STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385015	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Gresham Nursing & Rehab Center	5905 SE Powell Valley Rd Gresham, OR 97080

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50897 Based on observation and interview it was determined the facility failed to ensure residents were aware of the right to review survey results for 2 of 2 floors and failed to make survey results were readily accessible for 1 of 2 floors reviewed for resident rights. This placed residents and the public at risk for not being informed of the facility's survey history. Findings include: On 6/27/24 at a resident meeting at 2:00 PM residents asked if they were allowed to know the results of the current survey when it was completed. None of the 8 residents attending were aware there was a copy of the survey results located on the first floor near the elevator. Residents further stated most second floor residents could not easily access the first floor without assistance from staff. On 6/28/24 at 2:00 PM no accessible survey results were observed on second floor. On 6/28/24 at 2:00 PM Staff 14 (Activities Director) stated there used to be a place by the nurses station on the second floor where the results of the survey were available in the past, but she believed it disappeared during a remodel. Staff 14 stated she did not think most residents were aware there were results of the survey available to residents. On 6/28/24 at 2:35 PM Staff 1 (Administrator) stated survey results were available by the first-floor entrance, which everyone uses for admission, appointments, outings. Staff 1 stated there was no copy on the second floor in the past six years. Staff 1 also stated if residents on the second floor wanted to see a copy of the survey results, They can ask staff.

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47000 Based on interview and record review it was determined the facility failed to ensure resident representatives were informed in writing of changes in financial coverage for 1 of 4 sampled residents (#340) reviewed for advance beneficiary notification. This placed residents and their representatives at risk for unknown financial liabilities and lack of knowledge regarding the right to appeal the decision. Findings include: Resident 340 was admitted to the facility for skilled care in 2/2023 with diagnoses including Alzheimer's disease. Resident 340's 3/2/23 Psychosocial History and Discharge Plan revealed the resident's family assisted her/him with decision-making and the resident was unable to make serious medical decisions for her/himself. Resident 340's 3/10/23 Admission MDS revealed the resident was severely cognitively impaired. Resident 340's undated Admission Record (a document in a patient's electronic health record that summarizes important details, including patient identification, allergies and contact information) identified Witness 2 (Family Member) as the resident's Emergency Contact #1, Care Conference Person, Power of Attorney (POA) and Representative Payee (a person or organization who receives Social Security or SSI [supplemental security income] benefits for anyone unable to manage his/her own benefits). Although Resident 340 was identified as severely cognitively impaired in assessments, a Notice of Medicare Non-Coverage (NOMNC) form was provided by facility staff and signed by the resident on 3/28/24. The form indicated the resident's covered services were scheduled to end on 3/30/23. According to the resident's health record, Resident 340 remained in the facility after 3/30/23 as a private pay resident after that date. No evidence was found in the resident's health record to indicate Witness 2 was provided with a NOMNC, her right to appeal the determination or notification of any other financial liabilities, including an advanced beneficiary notification. On 6/25/24 at 2:51 PM Witness 2 stated she informed Staff 12 (Social Services Director) on 2/27/23 she was Resident 340's POA and was responsible for making all medical and financial decisions for the resident. Witness 2 stated the facility never provided her with a NOMNC for Resident 340. Witness 2 stated she found out months later that the resident signed the form per request of the facility and accrued a bill ever since. On 6/26/24 at 3:00 PM Staff 12 (Social Services Director) stated Witness 2 was involved in Resident 340's care and was her/his POA. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 3:44 PM Staff 1 (Administrator) stated he issued Resident 340 the NOMNC and was present when the resident signed the form. Staff 1 stated he typically did not have a resident with a diagnosis of dementia sign the form but he did it in this case in the essence of time. Staff 1 stated he did not notify Witness 2 he had Resident 340 sign the form.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on observation and interview it was determined the facility failed to maintain a homelike and comfortable environment for 2 of 3 halls reviewed for environment. This placed residents at risk for living in an unkempt and uncomfortable environment. Findings include: 1. Observations of the facility's general environment and residents' rooms from 6/24/24 through 7/1/24 identified the following issues: -room [ROOM NUMBER] had wall damage behind the bed with missing paint and exposed drywall; -room [ROOM NUMBER] had wall damage behind the bed with missing paint, exposed drywall, several brown spots on the ceiling and a fan with dirty blades; -room [ROOM NUMBER] had wall damage on the right side of the bed with missing paint and exposed drywall; -room [ROOM NUMBER] had damage to the lower portion of the door with sharp/jagged edges; -room [ROOM NUMBER] had wall damage to the left of the door with missing paint and exposed drywall; -room [ROOM NUMBER] had lower wall damage on two walls including behind the bed with missing paint/drywall and a stained/dirty privacy curtain; -room [ROOM NUMBER] had wall damage behind the bed with missing paint and exposed drywall; -The 300 hall had a broken picture frame on the wall with sharp/jagged edges; -An overhead light was burned out in the dining room, as well as between rooms 27-28 and between rooms 39-40. On 7/1/24 at 9:26 AM Staff 1 (Administrator) and Staff 6 (Maintenance Director) acknowledged the identified concerns needed to be addressed. 