STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265629	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Healthcare	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and policy review, the facility failed to protect a resident's right to be free of physical abuse for one of two residents (Resident (R)16) reviewed for abuse out of a total sample of 15. This failure increased the risk of abuse towards residents. The facility census was 44. As a result of an Informal Dispute Resolution on 12/31/24, the deficiency was changed to past noncompliance, which began on 11/17/24. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented. The deficiency was corrected on 11/17/24. Findings include: Review of the facility's policy titled, Abuse and Neglect, revised 09/2024, revealed, . It is the policy of this home 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 . Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 10/18/24 and located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment, no behaviors exhibited, and diagnoses of schizophrenia, flaccid hemiplegia affecting left nondominated side, and unspecified visual loss. Review of R16's Care Plan, revised 06/06/23 and located in the EMR under the Care Plan tab, revealed, . At times I will lash out verbally and/or physically towards my peers . An intervention included, . Anticipate the noise and crowds that may make me irritable or on edge. I have several triggers these include: 1. Not having a way out of a big group or a loud room. 2. Peers yelling at me. 3. Peers yelling at staff. 4. People blocking my way when I want to leave an area. If these triggers are not addressed as they occur, I may hit my peers or begin cursing at them . Review of R40's annual MDS, with an ARD date of 09/08/24 and located in the MDS tab of the EMR, revealed an admitted [DATE], a BIMS score of six out of 15, indicating severe cognitive impairment, no behaviors exhibited, and diagnoses Alzheimer's disease, depression, and heart failure. (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

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 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Oregon Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Monroe, Oregon, MO 64473	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R40's Care Plan, revised 11/19/24 and located in the EMR under the Care Plan tab, revealed, . The resident is/has potential to be physically aggressive r/t [related to] Dementia . An intervention included, . Encourage resident to sit in his normal spot in the dining room where he will not feel closed into an area . Review of R40's Incident Note, dated 11/17/24 and located in the EMR under the Progress Note tab, revealed, . This nurse walked into dining room this morning at 0720 and noted staff started to move towards table resident was standing by. Resident was standing in front of other resident yelling and swung right hand back and punched the other resident in the left side of temple(face) making his sunglasses come off. Staff moved other resident's motorized wheelchair back and away from resident and this nurse moved to stand in front of resident when resident started to try and attempt to go up to other resident again. This nurse attempted to calm resident down and attempted to help him get back to his room but resident continued to raise his voice and threatened this nurse. This nurse observed resident walk down to his room and slam door. Ambulance and sherrif's [sic] office notified and resident sent to [hospital name] for evaluation. NOC [night] shift nurse called report to ER [emergency room] nurse [name] at 0825. Dr. [name] notified at 0840 . Review of the facility's investigation, dated 11/17/24, revealed, [R40] was sitting with his back to the wall at [R16]'s normal table in dining room. [R40]'s walker was sitting in [R16]'s normal seat. R16 went to move his walker and R40 began to cuss and yell at R16 as he stood and grabbed walker. This caused [R40] to be standing in front of [R16]. [R40] raised his right hand and struck [R16] in his left eye. This caused his ([R16]'s) sunglasses to fall to the floor.' '[R16] had sunglasses on and this resulted in a pin point scratch to the side of his face by his left eye. Resident denies pain with palpation. No bruising or swelling noted. [R16] denied any medical intervention.' Residents immediately separated. [R40] sent to his room. Room monitored to make sure staff knew his location. Sheriff deputy called to ensure safety in case [R40] came out of room. [R40] sent to [hospital name and location] for evaluation. [R40] started an Antibiotic on 11/16/24 for a UTI [urinary tract infection]. He has had symptoms of delusional behaviors in the last few days. On 11/18/24 at 11:27 AM, R40 was sitting in a chair in his room with a walker next to him. He was asked about the