When Surveyor informed DON-B and NHA-A that R4 had a dressing around R4's leg without an order, DON-B and NHA-A confirmed an order should be in place.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure adequate supervision and assistance to prevent accidents was provided for 1 resident (R) (R6) of 2 sampled residents. R6 had a history of inappropriately touching residents and staff. The facility did not implement an appropriate intervention to prevent recurrence. On 4/13/26, staff placed R6 within reach of R13. R6 touched and grabbed R13. Findings include: The facility's Abuse, Neglect and Exploitation policy, dated 4/2026, indicates: .The facility will develop and implement written policies and procedure that: a. Prohibit and prevent abuse, neglect, and exploitation of residents .3. The facility will provide ongoing oversight and supervision of staff in order to assure its policies are implemented as written .Employee Training: .5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect .Prevention of Abuse, Neglect and Exploitation: .A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behavior which might lead to conflict or neglect . On 4/13/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia. R6's Minimum Data Set (MDS) assessment, dated 3/13/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R6 had severe cognitive impairment. R6 had an activated Power of Attorney for Healthcare (POAHC). R6's care plan contained an intervention for cares in pairs due to sexually inappropriate behavior toward staff (initiated 2/25/25). R6's medical record indicated R6 was witnessed touching a resident's (R13's) breast on 2/15/26. (Of note: R6's care plan did not contain interventions to prevent R6 from inappropriately touching other residents.) On 4/13/26 at 9:28 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated 1:1 supervision was in place for R6 following the 2/15/26 incident until 3/6/26. NHA-A indicated staff education was completed, including agency and newly-hired staff, that included having male and female residents in separate areas in the dining room (which is where the 2/15/26 incident occurred). When given scenarios where R6 may be in close proximity to female residents other than in dining room, NHA-A indicated R6 was not able to transfer independently and staff were aware not to place R6 in close proximity to female residents. NHA-A confirmed R6's care plan indicated R6 had a history of sexual inappropriateness toward staff but did not specify to keep R6 at a distance from female residents. NHA-A stated if a resident wandered into R6's room, R6 was not able to reach out/touch the resident due to R6's disabilities. NHA-A encouraged Surveyor to observe R6's limitations. On 4/13/26 at 10:09 AM, Surveyor observed R6 in a wheelchair in the dining room/lounge. Certified (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant (CNA)-BB was seated to R6's left. R13 was seated to R6's right. R6 moved R6's left hand to touch CNA-BB's leg. CNA-BB moved R6's hand away and indicated R6 should not touch CNA-BB. At 10:11 AM, R6 again touched CNA-BB's leg. At 10:13 AM, R6 touched R13 with R6's right hand. CNA-BB moved R6's hand away and indicated R6 should not touch R13. CNA-BB was then called away to provide assistance in another area. R6 continued to touch R13's left arm and blanket. R13 attempted to pull away and grimaced. At 10:17 AM, CNA-N entered the dining room and took R13 to R13's room. On 4/13/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia. R13's MDS assessment, dated 1/19/26, had a BIMS score of 0 out of 15 which indicated R13 had severe cognitive impairment. R13 had an activated POAHC. On 4/13/26 at 10:51 AM, Surveyor interviewed CNA-BB who verified R6 kept reaching for CNA-BB's leg in the dining room. CNA-BB indicated it was the second time that day as R6 had also inappropriately touched CNA-BB while CNA-BB provided cares in R6's room earlier. CNA-BB asked R6 to keep R6's hands to R6's self. CNA-BB indicated R6 was previosly on 1:1 supervision. CNA-BB was not aware that R6 should not be seated within arm's reach of female residents. CNA-BB stated CNA-BB had worked the past 3 days and had seen R6 seated next to female residents. On 4/13/26 at 10:42 AM, Surveyor interviewed CNA-N who stated CNA-N was trying to find a coworker when CNA-N observed R6 holding