| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525165 | A. Building<br>B. Wing | 05/18/2026 |

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| Samaritan Nursing and Rehab | 531 E Washington St<br>West Bend, WI 53095 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect 70 of 71 residents residing in the facility.The facility did not ensure monitoring and documenting of cooling temperatures.The facility did not properly monitor dishwashing temperatures or conduct dishwashing in a manner that ensured dishes were washed and properly sanitized.The facility did not wash and sanitize dishes in the three-compartment sink per manufacturer's guidelines or the facility's policy.The facility did not consistently label food stored for resident consumption with received or open dates.The facility did not obtain food temperatures in a manner to prevent cross-contamination.Findings include:Food Cooling: The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 3ˆ501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celcuis (C) (135 Farenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less.The 2022 FDA Food Code documents at section 3ˆ501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3ˆ501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods.During the initial kitchen tour with [NAME] (CK)-F on 5/11/26 at 5:07 PM, Surveyor observed the following pre-cooked and cooled items in the walk-in cooler:~ A steam table container labeled Beef 5-10~ A steam table container labeled Chili 5-9~ A steam table container labeled Noodles 5-9~ A steam table container labeled Hot dogs 5-9~ A steam table container labeled Hot dogs 5-3~ An unlabeled and undated steam table container with what appeared to be chicken strips~ A steam table container labeled [NAME] 5-9~ A steam table container labeled Bacon 5-9~ Two undated steam table containers labeled MMS meat. Surveyor observed pre-cooked minced meat saved for future resident consumption in the containers. ~ A steam table container labeled Eggs 5-9During a continuous kitchen observation that began on 9:27 AM on 5/12/26, Surveyor observed the above pre-cooked food items still in the cooler for resident consumption. Surveyor also observed a container labeled Hamburgers 5-11 in the walk-in cooler. Surveyor interviewed CK-F who indicated the facility does not have a cooling log and places pre-cooked food for resident consumption in the cooler. During a kitchen tour with Dietary Manager (DM)-E that began at 1:58 PM on 5/12/26, DM-E indicated the facility had a food cooling log. DM-E showed Surveyor the cooling log which contained none of the pre-cooked items observed in the cooler. DM-E indicated the facility pre-cooks food and saves leftovers. DM-E indicated the facility's policy and procedure is for food to be cooled properly and for staff to monitor the temperatures of foods saved or pre-cooked. Surveyor and DM-E toured the coolers. DM-E verified all pre-cooked food saved for resident consumption should be on the food cooling log to ensure proper cooling. Dishwashing:The facility's undated Warewashing 101 policy indicates: .Dish Machine Start-Up .Ensure machine is meeting the<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | correct wash and rinse temperatures (see NSF data label posted on machine). Test sanitizing requirements .High temp = 160 surface temp .During a continuous kitchen observation that began at 9:27 AM on 5/12/26, Surveyor observed staff wash dishes. Surveyor observed Dietary Aide (DA)-G on the clean side of the dishwasher and another staff on the dirty side. DA-G wore gloves and an apron during dishwashing. DA-G removed two racks of clean dishes to dry. DA-G then went to the dirty side, cleaned food off of a dish, and put a rack of dirty dishes in the dishwasher. DA-G then returned to the clean side and removed clean dishes from the dishwasher to dry. DA-G did not remove gloves or an apron or complete hand hygiene. DA-G then went to the dirty side, cleaned food off of dishes, and loaded the dishes in the dishwasher. With the same gloved hands and apron, DA-G removed a clean rack of dishes to dry. Surveyor observed DA-G continuously move from the dirty to clean side of the dishwasher without removing gloves or an apron, or washing hands between tasks. Surveyor noted the dishwasher data plate indicated the machine was a high temperature washer; the wash temperature should be 160 degrees F and the sanitizer temperature should be 180 degrees F. Surveyor observed the dishwashing temperature log. The bottom of the form indicated high temperature wash 150 to 160 degrees F.During a kitchen tour with DM-E that began at 1:58 PM on 5/12/26, DM-E indicated kitchen staff are assigned to dishwashing. The policy and procedure for dishwashing is to have two staff to ensure one staff works on the dirty side and one staff handles the clean side, including hand hygiene and removing an apron if having to complete tasks on the opposite side. DM-E indicated the wash temperature of the dishwasher should be 150 to 160 degrees F. When Surveyor indicated the May 2026 dish log contained two entries, DM-E indicated DM-E would provide the March through May 2026 dish logs to Surveyor. DM-E indicated kitchen staff frequently do not start a new page with a new month.On 5/14/26, Surveyor reviewed the facility's dish logs for March, April, and May 2026 and noted the following:~ March 2026: Wash was documented at 180 to 181 degrees F throughout the month. Rinse was documented at 181 to 184 degrees F with one documentation of 178 degrees F throughout the month; Parts per million (PPM) was documented at 300 PPM consistently throughout the month.~ April 2026: Wash was documented at 170 to 186 degrees F throughout the month. Rinse was documented at 162 to 181 degrees F with 38 of 90 entries documented below the required 180 degrees F sanitization temperature. PPM was documented at 200 to 300 throughout the month. ~ May 2026: Wash was documented at 170 to 180 degrees F with one entry at 142 F and the dishwasher shut down for maintenance on 5/12/26. Rinse was documented at 118 degrees F (on 5/12/26) to 182 degrees F with 23 of 34 entries documented below the required 180 degrees F sanitization temperature. PPM was documented at 200 to 300 throughout the month. On 5/14/26 at 10:34 AM, Surveyor interviewed DM-E who indicated the dishwashing machine was a high temperature machine. DM-E indicated staff place a Hydrion Quat Sanitizer test strip near the exit of the clean side and document the temperature. DM-E indicated Quat Sanitizer strips are also used to test PPM which should be documented on the dishwashing machine. DM-E confirmed DM-E did not know the difference between a chemical sanitizer machine and a high temperature warewashing machine. Surveyor reviewed the facility's dishwashing machine data plate with DM-E who verified the data plate indicates a high temperature wash should reach 160 degrees F and a high temperature sanitization cycle should reach 180 degrees F. Quat Sanitizer:The facility's undated Warewashing 101 policy indicates: .Sanitizer test papers are most accurate when testing sanitizer solutions at 75 F.During an initial kitchen tour that began at 5:07 PM on 5/11/26, Surveyor interviewed CK-F who indicated staff wash dishes, including the cooks' dishes, and prepare sanitizer buckets in the three-compartment sink. CK-F indicated the log hung near the three-compartment sink is where staff document the time sanitizing buckets are prepared and record the PPM of the sanitizing solution. Surveyor reviewed the three-compartment sink log and noted Hydrion Quat Sanitizer strips on the clipboard. Surveyor noted the log did not contain the temperature of the sanitizing solution prior to testing.During a continuous kitchen observation conducted with DM-E on 5/12/26, DM-E verified the temperature of the sanitizing solution in the three-compartment sink is not tested prior to testing<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | PPM. DM-E verified the temperature of the sanitizing solution should be 75 degrees F prior to testing per the facility's policy. Food Storage:The facility's Safe Storage of Food policy, dated 9/1/21, indicates: .5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . During an initial kitchen tour that began at 5:07 PM on 5/11/26, Surveyor and CK-F observed the following open and undated foods in the dry storage area and coolers:~ An undated steam table container labeled beef base ~ Two undated steam table containers labeled onion and an undated plastic wrapped onion ~ A bag of shredded cheese~ A container of salad~ A package of hot dogs~ Two bags of dinner rolls~ Five packages of lunch meat~ A container of Silk soy milk~ A gallon of milk~ A steam table container of MMS meat in the walk-in cooler~ Two unlabeled and undated steam table containers of what CK-F indicated was pork for lunch on 5/12/26.