care and services he received at the facility. R40 stated he had no complaints, and he liked living at the facility. R40 stated he had not experienced any abuse, and he got along with the other residents in the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 11:03 AM, the Administrator was asked where the facility was in their investigation. The Administrator confirmed the incident was reported timely within the two hours to the State Agency as required. The Administrator stated the incident occurred on 11/17/24 two days ago. The Administrator stated she was called on 11/17/24 about R40 hitting another resident. The Administrator stated staff immediately called Emergency Medical Services (EMS) and the police before she arrived. The Administrator stated staff separated R16 and R40 went voluntarily to his room to cool down. The Administrator stated R16 sustained a small scratch on his eye from the sunglasses he was wearing. The Administrator explained R40 was currently receiving an antibiotic for a urinary tract infection that may have impacted a change in his behavior. The Administrator stated that the police, and EMS were at the facility when the Administrator arrived and R40 was resting on his bed. The Administrator stated R40 reported the reason why he hit R16 was because R16 spoke profanities to him that were offensive but later admitted R16 did not say the profanities. The Administrator stated R40 agreed to go to the hospital. The Administrator stated R40 only stayed at the hospital for a few hours and was sent back to the facility. The Administrator stated when R40 returned, she asked him about his past, and R40 revealed some trauma he had experienced as a child and young adult. She stated R40 also admitted he was aware he had dementia, and his past goes through his head at times that cause him to become upset. The Administrator stated they discussed a plan to deal with these things when they happen and R40's seating was changed in the dining room. The Administrator stated the staff were educated on the new interventions that included R40 was to be seated in the dining room in an area that was open, and when R40 had a change in behavior, they were to ask him to stay in his room to gather himself and have the nurses talk with him so he can vocalize his feelings. The Administrator stated R40 started on an antidepressant 09/18/24, and R40 revealed with the medication came strange dreams. The Administrator stated R40's antidepressant was changed to another antidepressant, and he had received behavioral counseling weekly for the past year. The Administrator stated R40 was now being evaluated for post-traumatic stress disorder (PTSD) since this incident had revealed secrets to his past. She stated R40 had previous incidents that involved yelling and threatening other male residents but no physical contact, and staff continued to monitor him. On 11/19/24 at 12:12 PM, R40 was observed in the main dining room with an open space to walk. Another male resident accompanied R40 at the table, and no behavioral symptoms were exhibited. On 11/19/24 at 12:19 PM, R16 was awake in bed watching television. R16 was asked about the incident in the dining room on 11/17/24 involving R40. R16 stated he remembered his eye was hit and pointed to his left eye. R16 stated his eye did not hurt and he had no hard feelings towards R40. R16 stated he understands everyone has a bad day. No bruise or skin tear was observed on R16's left eye. During an interview on 11/20/24 at 3:16 PM, Certified Nurse Aide (CNA)1 stated she was at the facility working the day R16 moved R40's walker in the dining room and R40 hit R16. CNA1 stated R40 had never hit another resident in the one year she has worked at the facility. CNA1 confirmed she had received an in-service at the facility recently on abuse. During an interview on 11/20/24 at 4:02 PM, Licensed Practical Nurse (LPN)1 was asked if the facility had a plan to prevent a recurrence between R16 and R40. LPN1 stated staff do not have the residents sit by each other. LPN1 stated the staff conduct an ongoing assessment of both residents for agitation/mood. LPN1 stated R40 had felt trapped in the dining room on 11/17/24, and they now make sure R40 has space and does not feel trapped. LPN1 stated the incident on 11/17/24 was not R40's normal behavior. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00245291

