

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Oregon Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Monroe, Oregon, MO 64473	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse when Resident #1 entered Resident #2's room and kicked Resident #2 in the shin resulting in pain and redness for Resident #1. The deficient practice affect one of four sampled residents. The facility census was 41.</p> <p>On 1/28/25, the Administrator was notified of the past noncompliance situation which occurred on 1/28/25. On 1/28/25, facility administration was notified of the incident, an investigation immediately began and corrective actions were implemented. The noncompliance was corrected on 1/30/25.</p> <p>Review of the facility's policy titled, Abuse and Neglect, revised 9/24, showed:</p> <ul style="list-style-type: none"> - It is the policy of this facility to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person; - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; - Physical Abuse: Physical action within the definition of abuse, including, but not limited to, hitting, slapping, pinching, and kicking; - The home's administration will prohibit neglect, verbal, mental or physical abuse. <p>Review of the facility's policy titled, Abuse and Neglect Procedure, revised 9/24, showed:</p> <ul style="list-style-type: none"> - All new employees will receive in-service training pertaining to all aspects of abuse prohibition before working a shift; - All current employees will receive in-service training pertaining to all aspects of abuse prohibition at least annually; - Training will include: identification of potential victims of abuse or neglect, appropriate interventions to deal with aggressive and stubborn residents; <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Administrative and licensed staff will be aware of potential situations of abuse during rounds and contact with staff, residents, and resident family members; - Protection: All residents will be immediately protected from harm, if another resident is the alleged perpetrator they shall immediately be assessed for treatment options; <p>1. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/15/24, showed:</p> <ul style="list-style-type: none"> - Resident has the diagnosis of hypertension (high blood pressure), diabetes (chronic disease when body can't produce insulin), thyroid disorder (a condition where the thyroid gland produces an abnormal amount of thyroid hormones), dementia (decline in cognitive abilities); - Resident scored seven on the BIMS (Brief Interview for Mental Status). This score indicates severe cognitive impairment; <p>Review of Resident #1s comprehensive care plan, dated 10/22/24 showed:</p> <ul style="list-style-type: none"> - Resident has an ADL self-care performance deficit due to dementia and limited mobility; - Resident uses a wheelchair for mobility and walker; - Resident is an elopement risk/wanderer and wanders aimlessly. Staff are to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books; - Resident has potential to be physically aggressive due to dementia (revised 1/29/25); - Staff monitor/document/report as needed any incident of resident posing danger to self and others; (revised 1/28/25); - Staff anticipate and meet the resident's needs; - Resident uses psychotropic medications for dementia, staff monitor/record occurrence of behavior symptoms (wandering, violence/aggression towards staff/others). <p>Record review of Resident #1s progress notes showed:</p> <ul style="list-style-type: none"> - 1/13/25 resident had behaviors of yelling out for their family member; - 1/22/25 resident had behaviors of yelling for staff for assistance; - 1/25/25 resident had behaviors of yelling; <p>Review of Resident #2s comprehensive care plan, dated 11/13/24 showed:</p> <ul style="list-style-type: none"> - Resident is able to voice their concerns and their memory is good; <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Resident is at risk for impaired skin integrity. <p>Review of Resident #2's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> - Resident has the diagnosis of hypertension, coronary artery disease (condition in which the arteries that supply blood to the heart become narrowed or blocked), heart failure (heart cannot pump enough blood to meet the body's needs), renal insufficiency, depression; - Resident is cognitively intact. <p>Review of the facility investigation, undated, showed events on 1/28/25:</p> <ul style="list-style-type: none"> - Resident #2 reports that Resident #1 wheeled into his/her room and yelled at Resident #2 to leave the room; - Resident #1 then wheeled up to Resident #2 and kicked him/her in the shin; - Resident #2 stated that staff arrived and removed Resident #1 from the room; - Resident #2 had a reddened area to the shin and ice was applied by the nursing staff; - Nurse Aide (NA) A heard Resident #2 yelling and went immediately to intervene and remove Resident #1 from Resident #2's room; - Director of Nursing (DON) was immediately notified; - The kick was not witnessed by staff or any other residents; - Resident #1 could not remember the incident when asked about it after being removed from the room; - Interventions put in place: Stop sign barrier across the front of resident #2's doorway entrance held in place by Velcro, resident #1 place on 30 minute checks to monitor for location and needs, primary care physician contacted and ordered Depakote (a medication to treat behaviors) for resident #1 due to aggressive behavior; - Resident #2 assessed each day with no bruising, redness or skin issues noted; - Director of Nursing (DON) reports Resident #1 has been acutely ill for the last several weeks with influenza, pneumonia, and hypoglycemia. Resident was in the hospital the prior week and had been given Haldol (a strong medication typically used to treat behaviors. Upon readmission he/she demonstrated increased behaviors, such as yelling for help, exit seeking and falls. He/She has slowly been improving; - The investigation did not include dates. <p>Review of in-service education, dated 1/30/25, showed staff were educated on Abuse and Neglect policy and reporting and Resident to resident altercations.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/6/25 at 10:00 A.M., the Resident #2 said:</p> <ul style="list-style-type: none"> - Resident #1 entered his/her room and immediately yelled at him/her to leave. Resident #2, while in their wheelchair kicked Resident #1 in the shin and left the room with the help of staff. Resident #1 never said anything during the altercation; - The injury he/she received from Resident #1 hurt after that first day of when it occurred and he/she experienced pain; <p>During an interview on 2/6/25 at 10:15 AM., Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> - He/She was present at the time of the incident and had spoken to Resident #1 after they were removed from Resident #2's room. Resident #1 could not recall the incident or kicking Resident #2 shortly after the incident; - Resident #2 said they were kicked in the shin and ice was applied to their leg as a precaution for swelling; - This type of behavior was uncharacteristic for Resident #1; - The Certified Nurses Aides (CNA)'s continue to complete 30 minute checks and the nurses continue hourly checks on Resident #1; - He/She has received staff education about abuse numerous times with the latest occurrence being 1/20/25; <p>During an interview on 2/6/25 at 11:30 A.M., the Administrator said:</p> <ul style="list-style-type: none"> -Although the incident was not witnessed by staff, the resident reported he/she had been kicked by a resident so the facility staff continued with the investigation and treated this incident as abuse. - On 1/28/25 physical assessment confirmed that there was redness on the residents shin; - On 1/28/25 she confirmed that interventions of 30 minute CNA checks were put in place for Resident #1, the primary physician had been contacted, an order obtained for Depakote for resident for behaviors and a stop sign barrier put in place for Resident #2's safety. - On 1/30/25 an in-service was conducted for all staff members regarding the Abuse and Neglect policy and reporting and resident to resident altercations. <p>MO248688</p>