47000 2. Resident 16 was admitted to the facility in 6/2024 with diagnoses including a right foot wound. Resident 16's 6/6/24 Admission MDS revealed the resident was cognitively intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 9:46 AM Resident 16 was observed in her/his room in bed with a blanket covering the length of her/his body. Resident 16 stated her/his room was freezing and her/his children brought extra comforters because the room was so cold. Resident 16 stated she/he complained to facility staff that the room was too cold on the day she/he admitted to the facility. Resident 16 stated an unidentified staff member blocked the vent in the room approximately five to seven days after she/he reported the temperature issue but the room was still cold. Resident 16 further stated she/he did not shower in the bathroom because it was excessively cold. On 6/26/24 at 9:22 AM Resident 16 was observed in her/his room in bed with a blanket covering the length of her/his body and wearing a hat. Resident 16 stated she/he often wore a hat in her/his room to keep warm and she/he preferred to keep the door to the bathroom closed at all times so the cold air would not blow into [her/his] room. The Surveyor entered the resident's bathroom and felt cold air blowing. On 6/26/24 at 9:59 AM Staff 23 (CNA) stated Resident 16 complained about her/his room being cold a couple of times, and when the resident did, Staff 23 stated she added the resident's concern to the maintenance book and offered the resident an extra blanket. Staff 23 stated Resident 16's room was known to be really bad when it came to temperatures. Staff 23 stated Resident 16's room temperatures fluctuated a lot and the room was sometimes really, really hot and sometimes really, really cold. On 6/26/24 at 10:09 AM Staff 6 (Maintenance Director) stated it was his practice to continue checking the temperatures of rooms with temperature complaints even after he felt the issue was addressed in order to ensure that the concern was resolved. Staff 6 stated Resident 16's room had a long history of temperature complaints but he did not take regular temperature readings of Resident 16's room. Staff 6 stated he was not aware Resident 16 complained that her/his room and bathroom were cold. At that time, Staff 6 took temperature readings of the resident's room and bathroom. The temperature reading to the left of the resident's head of bed was 69 degrees and the temperature in the resident's bathroom was 65 degrees. On 6/26/24 at 11:23 AM Staff 1 (Administrator) acknowledged the findings and stated resident room temperatures were determined according to resident preferences.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41453 Based on interview and record review it was determined the facility failed to ensure the Office of the State Long Term Care Ombudsman was notified of resident hospitalization s for 3 of 3 sampled residents (#s 40, 87 and 339) reviewed for hospitalization . This placed residents at risk for lack of advocacy by the Ombudsman's office. Findings include: 1. Resident 40 was admitted to the facility in 12/2023 with diagnoses including dementia and heart disease. Resident 40's 2/26/24 Discharge MDS indicated the resident was discharged to an acute care hospital. Review of Resident 40's health record revealed no documentation to indicate the state/local Ombudsman was notified Resident 40 was discharged to a hospital. On 7/1/24 at 11:02 AM Staff 1 (Administrator) stated the facility did not notify the Ombudsman of discharged residents. 43690 2. Resident 87 was admitted to the facility in 5/2024 with a diagnosis of spinal cord compression. A 5/23/24 Nursing Note indicated Resident 87 was sent to the hospital. No evidence was found in the resident's clinical record to indicate the Office of the State Long Term Care Ombudsman was notified of Resident 87's hospitalization . On 7/1/24 at 10:35 AM Staff 13 (Social Services) stated she was unaware the Office of the State Long Term Care Ombudsman's office was to be notified when a resident was sent to the hospital. On 7/1/24 at 10:46 AM Staff 1 (Administrator) stated the facility did not send out written hospital notifications to the Office of the State Long Term Care Ombudsman. 47000 3. Resident 339 was admitted to the facility in 6/2024 with diagnoses including congestive heart failure. A 6/17/24 Progress Note indicated Resident 339 was sent to the hospital. No evidence was found in Resident 339's health record to indicate a copy of the resident's transfer notice was sent to a representative of the Office of the State Long-Term Care Ombudsman for the hospitalization . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24 at 10:35 AM Staff 13 (Social Services Director) stated she was unaware a representative of the Office of the State Long-Term Care Ombudsman was to be notified when a resident was hospitalized . On 7/1/24 at 11:02 AM Staff 1 (Administrator) confirmed the facility did not send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman for Resident 339's hospitalization .