~ Seven cans of sausage gravy ~ Two cans of fancy tomatoes~ Two cans of sauerkraut~ Three cans of pimento pepper~ A tub of cream cheese frosting~ Two boxes of au gratin potatoesDuring a kitchen tour with DM-E that began at 1:58 PM on 5/12/26, DM-E verified the items observed in the dry storage area and cooler were unlabeled, undated, and/or open. DM-E indicated staff should label all food with a received date, an open date, and an item description if leftovers or prepped food are for an upcoming meal.Food Temperatures:The facility's Record of Food Temperatures policy, revised 1/2026, indicates: .Food temperatures will be verified using a thermometer which is clean, sanitized, and calibrated to ensure accuracy. During a continuous dining observation that began at 11:35 AM on 5/12/26, Surveyor observed DA-G obtain food temperatures at the steam table prior to lunch service. DA-G obtained the temperature of pork fried rice for regular, minced and moist, and pureed consistencies without sanitizing the thermometer between the regular and modified textures. On 5/13/26 at 2:15 PM, Surveyor interviewed DM-E who indicated staff are trained in the proper procedure for obtaining food temperatures and staff know to use a sanitizing wipe between obtaining temperatures. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection control program designed to help prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 71 residents (R) residing in the facility. The facility's infection surveillance line lists did not contain all pertinent information for identification, tracking, reporting, investigating, and mitigating infections.R59 was diagnosed with urinary tract infections (UTIs) in April and May 2026. R59 was not included in the facility's surveillance data for April.The facility did not ensure contact precautions were implemented and personal protective equipment (PPE) was provided for R4 who had a diagnosis of methicillin-resistant Staphylococcus aureus (MRSA) (a type of bacteria resistant to many antibiotics) with an open wound.R40 had an indwelling catheter and was not on enhanced barrier precautions (EBP).<br><br>Findings include:<br><br>The facility's Infection Prevention and Control Program, revised 3/2026, indicates: .The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee .The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigation of exposures of infectious diseases .A system of surveillance is used for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement .<br><br>The facility's Transmission Based (Isolations) Precautions policy, revised 3/2026, indicates: .9. Initiation of Transmission-Based Precautions: .An order for TBP will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission .The order will specify the type of precaution and reason .Signage that includes instructions for use of specific pesonal protective equipment (PPE) will be placed in a conspicuous location outside the resident's room .either the Centers for Disease Control and Prevention (CDC) category of TBP (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage .The facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on TBP .10. Contact Precautions: .Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment .Donning PPE upon room entry and discarding before exiting the room is done to contain pathogens .Residents experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained .should be placed on contact precautions even before a specific organism has been identified .Contact precautions will be used for residents infected or colonized with multidrug-resistant organisms (MDROs) in the following situations: 1. When a resident has wounds, secretions, or excretions that are unable to be covered or contained .<br><br>The facility's Enhanced Barrier Precautions policy, dated 4/2026, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs) .EBP refers to an infection control intervention designed to<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | reduce transmission of MDROs that employs targeted gown and glove use during high-contact resident care activities .An order for EBP will be obtained for residents with any of the following .indwelling medical devices (e.g., urinary catheters) even if the resident is not known to be infected or colonized with an MDRO. 3. Implementation of EBP: a. Make gowns and gloves available immediately near or outside the resident's room .b. Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities .4. High-contact resident care activities include: .Device care or use: .urinary catheters .<br><br>1. On 5/14/26, Surveyor reviewed infection control documentation provided by the facility for January through May 2026. The documetation did not contain surveillance information that mapped or tracked infections to identify trends or potentially mitigate infections. In addition, the surveillance data did not contain monthly analyses for follow-up activity.<br><br>On 5/14/26 at 1:43 PM, Surveyor interviewed Regional Nurse Manager (RNM)-W who indicated the facility's policy indicates the facility should complete a map of infections for each month that indicates the trends and percentages of infections and should present the data at monthly Quality Assurance and Performance Improvement (QAPI) meetings.<br><br>On 5/14/26 at 1:43 PM, Surveyor interviewed Infection Preventionist (IP)-H who indicated IP-H did not map infections except on an erasable board which did not currently contain any mapping. IP-H indicated IP-H attended one QAPI meeting (February 2026) and had provided one month of infection percentages during the meeting. IP-H indicated paper mapping of infections was not filled out in the facility's infection control binder and there was no monthly analyses of surveillance data or potential follow-up activity from January through May 2026.<br><br>2. On 5/11/26, Surveyor reviewed R59's medical record. R59 had diagnoses including dementia with behavioral disturbance, chronic kidney disease stage 4, and type 2 diabetes. R59 had urinary tract infections (UTIs) on 4/9/26 and 5/8/26. R59's Minimum Data Set (MDS) assessment, dated 5/8/26, stated R59 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. R59 had an activated Power of Attorney for Healthcare (POAHC).<br><br>On 5/13/26, Surveyor reviewed the facility's infection control surveillance line lists and noted R59 was not on the April 2026 surveillance line list.<br><br>On 5/14/26 at 11:49 AM, Surveyor interviewed IP-H who indicated R59 was diagnosed with a UTI in April and was also diagnosed and treated for conjunctivitis in April. IP-H verified R59 was not on the infection surveillance list and indicated R59 was missed. IP-H indicated R59 should be on the line list to ensure tracking and trending of infections is documented per the facility's policy and procedure.<br><br>3. Between 5/11/26 and 5/14/26, Surveyor reviewed R4's medical record. R4 was readmitted to the facility on [DATE] and had diagnoses including cellulitis of lower left limb, cellulitis of lower right limb, other streptococcus as the cause of diseases, proteus (mirabilis) (morganii) as the cause of diseases, bacterial infections of unspecified site, acute pyelonephritis, open wound of the great toe, and methicillin-resistant Staphylococcus aureus (MRSA) infection as the causes of diseases classified elsewhere. R4's MDS assessment, dated 4/8/26, stated R4 had a BIMS score of 12 out of 15, indicating moderately impaired cognition.<br><br>R4's care plan indicated R4 was on contact isolation precautions related to a MRSA-colonization wound.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | R4's Medication Administration Record (MAR) indicated staff should use contact precautions for R4 related to MRSA and risk of infection.