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on observation, interview, and record review, the facility failed to 1.) ensure staff was knowledgeable of the proper usage of insulin pens for one of one resident (Resident (R) 20) who received insulin through an insulin pen. This failure had the potential to cause R20 to receive an incorrect dose of insulin, and 2.) failed to ensure physician orders recorded the volume of tube feeding formula to be provided for one of one resident (R41) reviewed for tube feedings out of a total sample of 15. This failure had the potential to cause unexpected weight changes and/or R41's nutritional needs to be unmet. The facility census was 44. Findings include: 1. Review of the Electronic Medical Record (EMR) for R20 under the Census tab revealed an admitted [DATE]. The EMR under the Diagnoses tab revealed diagnoses including diabetes. Review of the physician orders under the Orders tab in the EMR revealed a physician's order for Humalog insulin (a fast-acting insulin used to manage blood sugars levels in diabetic patients), six units. Review of the manufacturer's instructions for the Humalog insulin pen, provided by the facility, revealed that after the needle set is attached to the insulin pen, the administration dial is to be set to two units and activated to prime (remove the air from) the needle set with insulin prior to administering the ordered dose of insulin. Observation of Certified Medication Technician (CMT) 1 on 11/20/24 at 4:40 PM revealed CMT1 attached the needle set to the pen, set the administration dial to six units, and administered the insulin. She did not prime the needle set. Interview with CMT1 on 11/20/24 at 4:30 PM revealed CMT1 lacked knowledge of the need to prime the needle set to remove the air before administering the ordered dose of insulin to R20. An interview with the Director of Nursing (DON) on 11/20/24 at 4:30 PM revealed the lack of knowledge to prime the needle set, as directed by the manufacturer's instructions, prior to preparing and administering the physician's ordered dose of insulin to R20. 2. Review of the EMR for R41 under the Census tab revealed an admitted [DATE]. Review of the Diagnoses tab of the EMR revealed diagnoses including a stroke, swallowing disorder, and feeding tube (a tube placed through the wall of the abdomen into to stomach for supplemental feedings). Review of the EMR under Orders tab revealed an order for Isosource (a nutritionally complete tube feeding formula) three times during the night for nutritional support and weight loss prevention. The order did not record the volume of Isosource to be administered. Review of the Progress Notes tab of the EMR revealed that on 11/07/23, the consulting dietitian had requested the physician orders to be clarified to include the volume of Isosource to be administered with each feeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 11/19/24 at 3:07 PM confirmed the physician orders lacked the volume of Isosource to be administered. An interview with the Registered Dietitian (RD) on 11/20/24 at 10:28 AM confirmed the physician orders for R41 lacked the volume of the Isosource to be administered. The RD confirmed they had asked for clarification on subsequent resident assessments for the last year and in five written assessment notes.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 36190 Based on interview and record review, the facility failed to employ a qualified director of food and nutrition services. This deficient practice had the potential to affect 44 of 44 residents who received meals prepared in the facility's only kitchen. The facility census was 44. Findings include: Review of the list of the facility's Key Personnel provided by the facility revealed [Name of the Dietary Manager (DM)] as Dietary Manager. Review of the DM's Food Services Director Job Description, dated 07/01/23, revealed the education required for the position was, Certification as Dietary Manager- Association of Nutrition and Foodservice Professionals (ANFP). During an interview on 11/19/24 at 1:47 PM, the DM was asked if she was a Certified Dietary Manager (CDM) or qualified in another route. The DS stated, No, but she had been the dietary manager at the facility since July of 2023. The DM stated she had worked at the facility for ten years as a dietary aide. The DM stated she had planned to complete a dietary manager's course to become a CDM but had not taken a course study in food safety and management course yet. During an interview on 11/21/24 at 9:36 AM, the Registered Dietitian (RD) confirmed she was not full time. The RD stated she was on a consulting basis and was onsite monthly. The RD stated she was aware DM was not a qualified dietary manager. The RD stated she had recommended the DM to go through a course to become a CDM, and she would be her preceptor. The RD stated she had recommended the DM get her certification in a course in food safety and management; however, she was not sure if that had happened. The RD stated she conducted monthly oversite of the DM. During an interview on 11/21/24 at 12:19 PM, the Administrator confirmed the DM had not been in the management position for two years yet and had not completed a course that would provide the DM with the credentials she needed to meet the regulation.