R13's arm and separated the residents. CNA-N indicated R13 did not say anything and does not have the ability to communicate. CNA-N indicated R6 does not have any restrictions and is able to go wherever R6 wants. CNA-N indicated staff use the buddy system when providing care because R6 makes sounds and touches staff inappropriately. CNA-N had not witnessed R6 touch other residents prior to the incident that morning. On 4/13/26 at 11:15 AM, Surveyor observed R6 reach out to shake hands with a fellow Surveyor and attempt to pull the Surveyor toward R6. R6 attempted to move R6's other hand up the Surveyor's sleeve. Surveyor stepped back and R6 removed R6's hand from the Surveyor's sleeve. R6 then reached toward Surveyor's chest with the same hand. On 4/13/26 at 1:52 PM, Surveyor interviewed Director of Nursing (DON)-B who was aware of the incident with R6 that morning and voiced frustration that staff did not know to keep R6 away from female residents. DON-B stated DON-B started an investigation for the incident that morning and placed R6 on 1:1 supervision.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During medication administration observations, 2 errors occurred during 29 opportunities which resulted in a 6.8% medication error rate that affected 2 residents (R) (R11 and R12) of 4 residents observed during medication pass. R11 and R12 did not receive medications as ordered because the medications were not reordered or available. Findings include: The facility's Administering Medications policy, revised 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 frame. 4. Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 1. On 3/30/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had a diagnosis of acute on chronic diastolic heart failure. R11's Minimum Data Set (MDS) assessment, dated 1/29/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's healthcare decisions. On 3/30/26 at 8:30 AM, Surveyor observed Licensed Practical Nurse (LPN)-M administer medications for R11. LPN-M did not administer R11's AM dose of spironolactone 12.5 milligrams (mg) because the medication was not available. R11's medical record contained the following order: ~ Spironolactone oral tablet 25 mg, give 0.5 tablet by mouth in the morning for edema (order date: 10/23/25) On 3/30/26 at 11:15 AM, Surveyor interviewed LPN-M who indicated spironolactone was not available in the medication cart or the facility's contingency stock. LPN-M stated the pharmacy would deliver the medication that evening. LPN-M indicated the previous nurse did not reorder the medication which happened often. 2. On 3/30/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including hyperlipidemia and atherosclerosis. R12's MDS assessment, dated 3/4/26, had a BIMS score of 12 out of 15 which indicated R12 had moderate cognitive impairment. R12 had an activated Power of Attorney for Healthcare (POAHC). On 3/30/26 at 8:47 AM, Surveyor observed LPN-M administer medications for R12 during medication pass. LPN-M did not administer R12's AM dose of rosuvastatin 20 mg because the medication was not available. R12's medical record contained the following order: ~ Rosuvastatin calcium 20 mg, give 1 tablet by mouth in the morning for hyperlipidemia (order date: 2/25/26) On 3/30/26 at 11:15 AM, Surveyor interviewed LPN-M who indicated rosuvastatin was not available in the medication cart or the facility's contingency stock. LPN-M stated the pharmacy would deliver the medication that evening. LPN-M indicated the previous nurse did not reorder the medication which happened often. On 3/30/26 at 1:40 PM, Surveyor interviewed Director of Nursing (DON)-B who stated medications should be available and staff should provide medications as ordered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure it was free from a significant medication error for 1 resident (R) (R3) of 6 sampled residents.R3 was admitted to the facility on [DATE] and had an order for vancomycin HCl intravenous (IV) 1250 milligrams (mg) twice daily for a right knee infection. R3 did not receive the antibiotic as ordered on 2/13/26, 2/20/26, 2/23/26, and 3/9/26. Findings include:The facility's Administering Medications policy, revised 5/2025, indicates: Medications must be administered in accordance with the orders, including any required time frame .if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the reason for it.On 3/30/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] post knee replacement with an infected joint and had diagnoses including hemiplegia, history of stroke, epilepsy, and chronic pain. R3's Minimum Data Set (MDS) assessment, dated 2/13/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. R3 was R3's own decision maker. R3 discharged home on 3/10/26. R3's comprehensive care plan, dated 2/6/26, indicated R3 was admitted with an antibiotic spacer in the right knee. The care plan contained an intervention to administer antibiotic medications as ordered. On 3/30/26, Surveyor reviewed R3's hospital discharge paperwork which indicated the following:~ An Infectious Disease Hospital Note, dated 2/5/26, indicated R3 had a (Staphylococcus) aureus methicillin-resistant prosthetic joint infection status post revision arthroplasty. A peripherally inserted central catheter (PICC) line was placed on 2/4/26. The noted indicated to continue vancomycin for 6 weeks. ~ A Hospital Discharge summary, dated [DATE], indicated R3 was to start vancomycin 1250 mg IV every 12 hours.Surveyor reviewed R3's February 2026 Medication Administration Record (MAR) and noted an order for vancomycin 1250 mg IV at 9:00 AM and 6:00 PM (9 hours and 15 hours between doses) rather than every 12 hours per the hospital discharge summary.The following doses were documented as 9 (indicating not administered and to see progress note):~ 6:00 PM dose on 2/13/26 - documented as 9 by Registered Nurse (RN)-E. There was no progress note to indicate why the dose was not administered.~ 9:00 AM and 6:00 PM doses on 2/20/26 - documented as 9 by RN-E. There were no progress note to indicate why the doses were not administered.~ 9:00 AM dose on 2/23/26 - documented as 9 by Registered Nurse Supervisor (RNS)-D. There was no progress note to indicate why the dose was not administered.Surveyor noted R3's vancomycin order was decreased to 1000 mg on 2/26/26 (per physician order) and to be scheduled at 9:00 AM and 9:00 PM (every 12 hours). There was a total of 17 days in which R3 received doses of vancomycin less than or more than 12 hours apart.An Infectious Disease Consult Note, dated 3/5/26, stated to continue vancomycin 1000 mg every 12 hours with an estimated end date of 3/18/26.Surveyor reviewed R3's March 2026 MAR and noted R3's order for vancomycin HCl IV 1000 mg ended after the 9:00 AM dose on 3/9/26. R3 did not receive the 9:00 PM dose of vancomycin on 3/9/26 as there was not an active order in R3's MAR at that time.Surveyor reviewed R3's February and March 2026 vancomycin trough levels (serum concentration of vancomycin to ensure adequate treatment - the therapeutic range is 10-20 millgrams/deciliter (mg/dL)) which were as follows:~ On 2/7/26 at 7:31 AM - 15.4 mg/dL~ On 2/15/26 at 6:58 AM - 19.1 mg/dL~ On 2/20/26 at 6:54 AM - 19.5 mg/dL~ On 2/26/26 at 7:30 AM - 20.6 mg/dL (the PM dose was held and dose decreased to 1000 mg per physician)~ On 2/28/26 at 8:23 AM - 17.1 mg/dL~ On 3/7/26 at 8:58 AM - 18.9 mg/dLOn 3/30/26 at 1:38 PM, Surveyor interviewed RNS-D regarding R3's missed doses of vancomycin. RNS-D verified RNS-D initialed R3's missed 2/23/26 AM dose. RNS-D could not recall why RNS-D documented a 9 but thought it had to do with R3's vancomycin lab level. RNS-D was aware of one missed dose with RN-E and stated education was provided that staff did not have to wait for lab results before administering IV vancomycin but had to wait to start it until after labs were drawn. On 3/30/26 at 2:04 PM, Surveyor interviewed Director of Nursing (DON)-B who was not aware R3 had 5 missed/undocumented doses of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vancomycin and thought staff may have held the medication on days R3's labs were drawn. Surveyor noted there was 1 missed dose on 2/20/26 during which a lab was ordered; however, the results were communicated to the facility at 3:51 PM and were within the therapeutic range. On 3/30/26 at 3:15 PM, Surveyor interviewed RN-E regarding R3's missed doses of vancomycin. RN-E could not recall specific dates or reasons for not administering vancomycin but thought it was because R3's vancomycin level results were not back yet. RN-E verified RN-E did not administer vancomycin at a later time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure a prescribed diet was provided for 1 resident (R) (R4) of 2 sampled residents. R4 had an order for a consistent carbohydrate (CCHO) diet. R4 was not provided with the designated CCHO diet dessert.Findings include: On 3/30/26, Surveyor requested the facility's policy related to residents receiving prescribed diets. The facility provided an Order Entry by Dieticians policy, dated 3/12/18, that detailed the process for entering a diet order and ensuring the order is correct in the resident's electronic health record (EHR).On 3/30/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes with diabetic chronic kidney disease. A care plan, initiated 12/12/25, indicated R4 had type 2 diabetes mellitus. A care plan, initiated 11/30/25, indicated R4 had a nutritional problem or potential nutritional problem related to diet restrictions .obesity, diabetes mellitus, congestive heart failure (CHF), and wound care as evidenced by therapeutic diet. R4 had a diet order for a consistent carbohydrate (CCHO) diet.On 3/30/26, Surveyor reviewed the facility's diet spreadsheet and noted residents on a CCHO diet should receive 4 ounces of cinnamon apple slices instead of an apple crisp square.On 3/30/26 at 12:22 PM, Surveyor observed staff deliver a lunch tray to R4's room. Surveyor observed the lunch tray and noted R4 received a full square of the apple orchard bar.On 3/30/26 at 12:27 PM, Surveyor interviewed Dietary Aid (DA)-W who showed Surveyor the diet spreadsheet for the day. When Surveyor noted residents on a CCHO diet should receive 4 ounces of cinnamon apple slices, DA-W stated DA-W provided apple crisp bars since there were no cinnamon apple slices on DA-W's cart for the lunch meal.On 3/30/26 at 1:00 PM, Surveyor interviewed Dietary Manager (DM)-X who confirmed DA-W should have had a CCHO dessert available to serve to residents. DM-X confirmed the diet spreadsheet should be followed.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on staff interview and record review, the facility did not have a qualified Social Worker. This practice has the potential to affect all 75 residents residing in the facility. Social Services Designee (SSD)-G did not meet the necessaray requirements for a qualified Social Worker in a facility licensed for 131 beds. Findings include: On 4/1/26 at 1:25 PM, Surveyor interviewed SSD-G who started working at the facility in June of 2025 and confirmed SSD-G was the facility's Social Services Designee. SSD-G verified SSD-G was not certified or licensed as a Social Worker and did not have a degree in a related field. SSD-G stated SSD-G had previous experience working in another facility where a Social Worker worked with SSD-G. On 4/1/26 at 1:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the facility has 131 licensed beds. NHA-A confirmed SSD-G is not a licensed or certified Social Worker. NHA-A was aware a facility with more than 120 beds requires a full-time qualified Social Worker.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on staff interview and record review, the facility did not ensure in-service training of at least 12 hours for 2 of 5 sampled Certified Nursing Assistants (CNAs). CNA-Z was hired on 6/14/21. CNA-Z did not receive at least 12 hours of in-service training during CNA-Z's most recent anniversary hire year.CNA-AA was hired on 10/23/23. CNA-AA did not receive at least 12 hours of in-service training during CNA-AA's most recent anniversary hire year.Findings include:1. On 4/13/26, Surveyor reviewed the required education training hours for CNA-Z who was hired by the facility on 6/14/21. Surveyor noted CNA-Z had not completed the required 12 educational training hours during CNA-Z's most recent anniversary hire year.(See interview under example 2)2. On 4/13/26, Surveyor reviewed the required education training hours for CNA-AA who was hired by the facility on 10/23/23. Surveyor noted CNA-AA had not completed the required 12 educational training hours during CNA-AA's most recent anniversary hire year.On 4/13/26 at 3:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding CNA-Z and CNA-AA's in-service training hours. NHA-A verified CNA-Z and CNA-AA did not complete the required 12 hours of education during their most recent anniversary hire year. NHA-A verified CNAs should receive at least 12 hours of in-service education per year.