<br><br>On 5/11/26 at 7:40 PM, Surveyor observed R4's room which contained a contact precautions sign near the door. The sign stated, STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit . Surveyor observed a storage unit affixed to R4's door that contained a box of gloves. Surveyor noted other storage areas on the unit were empty. Surveyor did not observe any gowns. Surveyor also did not observe a receptacle near the exit of R4's room to dispose of used PPE.<br><br>On 5/11/26 at 7:40 PM, Surveyor observed Certified Nursing Assistant (CNA)-AA enter R4's room without doning a gown and close the door. At approximately 7:45 PM, Surveyor observed CNA-AA exit R4's room with 3 clear plastic bags of soiled clothing and an incontinence brief in CNA-AA's ungloved hand. Surveyor interviewed CNA-AA who indicated R4 asked to be put to bed so CNA-AA provided care and transferred R4 to bed. While speaking with CNA-AA in the hallway, Surveyor observed CNA-AA reenter R4's room without donning a gown or gloves or completing hand hygiene. CNA-AA indicated CNA-AA was making sure CNA-AA had removed all of the soiled clothing and garbage. CNA-AA did not know CNA-AA needed to wear a gown and gloves to enter R4's room or to provide care for R4. CNA-AA thought CNA-AA only had to wear PPE if CNA-AA provided wound care.<br><br>On 5/11/26 at 7:48 PM, Surveyor observed CNA-BB enter R4's room without donning a gown or gloves. CNA-BB did not complete hand hygiene prior to entering or exiting the room. CNA-BB did not know CNA-BB needed to don a gown and gloves to enter R4's room. CNA-BB read the contact precautions sign near R4's door and verified CNA-BB should have worn PPE. CNA-BB indicated CNA-BB would not have been able to wear a gown because there weren't any available in the storage unit on R4's door.<br><br>On 5/11/26 at 7:59 PM, Surveyor observed CNA-CC load gloves and gowns into the PPE storage unit on R4's door and enter R4's room with two PPE receptacles. One bin was labeled gowns and the other was labeled garbage. CNA-CC did not don a gown or gloves prior to entering the room and did not complete hand hygiene prior to entering or exiting the room. CNA-CC read the contact precautions sign near R4's room and verified CNA-CC should have worn a gown and gloves and completed hand hygiene prior to entering R4's room.<br><br>On 5/11/26 at 8:02 PM, Surveyor observed CNA-DD knock and enter R4's room. CNA-DD did not don a gown or gloves or complete hand hygiene prior to entering or exiting the room. CNA-DD indicated CNA-DD did not have to wear PPE because CNA-DD did not provide care for R4. After reading the contact precautions sign, CNA-DD verified CNA-DD should have worn a gown and gloves to enter R4's room.<br><br>On 5/13/26 at 12:40 PM, Surveyor interviewed Wound Care Registered Nurse (WCRN)-EE who indicated R4 was on contact precautions due to MRSA in the urine. WCRN-EE indicated staff should don a gown and gloves prior to entering R4's room.<br><br>On 5/12/26 at 1:58 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a resident with MRSA should be on contact precautions. DON-B indicated staff should be aware of and follow TBP, including contact precautions when indicated. DON-B indicated DON-B provided additional training for staff to understand the difference between contact precautions and enhanced barrier<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | precautions (EBP), including the need to complete hand hygiene and don and doff PPE, including scenario training to identify which situations require PPE.<br><br>4. Between 5/11/26 and 5/13/26, Surveyor reviewed R40's medical record. R40 was admitted to the facility on [DATE] and had diagnoses including obstructive and reflux uropathy and infection, and inflammatory reaction due to indwelling urethral catheter. R40's MDS assessment, dated 4/30/26, stated R40 had a BIMS score of 13 out of 15, indicating intact cognition. R40 had an activated POAHC.<br><br>R40's care plan, dated 4/29/26, indicated R40 had a catheter for urinary retention and obstructive and reflux uropathy and had failed voiding trials. R40 was prone to UTIs and was admitted to the facility with a catheter-associated UTI. The care plan did not indicate R40 was on EBP.<br><br>On 5/11/26 at 6:38 PM, Surveyor interviewed R40 in R40's room. Surveyor did not observe an EBP sign on or near R40's door or a PPE cart nearby.<br><br>On 5/11/26 at 6:46 PM, Surveyor interviewed Registered Nurse (RN)-X who verified the entrance to R40's room did not contain an EBP sign or PPE cart. RN-X indicated EBP is only implemented if a resident with a catheter has an MDRO.<br><br>On 5/13/26 at 8:30 AM, Surveyor interviewed DON-B who verified an EBP sign and PPE cart should be outside R40's room.<br><br>On 5/13/26 at 1:30 PM, Surveyor noted there was not an EBP sign or PPE cart outside R40's room.<br><br>On 5/13/26 at 1:40 PM, Surveyor interviewed CNA-Y who described catheter care as donning gloves and cleansing the catheter tubing with an alcohol wipe before and after emptying. CNA-Y indicated CNA-Y did not wear a gown during the process. CNA-Y verified there was not an EBP sign or PPE cart outside R40's room. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored in accordance with the facility's policy. Two medication carts contained expired medication and syringes. One medication storage room contained expired medication and syringes. This practice had the potential to affect more than 4 of the 71 residents residing in the facility.The medication cart on 4 North contained 1 opened box of expired Mucinex DM, 1 opened bulk bottle of expired calcium with vitamin D, 9 expired Bisacodyl suppositories, and 8 expired syringes.The medication cart on 3A contained 1 opened bulk bottle of expired calcium with vitamin D and 12 expired syringes.The fourth floor medication storage room contained 1 expired bottle of Advil and 2 expired boxes of syringes.Findings include:The facility's Medication Storage policy, revised 12/2025, indicates: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.On 5/12/26 at 12:43 PM, Surveyor observed the 4 North medication cart with Mediation Technician (MT)-M who verified the following medications and medical supplies were expired:~ One opened box of Mucinex DM with an expiration date of 1/2026~ One opened bulk bottle of calcium 600 milligrams (mg) plus vitamin D 10 micrograms (mcg) with an expiration date of 4/2026~ Eight 1 milliliter (ml) 25 G syringes with expiration dates of 2/28/26~ Nine 10 mg Bisacodyl suppositories with expiration dates of 6/2025On 5/12/26 at 1:05 PM, Surveyor observed the third floor 3A medication cart with Licensed Practical Nurse (LPN)-S who verified the following medication and medical supplies were expired:~ One opened bulk bottle of calcium 600 mg plus vitamin D 10 mcg with an expiration date of 4/2026~ One 1 ml 25 G syringe with an expiration date of 2/28/26~ Eleven 3 ml 25 G 1-1/2 inch syringes with expiration dates of 2/28/26On 5/12/26 at 1:33 PM, Surveyor observed the fourth floor medication storage room with Director of Nursing (DON)-B who verified the following medication and medical supplies were expired:~ One unopened bottle of Advil (ibuprofen) 100 mg 24 chewable grape flavored tablets with an expiration date of 4/2026~ Two unopened boxes of 3 ml 25 G 1-1/2 inch syringes (100 in each box) with expiration dates of 2/28/26On 5/12/26 at 1:45 PM, Surveyor interviewed DON-B who indicated medication carts and storage rooms should not contain expired medications and medical supplies. |

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| | 525165 | A. Building<br>B. Wing | 05/18/2026 |

