

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Orchard Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 2841 Munding Drive Oregon, OH 43616	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, resident interview and review of facility policy the facility failed to honor resident choice for medication to be administered with pudding. This affected one resident (#45) of three residents reviewed for choices. The facility census was 117. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, and pneumonia. Review of the medical record for Resident #45 revealed she was admitted to the rehabilitation unit and then had a room change on 03/13/25 to the long term care unit. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #45 revealed she was cognitively intact. Interview on 03/17/25 at 10:47 A.M. with Resident #45 stated she has difficulty swallowing medications and needs pudding to get her medication down. Resident #45 further stated she was originally on the rehabilitation unit and did not have any problems with getting pudding with her medication as requested. Resident #45 stated when she moved to the long-term care unit, she no longer gets pudding with her medications, even when she requests pudding. Resident #45 further stated the nurses on the long-term care unit only give applesauce with her medications and she has trouble swallowing the pills because the applesauce goes down before the pills. Interview on 03/19/25 at 7:46 A.M. with Licensed Practical Nurse (LPN) #537 stated pudding is readily available for medication administration, adding, pudding is available in the kitchen and the nurses just go and get it. Observation on 03/19/25 at 9:24 A.M. of the medication cart LPN #660 was administering medication from revealed no pudding on top of the medication cart and during observation of medication storage revealed no pudding inside the medication cart. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 9:24 A.M. with LPN #660 stated she was asked by Resident #45 for pudding with her morning medications. LPN #660 stated she told Resident #45 she only had applesauce and if the resident wanted pudding LPN #660 would have to go to the kitchen to get the pudding therefore Resident #45 would have to wait for her medications. LPN #660 further stated she was aware Resident #45 preferred taking her medication with pudding and did not offer a reason for not having pudding readily available for Resident #45's morning medication administration. Interview on 03/19/25 at 11:18 A.M. with Registered Nurse (RN) #667 stated she cared for Resident #45 while she resided on the rehabilitation unit and recalled she preferred to take her medication whole in pudding. RN #667 stated we have a section on our report sheets that identify the preferred way a resident takes their medication. Interview on 03/19/25 at 11:22 A.M. with Resident #45 stated she requested her medication this morning be placed in pudding and was told by the nurse that she only had applesauce. Resident #45 stated applesauce does not work for her, but that she took the pills whole and hoped they would go down. Resident #45 further stated she is planning to buy her own pudding to keep in her room so she does not have to keep asking for pudding with her medication only to be told no. Interview on 03/19/25 at 5:17 P.M. with LPN #518 stated when a resident is admitted to her unit she inquires about the way the resident prefers to take their medication and the preferred method is put on the nursing report sheet to ensure the nurses will pass medications according to a resident's preferred method. Review of the facility policy titles Medication Administration - General Guidelines, dated November 2021 stated the facility should determine the most appropriate method for administering medications which considers each resident's safety, needs, medication schedule, preferences and functional ability. Review of the facility policy titled Federal and Ohio Residents Rights and Facility Responsibilities, dated 10/19 revealed residents have the right to a dignified existence. A facility must treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and facility policy the facility failed to ensure residents protected health information was kept confidential. This affected 12 residents (#43, #52, #323, #421, #422, #423, #425, #427, #428, #429, #430, and #431) reviewed for protected health information. The facility census was 117. Findings include: 1. Observation on 03/19/25 at 8:35 A.M. revealed Registered Nurse (RN) #593 was at the medication cart in the hallway and she walked away from her medication cart with the computer screen open and visible. Concurrent observation revealed Resident #52's information for medication administration was displayed on the computer screen. During the observation Resident #101 was seated in her wheelchair next to the medication cart. Interview on 03/19/25 at 8:38 A.M. with RN #593 verified she left her medication cart computer open and visible. 