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41453 Based on interview and record review it was determined the facility failed to provide residents with a written notice of the facility's bed hold policy at the time of transfer to the hospital for 1 of 3 sampled residents (#40) reviewed for hospitalization and discharge. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: Resident 40 was admitted to the facility in 12/2023 with diagnoses including dementia and heart disease. Resident 40's 2/26/24 Discharge MDS indicated the resident was discharged to an acute care hospital. Review of Resident 40's health record revealed no documentation to indicate the resident was notified of or provided a copy of the facility's bed hold policy prior to her/his 2/26/24 discharge. On 7/1/24 at 9:54 AM Staff 2 (DNS) confirmed a bed hold policy was not provided to Resident 40 when she/he transferred to a hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41453 Based on interview and record review it was determined the facility failed to revise and update a care plan intervention for clothing preferences and call light use for 1 of 2 sampled residents (# 45) reviewed for care planning. This placed residents at risk for unmet of care needs. Findings include: Resident 45 admitted to the facility in 11/2023 with diagnoses including paralysis and infection. Resident 45's 2023 comprehensive care plan indicated she/he preferred to get dressed in a shirt even when she/he stayed in bed. Resident 45's comprehensive care plan further indicated her/his call light was to be within reach and Resident 45 was encouraged to use it. Observations made from 6/24/24 through 6/27/24 revealed Resident 45 wore a hospital gown throughout the day. On 6/27/24 at 9:29 AM Staff 26 (CNA) and Staff 27 (LPN) stated Resident 45 rarely used her/his call light. When Resident 45 wanted something she/he yelled for assistance. Staff 26 stated Resident 45 preferred to wear a hospital gown. Staff 26 stated Resident 45 did not seem to have a preference between shirt or gown. On 6/28/24 at 10:57 AM Staff 28 (CNA) stated 2 years ago Resident 45 used her/his call light consistently and showed a preference for shirts. Staff 28 stated currently she did not see her/him use a call light and stated Resident 45 did not have a preference of clothing. On 6/28/24 at 11:00 AM Staff 29 (CNA) and Staff 30 (CNA) stated Resident 45 rarely ever used her/his call light. Staff 29 and Staff 30 stated she/he called out for assistance. Staff 29 and Staff 30 stated Resident 45 did not express a preference for wearing a shirt or hospital gown. On 6/28/24 at 11:52 AM Staff 25 (RN) Stated Resident 45 wore a shirt or one of the hospital gowns. Staff 25 stated Resident 45 did not really use her/his call light. Staff 25 stated when Resident 45 really needed something she/he yelled. Staff 25 confirmed Resident 45's care plan was not updated for her/his changed needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38140 Based on observation, interview and record review it was determined the facility failed to ensure foods were labeled and stored in a way to minimize food spoilage and cross contamination for 1 of 1 kitchen and 1 of 3 snack/resident refrigerators reviewed for sanitary food storage. This placed residents at risk for potential infections related to foodborne pathogens. Findings include: Review of the US FDA 2022 Food Code revealed: -food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded with a maximum of seven days. Observation on 6/24/24 at 9:12 AM of the following items placed on the dishwashing station by Staff 21 (Cook): -An undated plastic container of macaroni with red meat sauce. -A container of whipped topping dated 6/7. -A container of undated gelatin. Observation of the kitchen on 6/24/24 at 9:12 AM revealed the following: Freezer: -An open plastic bag with three waffles dated 4/16/24. -An undated open plastic bag of five garden burgers with freezer burn. -A box of undated garlic bread sticks. - A large piece of wrapped meat with no date. Walk-in refrigerator: -A box of individually wrapped Danish rolls dated 3/30. The box instructions directed if frozen, thaw overnight and serve. -A partially open plastic container of whipped topping dated 5/25. -An open undated plastic bag of five white slices of cheese. On 6/24/24 at 9:39 AM Staff 21 confirmed the items she placed on the dishwasher station were removed from the refrigerator and should have been removed from the refrigerator prior to that day. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/24 at 9:40 AM Staff 16 (Dietary Manager) confirmed the items in the freezer and refrigerator where not stored or labeled correctly and were past the date to serve. Staff 16 threw away items. Staff 16 stated the box of Danish rolls were frozen but did not know when they were pulled from the freezer. Observation on 6/27/24 at 8:33 AM of the station two snack/resident refrigerator with an undated or labeled plate with a blue lid of an uneaten lunch meal from 6/24/24 (baked pasta, broccoli and a roll). On 6/27/24 at 8:40 AM Staff 1 (Administrator) removed the undated and unlabeled plate of food from the station two snack/resident refrigerator. Staff 1 acknowledged he expected all food in the refrigerator to be labeled and dated. Staff 1 acknowledged the finding of the kitchen observations and stated he expected all food to be labeled, dated and discarded by the expiration date.