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| Samaritan Nursing and Rehab | 531 E Washington St<br>West Bend, WI 53095 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on staff interview and record review, the facility did not implement written policies and procedures that prohibit and prevent abuse for 1 staff (Registered Nurse (RN)-I) of 8 staff reviewed for caregiver background checks. The facility did not ensure a Certificate of Release or Discharge from Active Duty (DD214) was received from RN-I prior to RN-I's employment on 8/5/24.Findings include:The facility's undated Abuse, Neglect and Exploitation policy indicates: Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials check shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.The Wisconsin Department of Health Services (DHS) Wisconsin Background Check and Misconduct Investigation Program Manual, dated 10/2025, indicates new employees or contractors can temporarily work for up to 60 days pending official Department of Justice (DOJ) results, provided they meet strict conditions: .The employer must provide active supervision during the entire 60-day period, which includes periodic direct observation of the caregiver.On 5/13/26 at approximately 3:00PM, Surveyor reviewed background check information for 8 employees, including RN-I.RN-I was hired on 8/5/24. RN-I's Background Information Disclosure (BID) form indicated RN-I was discharged from the United States (US) Armed Forces in 2024 which was within the last 3 years of hire. The BID form indicated to attach a copy of a DD214 form if discharged within the last 3 years. The BID form was signed and dated by RN-I on 8/20/24 but did not contain a DD214 form.On 5/13/26 at 3:43 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the facility did not have a DD214 form for RN-I but requested RN-I obtain the form on 5/13/26 and provide it to the facility. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on staff, resident, and resident representative interview and record review, the facility did not ensure the comprehensive plan of care was reviewed and revised for 1 resident (R) (R59) of 22 sampled residents.R59's care plan was not revised to reflect the level of assistance R59 required to complete activities of daily living (ADLs). In addition, the care plan did not contain updated interventions to assist R59 with completing ADLs.Findings include:The facility's Comprehensive Care Plans policy, revised 12/2025, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences .The comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS) assessment .Other factors identified by the Interdisciplinary Team (IDT), or in accordance with the resident's preferences, will also be addressed in the plan of care .The comprehensive care plan will be reviewed and revised by the IDT after each Comprehensive and Quarterly MDS assessment.The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be use to monitor the residents progress . On 5/11/26, Surveyor reviewed R59's medical record. R59 had a diagnosis of dementia with other behavioral disturbance. R59's Minimum Data Set (MDS) assessment, dated 5/8/26, stated R59 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive impairmemt. R59 had an activated Power of Attorney for Healthcare (POAHC).On 5/11/26 at 6:33 PM, Surveyor interviewed R59's POAHC (POAHC-R) who expressed concern that staff do not assist R59 with toileting. POAHC-R stated POAHC-R came in daily to assist with changing R59's brief. POAHC-R stated R59 had a recent decline, was enrolled in Hospice services, and required assistance with hygiene after toileting. POAHC-R indicated R59 does not realize R59 requires assistance and staff do not assist R59. POAHC-R indicated R59 has behavioral concerns and refuses to allow staff to assist at times. POAHC-R stated despite R59's refusal of cares, staff are required to assist R59. POAHC-R also had skin and urinary tract infection concerns because R59 was not assisted with brief changes. On 5/12/26, Surveyor reviewed R59's care plan which indicated R59 had a history of refusing cares, including showers (initiated 11/4/25). The care plan contained a goal that R59 will not have any adverse effects from refusals of showers (revised 11/12/25). The care plan contained the following interventions: Encourage R59 to allow staff to assist with changing R59's brief. If R59 refuses, reapproach multiple times and make supervisor aware of the refusals (initiated 5/11/26); Encourage R59 to allow cares to be completed. Staff should attempt multiple times throughout the shift if R59 refuses cares, including showers (initiated 11/4/25). The care plan indicated R59 can toilet self with stand-by assistance from staff (initiated 11/21/25).A progress note, dated 5/8/26, indicated R59 refused to let anyone help and repeatedly stated, Get out of here and leave me alone. Staff called POAHC-R to assist, notified the physician, and obtained a urinalysis. (Of note: R59's medical record did not contain any other notes that indicated R59 refused assistance with cares.) On 5/13/26 at 8:42 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-U who indicated R59 is independent with most things, requires stand-by assistance with toileting, and refuses showers at times. CNA-U indicated staff ask R59 multiple times, however, R59 still refuses and does not receive cares some days. CNA-U stated asking R59 multiple times is the only intervention CNA-U knows to assist with helping R59 when R59 refuses cares. CNA-U indicated staff do not check on R59 or ask if R59 requires assistance in the bathroom because R59 is a stand-by assist only and staff do not assist with toileting, wiping, or changing R59's brief. CNA-U was unsure if R59 required more assistance since CNA-U last worked with R59. On 5/13/26 at 12:42<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PM, Surveyor interviewed POAHC-R who met with the facility and discussed concerns that R59's care plan is not updated and does not reflect the level of assistance R59 requires. POAHC-R believes staff are not aware of the level of assistance R59 requires for brief changes and toileting and indicated R59 requires more than stand-by assistance for toileting. POAHC-R stated R59's care plan should be more individualized and contain relevant and current interventions for R59's level of need. On 5/14/26 at 9:25 AM, Surveyor interviewed Regional Consultant (RC)-C and Director of Nursing (DON)-B. DON-B indicated R59 can be resistant to staff assisting with cares but allows POAHC-R to assist. DON-B confirmed POAHC-R frequently completes cares for R59. DON-B indicated R59 inconsistently changes R59's brief after incontinence episodes and stated staff offer assistance multiple times during the day however R59 declines. DON-B indicated R59 also declines assistance from POAHC-R at times. DON-B confirmed no other interventions have been attempted to assist R59 with accepting care from staff or to increase assistance with hygiene after toileting. DON-B indicated the facility will try to use different staff members or look at other interventions to assist R59 and confirmed R59's care plan should be updated. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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 the resident environment remained as free of accident hazards as possible for 3 residents (R) (R10, R51, and R42) of 4 sampled residents.R10 was known to smoke. A smoking assessment, dated 11/25/25, indicated R10 required assistance with smoking. The facility did not reassess R10 for smoking. R51 was known to smoke. A smoking assessment, dated 9/10/25, indicated R51 did not smoke. The facility did not reassess R51 for smoking. R42 was known to smoke. The facility did not complete a smoking assessment for R42.<br><br>Findings include:<br><br>The facility's Resident Smoking policy, dated 12/2025, indicates: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .5. All residents will be asked about tobacco use during the admission process, and during each Quarterly or Comprehensive Minimum Data Set (MDS) assessment process. 6. Residents who smoke will be further assessed, using the resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if the resident is safe to smoke at all .<br><br>On 5/12/26, Surveyor reviewed a list of residents who smoke provided by Nursing Home Administrator (NHA)-A. R10 and R51 were on the list.<br><br>1. On 5/12/26, Surveyor reviewed R10's medical record. R10 had diagnoses including cerebral ischemia, metabolic encephalopathy, anoxic brain damage, and dementia with other behavioral disturbance. R10's MDS assessment, dated 2/7/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. R10 had an activated decision maker.<br><br>R10's care plan, dated 7/4/25, indicated R10 smokes and R10's sister assists R10 who does not ask staff to smoke. The care plan indicated R10 requires monitoring and support for safe tobacco use. The care plan contained an intervention to monitor for safe smoking practices and supervise smoking per policy.<br><br>R10's medical record contained a smoking assessment, dated 11/25/25, that indicated R10 required assistance with smoking and R10's smoking materials should be stored at the nurses' station.<br><br>On 5/13/26 at 3:08 PM, Surveyor interviewed NHA-A who indicated the smoking assessment completed on 11/25/25 was the last smoking assessment completed for R10. NHA-A indicated assessments should have been completed in February and May of 2026.