51529 2. Observation on 03/17/25 at 2:02 P.M. of the medication cart located at C wing nurses station revealed a paper report sheet face up with residents' (#323, #425, #427, #428, #429, #430, and #431) full names corresponding room numbers, and a list of issues and needs. Subsequent interview with Registered Nurse (RN) #621 confirmed this observation and she stated she usually turns the paper over when she walks away from the medication cart. 3. Observation on 03/18/25 at 7:44 A.M. of the medication cart located outside room [ROOM NUMBER] revealed a paper report sheet face up with residents' (#43, #421, #422, and #423) full names corresponding room numbers, and a list of issues and needs. Subsequent interview with Licensed Practical Nurse (LPN) #624 confirmed this observation. Review of facility policy titled Documentation for Security and Privacy Compliance dated 01/06/25 stated documents would be maintained in accordance with the Health Insurance Portability and Accountability Act Privacy and Security Rule. This deficiency represents non-compliance investigated under Complaint Number OH00161938.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure residents received adequate tube feeding (liquid nutrition through a feeding tube) to maintain weight. This affected one (#16) of two residents reviewed for enteral nutrition (tube feeding). The facility identified four additional residents (#51, #98, #116, and #322) received tube feedings (TF). The facility census was 117. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus, and gastrostomy status. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had impaired cognition and was dependent on staff for nutrition. Further review revealed she received nutrition and hydration via tube feeding. Additionally, Resident #16 had a significant weight loss and was not on a prescribed weight-loss regimen. Review of the weight history for Resident #16 revealed a current weight obtained 03/15/25 of 161.2 pounds with a basal metabolic index (BMI) of 32.6, indicating she was overweight. Further review revealed a weight obtained 02/13/25 of 172.8 pounds, reflecting a significant weight loss of 6.7% over 30 days. Additionally, Resident #16's weight on 12/19/24 was 176.5 pounds, reflecting a significant weight loss of 8.7% over 90 days. Further, Resident #16's weight on 09/13/24 was 182.9 pounds, reflecting a significant weight loss of 11.8% over 180 days. Review of the weight history for Resident #16 revealed her weight was in the 180-pound range from September 2024 through December 2024. Further review revealed Resident #16's weight declined from 184.8 pounds (12/02/24) to 176.5 pounds (12/19/24), and remained in the 170-pound range through 02/13/25 (172.8 pounds). Continued review revealed Resident #16's weight continued to decrease from 168.6 pounds (2/20/25) to 167.6 pounds (03/06/25), and finally to 161.2 pounds (03/15/25). Review of the Nutrition Assessment completed 12/20/24 revealed Resident #16 was readmitted from the hospital at 177.8 pounds. A recommendation was provided to provide tube feeding (TF) Glucerna 1.2 at 65 ml per hour to meet Resident #16's estimated nutrition needs. Review of the physician order initiated 12/20/24 revealed Resident #16 received Glucerna 1.2 at 65 ml per hour until the order discontinued on 01/13/25. Review of the Nutrition Assessment completed 01/13/25 revealed Resident #16 was receiving Glucerna 1.2 at 65 ml per hour and had two incidents of emesis (vomiting). A recommendation was provided to decrease the TF rate to 50 ml per hour to help decrease the potential for emesis. Review of the physician order initiated 01/13/25 revealed Resident #16 received Glucerna 1.2 at 50 ml per hour. Review of a nutrition progress note dated 02/03/25 revealed Resident #16 was having periods of nausea and vomiting and the symptoms were potentially caused by a recent antibiotic. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Nutrition Assessment completed 02/14/25 revealed Resident #16 had a weight loss of 7.8% over 90 days and 17.5% over 180 days. Further review revealed Resident #16 received Glucerna 1.2 at 50 ml per hour at the time of the assessment and a recommendation was made to increase the TF rate to 65 ml per hour. Review of the current physician order initiated 02/12/25 revealed Resident #16 received Glucerna 1.2 at 50 ml per hour. Review of a nurses progress note dated 3/16/2025 and timed 10:50 P.M. revealed Resident #16 had no further emesis since 8:30 P.M. and the TF was restarted. Interview on 03/18/25 at 10:47 A.M. with Licensed Practical Nurse (LPN) #651 revealed she had just provided care to Resident #16 who vomited at the conclusion of the care. LPN #651 was not aware of previous incidents with Resident #16 vomiting. Interview on 03/18/25 at 11:56 A.M. with LPN #624 revealed she was