<br><br>2. On 5/13/26, Surveyor reviewed R51's medical record. R51 had diagnoses including alcoholic cirrhosis of liver, pyogenic arthritis, and chronic obstructive pulmonary disease (COPD). R51's MDS assessment, dated 3/19/26, stated R51 had a BIMS score of 15 out of 15, indicating intact cognition. R51 had an activated decision maker.<br><br>R51's care plan, dated 10/31/25, indicated R51 will adhere to the facility's tobacco/smoking policies<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (initiated 5/24/24) and contained an intervention to conduct a smoking safety evaluation on admission and as needed (initiated 5/24/24).<br><br>R51's medical record indicated (on 9/10/25) that R51 was not a smoker.<br><br>On 5/13/26 at 3:08 PM, Surveyor interviewed NHA-A who indicated R51 smokes and NHA-A would obtain R51's most recent smoking assessment. NHA-A indicated R51 should have had a smoking assessment completed after the 9/10/25 assessment that indicated R51 was not a smoker. Surveyor also requested an updated list of residents who smoke.<br><br>On 5/13/26, Surveyor reviewed a smoking assessment for R51, dated 5/13/26, that indicated R51 does not smoke. Surveyor again reviewed R51's care plan which indicated was a smoker.<br><br>On 5/14/26 at 10:25 AM, NHA-A provided Surveyor with an updated list of residents who smoke. NHA-A confirmed R51 smokes and requires assistance with smoking. NHA-A verified residents on the list, including R51, do not have up-to-date smoking assessments.<br><br>3. Between 5/11/26 and 5/13/26, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including diabetes and dementia. R42's MDS assessment, dated 4/21/26, stated R42 had a BIMS score of 15 out of 15, indicating intact cognition. The MDS assessment indicated R42 did not use tobacco. R42 had a Guardian who assisted with healthcare decisions.<br><br>R42's care plan, dated 4/18/26, indicated R42 requires supervision while smoking and the charge nurse should be notified immediately if R42 violates the facility's smoking policy.<br><br>R42's medical record did not contain a smoking assessment.<br><br>On 5/12/26 at 9:54 AM, Surveyor interviewed Guardian (GRD)-T via phone. GRD-T indicated R42 smokes and has had no accidents, including dropping ashes or sustaining burns. GRD-T stated R42's smoking supplies are kept by staff.<br><br>On 5/12/26 at 11:52 AM, Surveyor interviewed R42 who indicated R42 smokes independently and keeps R42's smoking supplies.<br><br>On 5/12/26 at 11:54 AM, Surveyor interviewed Registered Nurse (RN)-P who verified R42 had R42's smoking supplies but is supposed to store the supplies at the nurses' station and request them when R42 wants to smoke. RN-P indicated RN-P was not aware of any smoking accidents/hazards for R42.<br><br>On 5/12/26 at 12:53 PM, Surveyor observed R42 smoking on the patio in a safe manner. R42 obtained and returned smoking supplies to the nurse.<br><br>On 5/13/26 at 3:07 PM, Surveyor interviewed NHA-A who verified the facility did not have a smoking assessment for R42. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide appropriate cather care and services for 1 resident (R) (R40) of 2 sampled residents. R40 had an indwelling catheter and was prone to urinary tract infections (UTIs). R40's catheter bag was in contact with the floor on multiple occasions.Findings include:The Centers for Disease Control and Prevention and Healthcare Infection Control Practices Advisory Committee - Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (2009) indicates: .III. Proper Techniques for Urinary Catheter Maintenance .B. Maintain unobstructed urine flow .2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.Between 5/11/26 and 5/13/26, Surveyor reviewed R40's medical record. R40 was admitted to the facility on [DATE] and had diagnoses including obstructive and reflux uropathy and infection, and inflammatory reaction due to indwelling urethral catheter. R40's Minimum Data Set (MDS) assessment, dated 4/30/26, stated R40 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. R40 had an activated Power of Attorney for Healthcare (POAHC) who assisted with healthcare decisions.R40's care plan, dated 4/29/26, indicated R40 had a catheter for urinary retention and obstructive and reflux uropathy and had failed voiding trials. R40 was prone to urinary tract infections (UTIs) and was admitted to the facility with a catheter-associated UTI.On 5/11/26 at 6:38 PM, Surveyor interviewed R40 in R40's room. R40's catheter bag was hung underneath R40's wheelchair and in contact with the floor. On 5/11/26 at 6:46 PM, Surveyor interviewed Registered Nurse (RN)-X who verified R40's catheter bag was on the floor. RN-X donned gloves and readjusted the catheter bag so it was not touching the floor.On 5/13/26 at 8:30 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R40's catheter bag should not be on the floor.On 5/13/26 at 1:30 PM, Surveyor noted R40's catheter bag was hung underneath R40's wheelchair and in contact with the floor.On 5/13/26 at 1:40 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-Y who verified R40's catheter bag should not be on the floor and should be hung higher on the wheelchair. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on observation, staff interview, and record review, the facility did not ensure adequate nursing oversight for the administration of as needed (PRN) narcotic medication for 1 resident (R) (R5) of 1 sampled resident.Medication Technician (MT)-M administered PRN hydromorphone HCL (a narcotic pain medication) to R5 and completed pre-and post-pain assessments without a licensed nurse.Findings include:The facility's Medication Technician job description, signed by MT-M on 5/8/23, indicates: The Medication Technician (MT) plays an essential role in supporting safe, accurate, and timely medication administration for residents under the supervision of licensed nursing staff and in accordance with state regulations, facility policies, and scope of practice.From 5/12/26 to 5/14/26, Surveyor reviewed R5's medical record. R5 had a diagnosis of heart failure. R5's Minimum Data Set (MDS) assessment, dated 4/16/26, stated R5 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition.R5's medical record contained an order, dated 5/5/26, for hydromorphone HCL oral tablet 2 milligrams (mg), may give 1-2 tablets every 1 hour PRN for mild to moderate pain.On 5/12/26 at 12:28 PM, Surveyor observed MT-M speak with R5 who indicated R5's left lower extremity pain was a 9 on a scale of 1 to 10 (with 10 being the worst pain.) MT-M reviewed R5's Medication Administration Record (MAR) and indicated MT-M would give R5 two 2 mg tablets of hydromorphone HCL. MT-M informed Surveyor the medication was ordered 1-2 tablets every hour as needed for pain. MT-M removed 2 tablets of hydromorphone HCL from a locked narcotic box in the medication cart and wrote the time, date, name of the medication, and amount of remaining tablets in the facility's narcotic monitoring book. MT-M administered the medication to R5.R5's medical record indicated MT-M reassessed R5's pain on 5/12/26 at 1:52 PM which was documented as 0 out of 10.On 5/13/26 at 10:15 AM, Surveyor interviewed MT-M who indicated if a resident can inform MT-M the resident is in pain, MT-M can administer PRN medication, including narcotics. MT-M indicated if it is less obvious what the resident needs, MT-M consults with the nurse. MT-M indicated MT-M asked an unnamed nursing manager to let Hospice know R5 was complaining of left lower extremity pain after administering hydromorphone HCL on 5/12/26.On 5/13/26 at 10:25 AM, Surveyor interviewed Registered Nurse (RN)-P who indicated MT-M can administer PRN narcotic medication without consulting a nurse. RN-P indicated RN-P glances at MARs for residents who receive medication from MT-M and stated MT-M is good about letting nurses know about any concerns.On 5/13/26 at 2:59 PM, Surveyor interviewed Director of Nursing (DON)-B who was not certain of the facility's policy but indicated a Medication Technician should have a nurse talk to a resident before administering hydromorphone so the nurse can complete an assessment. DON-B also indicated a Medication Technician should inform a nurse prior to administering PRN narcotic medication. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**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 the accurate and safe administration of medication for 2 residents (R) (R3 and R35) of 16 sampled residents. R3 had medication in R3's room. R3 did not have an order to self-administer medication or a self-administration of medication assessment that indicated R3 could safely and accurately self-administer medication. In addition, R3 did not have a care plan for self-administration of medication or to store medication at the bedside. R35 had medication in R35's room. R35 did not have an order to self-administer medication or a self-administration of medication assessment that indicated R35 could safely and accurately self-administer medication. In addition, R35 did not have a care plan for self-administration of medication or to store medication at the bedside. Findings include: The facility's undated Resident Self-Administration of Medication policy indicates: .A resident may only self-administer medication after the facility's Interdisciplinary Team (IDT) has determined which medications may be self-administered safely .When determining if self-administration is clinically appropriate for a resident, the IDT should consider the following: The resident's physical capacity to swallow without difficulty, open medication bottles, administer injections; The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; The resident's capability to follow directions and tell time to know when medications need to be taken; The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and side effects .The resident's ability to ensure medication is stored safely and securely .The results of the assessment are recorded on the Medication Self Administration Assessment Form .Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: The manner of storage prevents access by other residents .All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party The care plan must reflect resident self-administration and storage arrangements for such medications .1. On 5/11/26 at 7:52 PM, Surveyor interviewed R3 and observed medication in R3's room. R3 indicated R3 used the medications. R3 indicated several of the bottles were stoma powder and the other medications were for R3's wounds. Surveyor observed the following medications (not including 6 bottles of stoma powder and two bottles of barrier spray) on a table in R3's room: ~ A container of lidocaine 2% zinc oxide 12% (primarily used to treat discomfort of hemorrhoids, anal fissures, and minor skin irritations) with a pharmacy label that contained R3's name ~ A bottle of Puracyn Plus Spray (a hypochlorous acid solution for cleansing, irrigating and debriding wounds) without a pharmacy label On 5/11/26, Surveyor reviewed R3's medical record which indicated R3 was admitted to the facility on [DATE]. R3 had diagnoses including rectal cancer, liver cancer, peritoneal cancer, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 3/7/26, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. R3's Medication Administration Record (MAR) did not contain orders for bedside medication, self-administration of medication, or for the lidocaine and Puracyn medications. R3's medical record did not contain a self-administration of medication assessment. R3's care plan did not include bedside medication or self-administration of medication. On 5/12/26 at 12:47 PM, Surveyor observed the lidocaine and Puracyn in R3's room. On 5/14/26 at 9:13 AM, Surveyor observed the lidocaine and Puracyn in R3's room. On 5/14/26 at 9:20 AM, Surveyor interviewed Registered Nurse (RN)-Z who indicated residents should not have medications in their rooms. RN-Z indicated if medication is found in a resident's room, staff should remove the medication and check if the resident has orders. If not, (continued on next page) |

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| | 525165 | A. Building<br>B. Wing | 05/18/2026 |

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| Samaritan Nursing and Rehab | 531 E Washington St<br>West Bend, WI 53095 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | staff should call the physician and obtain an order. On 5/14/26, Surveyor requested R3's self-administration of medication assessment. On 5/14/26 at 8:50 AM, Nursing Home Administrator (NHA)-A indicated a self-administration of medication assessment for R3 had not been done. NHA-A indicated there should be a physician's order for all medications and an order for all bedside medications. NHA-A indicated a self-administration of medication assessment should completed for all residents who have bedside medications. NHA-A indicated bedside medication and self-administration of medication should be a part of a resident's care plan if applicable. 2. On 5/11/26 at 7:16 PM, Surveyor interviewed R35 and observed medications in R35's room. Surveyor noted the following medications on a table at the end of R35's bed in view from the door into the hallway: ~ An unopened earwax removal kit ~ An unopened container of simethicone 250 milligrams (mg) (for gas relief)~ An unopened container of Soothe XP eye drops On 5/11/26 at 8:07 PM, Surveyor interviewed R35 who indicated R35 needed the medications. R35 indicated R35 asked family to bring the medications a while ago because R35 was embarrassed about having gas during cares and want to prevented it if possible. R35 indicated R35 needs the eye drops for cataracts and R35 sometimes gets earwax build up that staff won't clean. On 5/11/26, Surveyor reviewed R35's medical record which indicated R35 was admitted to the facility on [DATE]. R35 had diagnoses including congestive heart failure, chronic kidney disease, type 2 diabetes, and peripheral vascular disease. R35's MDS assessment, dated 3/31/26, stated R35 had a BIMS score of 13 out of 15, indicating intact cognition. R35's MAR did not contain physician orders for the earwax removal kit or Soothe XP eye drops. R35 had an order for simethicone oral tablet 80 mg, give one tablet by mouth as needed (PRN) for gastroesophageal reflux disease (GERD) (start date 1/2/26). Surveyor noted the order contained a different strength than the 250 mg tablets observed in R35's room. R35 did not have orders for bedside medications or self-administration of medication. R35's medical record did not contain a self-administration of medication assessment. R35's care plan did not include bedside medications or self-administration of medication. On 5/12/26 at 12:42 PM, Surveyor observed the simethicone tablets, earwax removal kit, and Soothe XP eye drops in R35's room. The medications were visible from the hallway. On 5/13/26 at 8:28 AM, Surveyor observed the simethicone tablets, earwax removal kit, and Soothe XP eye drops in R35's room. The medications were visible from the hallway. On 5/14/26 at 9:10 AM, Surveyor observed the simethicone tablets, earwax removal kit, and Soothe XP eye drops in R35's room. The medications were visible from the hallway. On 5/14/26 at 9:20 AM, Surveyor interviewed RN-Z who indicated residents should not have medications in their rooms. RN-Z indicated if medications are found in a resident's room, staff should remove the medication and check if the resident has orders. If not, staff should call the physician to obtain an order. On 5/14/26, Surveyor requested R35's self-administration of medication assessment. On 5/14/26 at 8:50 AM, NHA-A indicated a self-administration of medication assessment for R35 had not been done. NHA-A indicated there should be a physician's order for all medications and an order for all bedside medications. NHA-A indicated a self-administration of medication assessment should be completed for all residents who have bedside medications. NHA-A indicated bedside medications and self-administration of medication should be a part of a resident's care plan if applicable. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**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 it served food at a safe and palatable temperature for 2 residents (R) (R72 and R37) of 2 sampled residents.On 5/12/26, R72 and R37 were served hot food that was below the recommended temperature of 135 degrees Fahrenheit (F) and cold food that was above the recommended temperature of 41 degrees F.Findings include: The facility's Record of Food Temperatures policy indicates: Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food means food that requires time/temperature control for safety to limit the growth of pathogens such as bacterial or viral organisms capable of causing disease .Food temperatures will be checked on all items prepared in the dietary department. 2. Hot foods will be held at 135 degrees Fahrenheit (F) or greater .4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees F .8. If the food temperature falls into an unsafe range, immediately follow procedures for reheating previously cooked food. 9. Potentially hazardous food that is cooked and cooled must be reheated so all parts of the food reach an internal temperature of 165 degrees F for at least 15 seconds before holding for hot service .11. No food will be served that does not meet the Food Code standard temperatures.1. From 5/11/26 through 5/13/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] with diagnoses that included nondisplaced fracture of the right humerus, diabetes, and chronic kidney disease. R72's Minimum Data Set (MDS) assessment, dated 4/6/26, stated R72 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition.On 5/11/26 at 7:49 PM Surveyor interviewed R72 who indicated food was not cooked right, didn't taste the way it should, and was always cold. R72 indicated R72 usually just eats the cold food but it is not appetizing. R72 expressed displeasure and indicated R72 received food R72 did not want. R72 indicated R72 recently did not want what was on R72's meal tray and asked for a hot dog, however, the kitchen sent the same thing that was on R72's tray. A Certified Nursing Assistant (CNA) eventually got R72 a hot dog. On 5/12/26 at 12:47 PM, Surveyor observed Dietary Aide (DA)-L prepare room trays for the lunch meal. DA-L prepared R72's tray and obtained temperatures of the food. The pork fried rice was 130 degrees F, the egg roll was 134 degrees F, and the Jell-O was 43 degrees F. The food did not meet the Food Code standard temperatures for hot or cold food.2. From 5/11/26 through 5/13/26, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] with diagnoses that included fracture around internal prosthetic left knee joint, fracture of left femur, and anemia. R37's MDS assessment, dated 4/19/26, had a BIMS score of 14 out of 15, indicating intact cognition.On 5/11/26 at 8:44 PM, Surveyor interviewed R37 who stated food ran the gauntlet from being horrid to very good. R37 stated food was served in Styrofoam cups on 5/10/26 (Mother's Day), including soup, stale crackers, and iceberg lettuce. R37 indicated there was no protein and the meal was sparse. R37 stated R37 kept extra food in R37's room in case the food was not palatable.On 5/12/26 at 12:47 PM, Surveyor observed DA-L prepare room trays for the lunch meal. DA-L prepared R37's tray and obtained temperatures of the food. The pork fried rice was 125 degrees F, the egg roll was 128 degrees F, and the Jell-O was 48 degrees F. (Of note: R37's tray was the last to be prepared and the last to be placed in the food cart for delivery to residents on the East wing.) R37's food was not reheated or cooled to the proper temperature prior to being placed in the cart and did not meet the Food Code standard temperatures for hot or cold food.On 5/12/26 at 12:49 PM, Surveyor interviewed DA-L and asked what food holding temperatures should be and the procedure for if food is not at the proper temperature. DA-L indicated hot foods should be 135 degrees F and cold foods should be under 50 degrees F. If the food is not at the correct temperature, dietary staff should call the kitchen and notify the cook. Surveyor observed DA-L put R37's hot food (which was below 135 degrees F) and R37's cold food (which was above 41 degrees F) on the tray without contacting the cook.On 5/12/26 at 12:56 PM, Surveyor requested a sample tray from DA-L after R37's food was plated and placed in (continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the cart. DA-L was only able to give Surveyor an eggroll since there was only enough food made to feed the residents. The eggroll looked and tasted good, but was lukewarm. On 5/12/26 at 1:01 PM, Surveyor interviewed R37 who indicated R37 did not yet receive a lunch tray.On 5/12/26 at 1:06 PM, Surveyor interviewed and observed CNA-N who indicated kitchen staff usually prepare food and put it in the delivery cart. CNA-N indicated CNA-N donned a gown and gloves to deliver R37's tray but removed the PPE since CNA-N did not have a mask. (Of note: R37 was on enhanced barrier precautions (EBP) for wounds and PPE was not required to deliver a tray.) CNA-N left R37's tray on the food cart and left the cart door open.On 5/12/26 at 1:15 PM, Surveyor observed CNA-O deliver R37's tray. The food cart door was left open while trays were being delivered. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>Based on staff interview and record review, the facility did not implement their antibiotic stewardship program to ensure the accurate use of antibiotics for 2 residents (R) (R59 and R6) of 8 sampled residents.R59's medical record indicated R59 had urinary tract infections (UTIs) in April and May 2026 and was treated with antibiotic therapy. R59's UTIs were not included on the facility's infection surveillance line list, including criteria for antibiotic therapy. R6's medical record indicated R6 was started on antibiotic therapy for a UTI in May 2026 without completed criteria that indicated R6 had a UTI.Findings include:<br><br>The facility's Infection Prevention and Control Program, revised 3/26, indicates: This facility maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infection .The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigation of exposures of infectious diseases .An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program .Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. C. The infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program .<br><br>The facility's Antibiotic Stewardship Program, revised 1/2026, indicates: It is the policy of this facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use .The antibiotic stewardship program leaders uses existing resources to support antibiotic stewards' efforts by working the following partners: Infection Preventionist uses expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation, and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resident resistant organisms .4. The program includes antibiotic use protocols and a system to monitor antibiotic use .Antibiotic use shall be measured by monthly prevalence, antibiotic starts, and/or antibiotic days of therapy .<br><br>1. On 5/11/26, Surveyor reviewed R59's medical record. R59 had diagnoses including dementia with behavioral disturbance, chronic kidney disease stage 4, type 2 diabetes mellitus, and UTI (dated 4/9/26) with antibiotic treatment of Macrobid 100 milligrams (mg) twice daily, changed to Bactrim SS (sulfamethoxazole-trimethoprim 400/80 mg) 1 tablet by mouth twice daily for five days. R59 also had a UTI on 5/8/26 with antibiotic treatment of Macrobid 100 mg for seven days. R59's Minimum Data Set (MDS) assessment, dated 5/8/26, stated R59 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. R59 had an activated power of attorney (POA) for healthcare decisions.<br><br>On 5/13/26, Surveyor reviewed the facility's infection control surveillance line lists. Surveyor noted R59's UTIs in April and May 2026 were not documented on the infection surveillance line lists, including documentation of the culture, the antibiotic prescribed, the length of the antibiotic, and infection criteria as to wheter R59 met the criteria for antibiotic therapy.<br><br>On 5/14/26 at 11:49 AM, Surveyor interviewed Infection Preventionist (IP)-H who indicated R59 was<br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | diagnosed with a UTI in April and May 2026 and diagnosed and treated for conjunctivitis in April 2026. IP-H confirmed R59 received antibiotic therapy for a UTI in April and May 2026. IP-H indicated the facility follows the McGeer criteria for infections and documents the criteria is met through an assessment in the resident's medical record. IP-H verified R59's prescribed antibiotics for a UTI and conjunctivitis in April and a UTI in May were not on the infection surveillance line list. IP-H verified R59's antibiotics were not documented with the appropriate data for antibiotic stewardship and assessments were not completed for the UTIs and conjunctivitis infections in April and May. IP-H indicated the infections, criteria, and antibiotics were not documented or monitored in accordance with the facility's policies and procedures and were missed.