familiar with Resident #16 and was aware she had emesis that morning and was also aware Resident #16 had emesis the previous Sunday (03/16/25). LPN #624 was not aware of additional incidents of Resident #16 vomiting. Interview on 03/19/25 at 9:20 A.M. with Dietetic Technician, Registered (DTR) #597 revealed she worked in the facility five days per week and monitored Resident #16's weights and TF in coordination with an offsite Registered Dietitian and an onsite Nurse Practitioner (NP). DTR #597 stated she was aware Resident #16 vomited and stated she and the NP determined the cause was likely due to infections and did not believe the vomiting was due to the TF formula. Further interview confirmed the staff decreased the TF rate in response to Resident #16's emesis. Additionally, DTR #597 stated she had not considered providing a more concentrated TF formula (to provide more nutrition in less volume) nor had she discussed the possibility of providing a medication to encourage digestion. Follow-up interview on 03/19/25 at 2:21 P.M. with DTR #597 confirmed Resident #16's TF rate was decreased in January because she was not tolerating it. Additionally, DTR #597 stated she spoke with the NP after the previous interview and learned there was a contraindication with providing a medication to Resident #16 to improve digestion. Interview on 03/19/25 at 2:25 P.M. with DTR #597 and NP #700 revealed they were aware of Resident #16's weight loss and emesis and continued to monitor Resident #16's tolerance to the TF. NP #700 stated there was no concern Resident #16 could not tolerate the TF, she felt Resident #16's intolerance was more likely attributed to infections and receiving antibiotics. Further interview revealed the interventions they implemented to offset the weight loss was administering Zofran (an anti-nausea medication) to offset the nausea and vomiting. NP #700 stated the Zofran was not scheduled routinely but was provided on an as-needed basis. Further interview confirmed Resident #16 lost 23 pounds in the last three months, and NP #700 confirmed the TF rate remained at 50 ml per hour (less than the desired rate of 65 ml per hour) to offset the nausea and vomiting. Continued interview with DTR #597 and NP #700 confirmed the facility did not attempt a more concentrated formula to provide more nutrition in less volume, and did not try a different way to administer the TF, such as bolus feedings (feeding a specific TF amount at one time, and letting the stomach digest it) rather than continuous TF. Further, DTR #597 confirmed Resident #16 was not receiving additional calories or protein from any supplements. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Follow-up interview on 03/20/25 at approximately 10:00 A.M. with DTR #597 confirmed the TF rate was 50 ml per hour and there was no plan to increase the rate, to meet Resident #16's estimated nutrition needs, while they monitored Resident #16's tolerance to the lower rate. Telephone interview on 03/20/25 at 1:06 P.M. with Resident #16's family member revealed the family member had concerns regarding Resident #16's intolerance of the TF. Resident #16's family member stated Resident #16 could not tolerate the TF at the higher rate at the hospital or at the facility. Review of the policy Weight Monitoring, reviewed 01/06/25, revealed the purpose was to monitor weight changes and ensure adequate provision of nutrition for all residents. Additionally, the Dietitian/Dietetic Technician will evaluate weights and will initiate appropriate interventions as indicated.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on medical record review, observation, staff interview, and review of facility policies the facility failed to ensure oxygen was administered as ordered. This affected two (Residents #50 and #29) of four residents reviewed for oxygen use. The facility identified 32 residents who were prescribed oxygen. The facility census was 117. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia (low oxygen level) and hypercapnia (elevated carbon dioxide level), chronic obstructive pulmonary disease, emphysema, obstructive sleep apnea, and chronic heart failure. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 required moderate assistance with toileting, showering, footwear, personal hygiene, transferring and the resident required supplemental oxygen via continuous positive airway pressure (CPAP) machine. Review of the medical record for Resident #50 revealed a provider order dated 03/12/25 for the use of a CPAP machine with three liters of oxygen while sleeping. Additionally, there was a provider order dated 01/10/25 for continuous oxygen via nasal cannula at three liters. Observation on 03/17/25 at 2:38 P.M. of Resident #50's oxygen tank on her motorized wheelchair revealed the oxygen tank was empty. Subsequent interview with Registered Nurse #621 confirmed the oxygen tank was empty. 47057 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, and dependence on supplemental oxygen. Review of the current physician orders from 03/25 for Resident #29 revealed oxygen at two liters per minute per nasal cannula (nc). Review of the quarterly MDS assessment dated [DATE] for Resident #29 revealed he had mild cognitive impairment and required the use of oxygen. Observation on 03/17/25 at 9:29 A.M. of Resident #29 revealed he was wearing his oxygen and it was running at three and half liters per minute. Observation on 03/18/25 at 10:57 A.M. of Resident #29 revealed he was wearing his oxygen and it was running at three and half liters per minute. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/25 at 11:00 A.M. with Licensed Practical Nurse (LPN) #686 verified the oxygen order for Resident #29 stated oxygen was to administered at two liters per minute and further verified the oxygen for Resident #29 was running at three and half liters per minute. Review of facility policy titled Medication Administration - General Guidelines dated November 2021 indicated medications would be administered as prescribed. Review of facility policy titled Oxygen Administration dated 06/08/22 indicated staff would check the physician's order for liter flow rate and method of delivery. The resident is also to checked at regular intervals to ensure the correct oxygen liter flow, contents of oxygen cylinder, level of fluid in humidifier, and the resident's respiration status to determine further oxygen needs.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on record review, staff interview, and review of facility policy, the facility failed to ensure residents did not receive unnecessary medications. This affected one resident, (#69), out of 6 residents reviewed for unnecessary medications. The current census is 117. Findings include: Record review for Resident #69 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #69 include dementia, depression, myocardial infarction, pulmonary fibrosis, and syncope and collapse. Review of Resident #69's Minimum Data Set (MDS) dated [DATE] revealed the resident has impaired cognition and received antibiotics during the review period. Review of Resident #69's care plans dated 06/11/21 revealed a focus for Enhanced Barrier Precautions due to infections with colonization of multi-drug resistance organisms, (MDRO). Review of Resident #69's medication orders revealed on 08/08/24 the resident was ordered to receive an antibiotic, Cephalexin 250 milligrams (mg) daily prophylactic for urinary tract infections. Review of Resident #69's medication administration records (MAR) reviewed from 08/2024 to 03/2025 revealed the resident was receiving Cephalexin per physician order. Review of Resident #69's urinalysis testing and blood testing dating from 09/2024 to 02/2025 revealed no evidence of any infection in the results. No organisms were noted in the urine samples and the white blood cell counts were within normal ranges. No abnormal lab results were noted in the records. Review of the facility's infection report dated 09/24/24 revealed Resident #69 was diagnosed with cystitis, a common form of urinary tract infection. Per the infection report the resident was ordered to receive Levaquin 250 mg once a day for four days. Per the report the resident was to remain on prophylactic Cephalexin as previously ordered. No further infections were noted in Resident #69's medical records. Review of the facility policy titled Medication Administration - Preparation and General Guidelines, dated November 2021 stated if a medication seems to be unrelated to the resident's current diagnosis or condition the nurse calls the provider pharmacy for clarification or if necessary conducts the prescriber and the resulting order clarification is documented in the resident's medical record. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 3:08 P.M. with Infection Control Preventionist (ICP) Registered Nurse (RN) #574 revealed Resident #69 had no signs or symptoms of an active infection requiring the administration of the antibiotics per the McGeer's protocols, which is the protocol the facility follows for antibiotics. ICP RN #574 stated Resident #69 had a history of infections, including cystitis in 09/2024, and the resident received Levaquin antibiotic for the infection. ICP RN #574 verified the primary physician ordered the Cephalexin antibiotic on 08/08/24 and ordered it to be continued prophylactically. ICP RN #574 verified there was no documentation for the rationale to continue the antibiotic when Resident #69 is not showing any signs or symptoms of urinary tract infections.