<br><br>2. On 5/14/26, Surveyor reviewed R6's medical record. R6 had diagnoses including UTI and vascular dementia. R6's MDS assessment, dated 4/2/26, had a BIMS score of 8 out of 15, indicating moderately impaired cognition.<br><br>Surveyor reviewed the facility's antibiotic stewardship documentation and noted R6 was started on antibiotic therapy for a UTI on 5/5/26. The antibiotic stewardship documentation to did not indicate R6 met the criteria for a UTI that should be treated with an antibiotic.<br><br>On 5/14/26 at 1:19 PM, Surveyor interviewed IP-H who indicated documentation of criteria for a UTI should have been completed. IP-H indicated if R6 had not met the criteria for antibiotic treatment, the physician should have been updated to stop any unnecessary antibiotic therapy. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure influenza and pneumococcal vaccines were administered for 1 resident (R) (R10) of 5 sampled residents.R10 signed consent for influenza and pneumococcal vaccines on 2/24/26. R10 did not receive the vaccines.Findings include:The facility's Influenza Vaccination policy, revised 1/19/26, indicates: Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refused to receive the vaccine .Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record or the staff's medical file.The facility's Pneumococcal Vaccine policy, revised 1/2026, indicates: Each resident will be offered a pneumococcal immunization .A consent form shall be signed prior to administration of the vaccine and filed in the individual's medical record.On 5/14/26, Surveyor reviewed R10's medical record. R10 had a diagnosis of dementia. R10's Minimum Data Set (MDS) assessment, dated 2/7/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severely impaired cognition.R10's medical record contained an influenza and pneumococcal vaccine form, signed on 2/4/26, that indicated R10 consented to up-to-date influenza and pneumococcal vaccines. R10's vaccination record did not indicate R10 received the vaccines on or after 2/4/26. R10's immunization record indicated R10 was due for influenza and pneumococcal vaccines.On 5/14/26 at 10:12 AM, Infection Preventionist (IP)-H acknowledged the influenza and pneumococcal vaccination form signed on 2/4/26 indicated R10 consented to both vaccines. IP-H did [NAME] have documentation to indicate either vaccine was administered to R10.On 5/14/26 at 10:25 AM, Surveyor interviewed Regional Nurse Manager (RNM)-W who indicated since consent for influenza and pneumococcal vaccines was signed on 2/4/26, R10 should have received both vaccines. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not screen, educate, or offer the COVID-19 vaccination to 3 residents (R) (R10, R59, and R7) of 5 sampled residents.R10's COVID-19 vaccination form signed on 6/13/25 was incomplete. The form did not indicate whether R10 consented to or declined the vaccination. R10's medical record did not indicate whether or not a COVID-19 vaccine was provided.R59's medical record did not indicate R59 was offered or declined a COVID-19 vaccination since admission on [DATE].R7's medical record did not indicate R7 was offered or declined a COVID-19 vaccination since admission on [DATE].Findings include:The facility's Infection Prevention and Control Program, revised 3/2026, indicates: Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility. The resident's medical record includes documentation that indicates, at a minimum, the following: i. The resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; and ii. Each dose of COVID-19 vaccine administered to the resident, or iii. If the resident did not receive the COVID-19 vaccine due to medication contraindications or refusal.1. On 5/14/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had a diagnosis of dementia. R10's Minimum Data Set (MDS) assessment, dated 2/7/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severely impaired cognition.Surveyor reviewed a signed COVID-19 form, dated 6/13/25, that didn't indicate whether R10 accepted or declined the vaccine. Acceptance or refusal of the vaccine was not documented in R10's medical record.On 5/14/26 at 10:12 AM, Surveyor interviewed Infection Preventionist (IP)-H who indicated there appeared to be an x by decline but could not be certain. IP-H reviewed R10's medical record and verified there were no progress notes or documentation to indicate R10 had accepted or declined the COVID-19 vaccine.On 5/14/26 at 10:18 AM, Surveyor interviewed Regional Nurse Manager (RNM)-W who indicated R10's COVID-19 form was signed on 6/13/25 but did not indicate whether R10 accepted or declined the vaccine. RNM-W reviewed R10's medical record and verified there was no documentation to indicate the vaccine was administered. RNM-W indicated if a resident signs consent for a vaccine, the resident should receive the vaccine.2. On 5/14/26, Surveyor reviewed R59's medical record. R59 was admitted to the facility on [DATE] and had diagnoses of heart failure and diabetes. R59's MDS assessment, dated 5/8/26, stated R59 had a BIMS score of 5 out of 15, indicating severely impaired cognition.On 5/14/26, Surveyor reviewed R59's medical record which did not contain documentation to indicate R59 was screened, educated, or offered a COVID-19 vaccine.On 5/14/26 at 10:25 AM, Surveyor interviewed RNM-W who verified R59's medical record did not contain a signed consent or declination for the COVID-19 vaccine. RNM-W stated the facility's practice is to offer the COVID-19 vaccine.On 5/14/26 at 10:27 AM, Surveyor interviewed IP-H who indicated staff should offer the COVID-19 vaccine upon admission and annually.3. On 5/14/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of diabetes. R7's MDS assessment, dated 2/24/26, had a BIMS score of 5 out of 15, indicating severely impaired cognition.On 5/14/26, Surveyor reviewed R7's medical record which did not contain documentation to indicate R59 was screened, educated, or offered a COVID-19 vaccine.On 5/14/26 at 10:29 AM, Surveyor interviewed RNM-W who confirmed R7's medical record did not indicate R7 received a COVID-19 vaccine.On 5/14/26 at 10:30 AM, Surveyor interviewed IP-H who confirmed R7's medical record did not indicate an up-to-date COVID-19 vaccine was offered. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation and staff interview, the facility did not ensure nurse staffing was posted daily. This practice had the potential to affect all 71 residents residing in the facility.The facility did not post nurse staffing on 5/12/26 or 5/14/26.Findings include:Division of Quality Assurance (DQA) memo 12-020 Clarification Concerning Posting Requirements for Nurse Staffing indicates: .Nursing homes must post information about the number of staff directly responsible for resident care on each shift. This information must be posted in a prominent place, readily accessible to residents and visitors at the start of each shift .The information that is posted must include the following: .3. The total number of staff directly responsible for resident care per shift for each of the following categories: licensed (Registered Nurses (RNs), Licensed Practical Nurses (LPNs)), and unlicensed (Certified Nursing Assistants (CNAs)). (For example, 1 RN, 2 LPNs, 4.5 CNAs.) The number of RNs must be separate from the number of LPNs. 4. The actual hours worked per shift for each of the following categories: licensed (RNs, LPNs), and unlicensed (CNAs). 5. Resident census .Information is to be posted daily and must be present at the start of each shift. Nursing homes can choose to post staffing information for the entire day or for the current shift .Upon entrance to the facility on 5/12/26 and throughout the day, Surveyor did not observe a nurse staffing posting.On 5/13/26 during an environmental tour of the third floor at 10:19 AM, the fourth floor at 10:22 AM, and the ground floor at 12:47 PM, Surveyor did not observe a nurse staffing posting.On 5/13/26 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified nurse staffing was not posted. NHA-A indicated nurse staffing should be posted and visible to staff, residents, and visitors.On 5/13/26 at approximately 1:30 PM, Surveyor observed a nurse staffing posting on the ground floor.On 5/14/26 during an environmental tour of the third floor at 10:45 AM, the fourth floor at 10:48 AM, and the ground floor at 10:51 AM, Surveyor did not observe a nurse staffing posting. |