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on observation, record review, resident interview, staff interview, and review of the facility policy the facility failed to ensure medications were stored securely and administration carts were locked when left unattended. This affected on resident (#57) reviewed for medications storage and had the potential to affect two residents (#14 and #18) that were cognitively impaired and independently mobile residing on the A hall. The facility census was 117. Findings include: 1. Medical record review for Resident #57 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, type two diabetes mellitus, bipolar disorder, and depressive state schizoaffective disorder. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 required extensive assistance with toileting, lower body dressing, personal hygiene, and was dependent for footwear, bathing and toileting. Interview on 03/17/25 at 9:02 A.M. with Resident #57 revealed she was given an incorrect number of pills on the previous day so she put the extra pills in her purse. Subsequent observation revealed Resident #57 opened her purse and removed one blue pill and one orange pill. Interview on 03/17/25 at 9:13 A.M. with Licensed Practical Nurse (LPN) #657 confirmed one blue pill and one orange pill were in Resident #57's purse. LPN #657 identified the pills as Zoloft (antidepressant) and Senna (bowel regulation). 47057 2. Observation on 03/19/25 at 8:35 A.M. revealed Registered Nurse (RN) #593 walked away from the A hall medication cart, leaving it unlocked and out of sight and walked into Resident #52's room to administer medication. Subsequently RN #593 exited Resident #52's room and returned to the unlocked medication cart, obtained a pair of gloves and then returned to Resident #52's room. Again the A hall medication cart was left unattended and unlocked. Concurrent observation revealed Resident #101 was sitting in her wheelchair next to the medication cart. Interview on 03/19/25 at 8:38 A.M. with RN #593 upon returning the A hall medication cart, verified the cart had been left unattended and unlocked. Interview on 03/19/25 at 8:52 A.M. with LPN #518 identified two residents (#14 and #18) residing on the A hall that are independently mobile and cognitively impaired. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Storage in the Facility, revised 01/18 revealed medications and biologicals are stored safely, securely, and properly. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Review of the facility policy titled Preparation and General Guidelines, revised 12/19 revealed during administration of medications, the medication cart is kept closed and locked when out of the sight of the medication nurse. This deficiency represents non-compliance investigated under Complaint Number OH00161938.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Orchard Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 2841 Munding Drive Oregon, OH 43616	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, staff interview, and facility policy the facility failed to ensure infection control procedures were followed. This affected one (#9) of one residents reviewed for indwelling urinary catheter and one (#322) of one residents reviewed for enhanced barrier precautions. The facility identified five residents with an indwelling urinary catheter who utilize a wheelchair and 66 residents that required enhanced barrier precautions. The facility census was 117. Findings include: 1. Based on medical record review Resident #9 was admitted on [DATE]. Diagnoses included multiple sclerosis, paraplegia, and neuromuscular dysfunction of bladder. Review of the Minimum Data Set (MDS) assessment, dated 01/09/25, revealed Resident #9 was cognitively intact and had limited range of motion on both sides of the upper and lower extremity and dependent for transfers. Resident #9 had an indwelling catheter. Review of the care plan, dated 10/30/23, verified Resident #9 was at risk for infection and/or trauma due to a suprapubic catheter and a diagnosis of neuromuscular dysfunction of bladder. Interventions include to check indwelling urinary catheter for patency, kinks in tubing every shift, monitor for signs and symptoms of urinary tract infection, and provide proper care if the urinary catheter leaked. Observation on 03/18/25 at 12:55 P.M. revealed Resident #9 was in her wheelchair, wheeling herself through the hallways of the common area and in the dining room with approximately five to seven inches of the urinary catheter tubing laying and dragging along the floor. Interview on 03/18/25 at 12:58 P.M. with Certified Nursing Assistant (CNA) #600 verified Resident #9's urinary catheter tubing was laying and dragging on the floor. 47057 2. Review of the medical record for Resident #322 revealed an admitted [DATE] with diagnoses of respiratory failure, percutaneous endoscopic gastrostomy tube (feeding tube into the stomach), anoxic encephalopathy (occurs when there is not enough oxygen to the brain leading to impairment), and tracheostomy. Review of the admission MDS for Resident #322 revealed the assessment was in progress. Review of the current physician orders date 03/25 for Resident #322 revealed an order for enhanced barrier precautions (EBP) (this required the use of gloves and gown during care for high contact interactions to prevent infection by way of artificial orifices for a resident, tracheostomy and feeding tube) for tracheostomy and feeding tube. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan initiated 03/19/25 for Resident #322 revealed enhanced barrier precautions were care planned with interventions of gown and gloves required for high contact interactions. Observation on 03/17/25 at 8:57 A.M. of Resident #322's room revealed the resident had a tracheostomy and tube feeding running. Further observation revealed Resident #322's room did not have posted any signage for EBP to alert staff, and there was no personal protective equipment (PPE) immediately available prior to entering the room to don when providing high contact care. Interview on 03/17/25 at 8:58 A.M. with Registered Nurse (RN) #620 stated Resident #322 was admitted last week and verified no EBP signage on the door or PPE available for donning for high contact care for Resident #322. Review of the facility policy titled Enhanced Barrier Precautions dated 07/22 revealed enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multi drug resistant organisms. EBP are to be used with residents with indwelling medical devices such as feeding tube and tracheostomy. Gowns and gloves are to be used for high-contact resident care activities. Implementation of EBP will be to post signs that indicates the care activities that require the use of gown and gloves and make gowns and gloves available for resident room.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on medical record review, observation, staff and resident interviews, and review of the facility wheelchair cleaning schedule, the facility failed to ensure wheelchairs were clean. This affected two (Residents #9 and #58) of four residents reviewed for environment. The facility census was 117. Findings include: 1. Review of the medical record for Resident #58 revealed he was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis affecting his right side, chronic obstructive pulmonary disease, type two diabetes mellitus, chronic heart failure, hypertension, and dysphagia. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #58 had mild cognitive impairment. This resident had impairment to his upper and lower extremities on one side and required extensive assistance with dressing, toileting, upper body dressing, and personal hygiene. Resident #58 was dependent for lower body dressing, footwear, and transfers. Resident #58 utilized an electric wheelchair for mobility. Observation on 03/17/25 at 8:43 A.M. of Resident #58 sitting in his power wheelchair revealed there was a significant amount of accumulated debris, dirt, and dust on the frame and cushion of the chair. Concurrent interview with Resident #58 confirmed the chair was dirty and had been cleaned only once since he obtained the chair approximately one year ago. Observation on 03/19/25 at 3:57 P.M. of Resident #58 sitting in his power wheelchair revealed there was a significant amount of accumulated debris, dirt, and dust on the frame and cushion of the chair. Concurrent interview with Licensed Practical Nurse #503 revealed resident wheelchairs were supposed to be cleaned nightly. LPN #503 confirmed Resident#58's wheelchair was dirty and should have been cleaned. Observation on 03/20/25 at 8:56 A.M. of Resident #58 sitting in his power wheelchair revealed there was a significant amount of accumulated debris, dirt, and dust on the frame and cushion of the chair. Concurrent interview with Certified Nursing Assistant #600 confirmed Resident#58's wheelchair was dirty. 2. Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, paraplegia, and neuromuscular dysfunction of bladder. Review of the Minimum Data Set 3.0 (MDS) assessment, dated 01/09/25, revealed the resident was cognitively intact, had limited range of motion on both sides of the upper and lower extremity, and utilized a wheelchair for mobility. Resident #9 was dependent for transfers and had a urinary catheter. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/18/25 at 12:56 P.M. revealed Resident #9 in her wheelchair in the dining room. Resident #9's wheelchair was heavily coated with dirt and dust throughout the visible areas of the seat, frame and wheels. Subsequent interview with Resident #9 confirmed the wheelchair was dirty and she did not know the last time it was cleaned. Interview on 03/18/25 at 12:59 P.M. with CNA #600 verified Resident #9's wheelchair was dirty and in need of a deep cleaning. Review of the facility's wheelchair cleaning schedule revealed Resident #9 and Resident #58's wheelchairs were scheduled to be cleaned on Sundays. The cleaning schedule stated all wheelchairs would be taken into the shower room to be cleaned.		