STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385018	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Benedictine Nursing Center	540 South Main Street Mount Angel, OR 97362

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on interview and record review it was determined the facility failed to identify and reflect risk factors in the care plan related to pressure ulcers for 1 of 3 sampled residents (#2) reviewed for pressure ulcers. This placed residents at risk for pressure injuries and skin breakdown. Findings include: Resident 2 admitted to the facility in 8/2023 with diagnoses including a colostomy (redirects the colon to an opening in the abdominal wall, called a stoma, which is attached to a colostomy bag to collect bowel movements) and cellulitis of the abdomen. The Admission MDS dated [DATE], revealed Resident 2 was cognitively intact. A care plan dated 8/8/23, revealed Resident 2 had a colostomy, impaired skin integrity, a wound around the stoma, nonhealing skin graft to the buttocks, and history of pressure injury. Staff were to monitor the ostomy appliance and belt for moisture and tightness twice daily, encourage the resident to loosen her/his belt when lying down, and monitor for signs and symptoms of infection. The care plan did not identify Resident 2 had a history of skin breakdown from the ostomy belt or that Resident 2 refused ADL and ostomy cares. A review of Resident 2's clinical record from 7/1/24 through 9/19/24, revealed the resident refused ADL care and ostomy care, but no evidence was found a risk verses benefit form was completed. A 7/24/24 Facility Reported Incident revealed the following: -Resident 2 had a Stage 3 (full thickness loss of skin that exposes subcutaneous fat) pressure injury from her/his ostomy belt. The wound was measured, cleansed, and treatment orders were put into place. -Resident 2 had a pattern and long history of refusals, poor hygiene, and poor safety insight. Resident 2's care was mostly independent. -Resident 2 was seen at the wound clinic on 7/17/24, with no identified skin issues. The wound potentially developed between 7/17/24 and 7/24/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff 10 (LPN), Staff 9 (Agency RN), and Staff 11 (RN) all indicated they worked with Resident 2 prior to and upon discovery of the wound, and Resident 2 refused ostomy changes and skin assessments. Staff 10 indicated Resident 2 refused more care than she/he allowed. -It was determined due to Resident 2's wound history, medical background, refusals of care, wound care clinic visits and interviews, neglect was not substantiated. On 9/17/24 at 11:01 AM and 2:26 PM, Resident 2 stated she/he had her/his ostomy bag for [AGE] years and I know how to change it. Resident 2 stated she/he allowed staff to change her/his ostomy bag at times but changed the ostomy bag on her/his own. Resident 2 stated when staff came to change or look at her/his ostomy bag, it was not always a convenient time because she/he was in the middle of watching a movie. Resident 2 stated she/he had a sore from the ostomy belt but had not worn the belt since the wound was discovered. On 9/17/24 at 11:17 AM, Staff 14 (CNA) and Staff 15 (CNA) and at 12:08 PM, Staff 13 (CNA) stated Resident 2 was alert and oriented, hard of hearing, and became anxious easily. Staff 14 and Staff 15 stated Resident 2 refused care, including changing her/his soiled clothing or removing her/his ostomy belt for showers. Staff 14 and Staff 15 stated the resident had a history of skin breakdown under and around the ostomy belt due its tightness around Resident 2's waist and the resident's refusal of care. Staff 14, Staff 15, and Staff 13 stated they did not recall seeing any wounds around the resident's ostomy belt when assisting with ADL cares. On 9/18/24 at 10:41 AM Staff 9 stated Resident 2 was particular with her/his colostomy care and staff were to place pads under the ostomy belt to reduce friction and sheering of the skin, although this was not always successful. Staff 9 stated when attempting to assess or change the colostomy bag the resident would refuse, say it was fine, ask Staff 9 to come back later because she/he was watching a movie. Staff 9 stated they educated the resident but was unsure if the resident had completed a risk verses benefit form due to Resident 2's refusals. On 9/18/24 at 11:52 AM, Staff 10 stated Resident 2 admitted with a history of skin breakdown around the ostomy belt, a history of non-compliance related to her/his ostomy care, and refusal to allow staff to assess or change her/his ostomy belt and ostomy bag. This resulted in the ostomy bag leaking, causing bowel movements to run underneath the resident's ostomy belt. Staff 10 stated the resident was seen regularly at the wound clinic for her/his ostomy care and skin breakdown. Staff 10 stated after the wound was found, the resident no longer used the ostomy belt and new orders were received from the wound clinic. An observation on 9/18/24 at 1:16 PM revealed Resident 2's right hip wound was completely healed, with no open areas observed. However, the resident's skin was red, dry, and flaky. Resident 2's ostomy bag was in place, without an ostomy belt and the resident indicated her/his skin felt much better. On 9/19/24 at 9:50 AM Staff 11 stated Resident 2 was non-compliant with her/his ostomy care. Staff 11 stated a CNA alerted her on 7/27/24 about a wound on the resident's right hip caused by the ostomy belt. Staff 11 stated the ostomy belt was digging into the resident's skin and the wound was deep. Staff 11 stated she cleansed the wound, orders were initiated, and Staff 2 (DNS) was informed of the incident. Staff 11 stated she could not speak to a risk verses benefit form. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 11:11 AM, Staff 2 stated she was informed and visualized the wound on 7/27/24. Staff 2 stated the resident was non-complaint with her/his ostomy care and the ostomy belt was a false sense of security for the resident. Staff 2 stated CNA staff were expected to do a full head to toe assessment when providing ADL care two times daily and report any skin breakdown to the nurses. Staff 2 acknowledged the care plan did not include Resident 2's refusal of care or identify her/his history of skin breakdown related to the use of the ostomy belt. Staff 2 stated a risk verses benefit form should have been completed and would have been beneficial for Resident 2. On 9/19/24 at 2:56 PM Witness 17 (Wound Clinic RN) stated she saw Resident 2 at the wound clinic for her/his ostomy care and indicated the resident's ostomy belt was always too tight and digging into her/his belly. Staff 17 stated she saw the resident on 7/17/24 and did not visualize a wound to the resident's right hip. Staff 17 stated she/he was seen again on 7/25/24 and the resident was no longer wearing the ostomy belt.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on interview and record review the facility failed to prevent an avoidable fall related to fall safety for 1 of 3 sampled residents (#1) reviewed for accidents. Resident 1 fell out of bed and sustained a right shoulder fracture. Findings include: Resident 1 was admitted to the facility in 7/2024 with diagnoses including quadriplegia (paralysis that affects all a person's limbs and body from the neck down) and a Stage 4 (full thickness skin loss) pressure injury. The Admission MDS dated [DATE], revealed Resident 1 was cognitively intact. A care plan dated 7/25/24, revealed Resident 1 was limited in performing ADLs and was encouraged to perform as much of her/his ADLs as their condition allowed. Staff were to follow the most recent instructions and posted wall signs for mobility, transfers, exercises, and restorative programs. A revision on 7/27/24, revealed Resident 1 had half siderails on both sides of her/his bed to assist with repositioning and bed mobility. Two undated bedside care plans revealed the resident required the assistance of one or two people to roll from side to side in bed and required the assistance of two-people for scooting and repositioning. The resident had a Foley catheter and was incontinent of bowel. A Fall Investigation dated 8/22/24 revealed the following: -Staff 6 (Agency CNA) had multiple interactions with Resident 1 throughout her shift on 8/17/24 and followed the care plan. However, when she recognized the resident's positioning was possibly unsafe, she did not request a second staff person to assist with repositioning the resident prior to providing incontinent care. This created additional risk, contributing to Resident 1's fall. Staff 6 acknowledged Resident 1's positioning in bed led to her/his fall. -Resident 1 stated Staff 6 was going to provide cares and she/he was supposed to roll to the left side. Resident 1 indicated she/he was close to the edge of the mattress and the CNA pushed me too far over. When Staff 6 realized she/he was too close to the edge of the mattress, Resident 1 fell off the bed. -Staff 2 (DNS) determined and indicated Staff 6 recognized the potential safety issue with Resident 1's positioning but did not seek peer assistance. While this was a safety risk that led to an injury, it was not a willful infliction of injury or failure to provide a necessary service. However, the fall was an avoidable situation. On 9/16/24 at 5:18 PM, Resident 1 stated on 8/17/24, Staff 6 was going to provide care and had her/him too close to the edge of the bed, causing her/him to fall out of the bed. Resident 1 stated her/his right arm caught in the bed railing, resulting in a fractured right shoulder. Resident 1 stated she/he was a quadriplegia and needed assistance with cares and most of the time two staff would assist her/him with repositioning and care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/17/24 at 1:43 PM Staff 8 (Physical Therapist) stated Resident 1 was able to use her/his arms and required one staff person to assist with rolling in bed but required two staff to reposition her/him in bed. Staff 8 stated the resident had a care plan in her/his room and pictures on the wall to ensure staff assisted the resident appropriately. On 9/18/24 at 9:58 AM, Staff 6 stated she worked on 8/17/24 which was her first time working at the facility. Staff 6 stated she received a report from a male nurse who indicated Resident 1 required one-person assistance for all her/his ADL care needs. Staff 6 stated she did not review or have access to the care plan. Staff 6 stated she did not know where the bedside care plan was located for Resident 1. Staff 6 stated she interacted with Resident 1 throughout the shift because the resident used her/his call light often. Staff 6 stated the resident was close to the edge of the bed but indicated the resident refused to be repositioned prior to providing incontinence care. Staff 6 stated when she went to gather supplies in the room for incontinent care, Resident 1 slid out of bed but did not fall. Staff 6 stated Resident 1's right arm was stuck in the side rail. Staff 6 stated she called for assistance, and a nurse entered the room to assess and help get the resident back into bed. Staff 6 further stated the resident did not report any pain or discomfort in the right shoulder. On 9/18/24 at 2:14 PM, Staff 3 (Agency RN) stated on 8/17/24, Staff 6 alerted her that Resident 1 was too close to the edge of the bed and had slid out of bed, legs first. Staff 3 stated when she entered the room, the resident was holding onto the side rail with her/his right arm and said, get me up. Staff 3 stated she assessed the resident, who was able to move both her/his arms and denied any pain to her/his right arm or shoulder area. Staff 3 stated the resident was put back into bed. On 9/18/24 at 2:27 PM, Staff 4 (LPN) stated she was aware Resident 1 fell out of bed on 8/17/24, and her/his right arm was caught in the bed rail, but the resident did not complain of any pain to the right shoulder until 8/20/24, which an X-ray was ordered. However, the resident was out to an appointment when the technician arrived on 8/20/24. Staff 4 stated Resident 1 was sent out to the hospital on 8/21/24, due to a critical lab result, and an X-ray of the right shoulder was obtained and revealed a fractured right shoulder. On 9/19/24 at 10:40 AM Staff 2 stated she completed the investigation regarding Resident 1's fall out of bed on 8/17/24. Staff 2 confirmed Resident 1 was too close to the edge of the bed, causing the resident to fall and fracture her/his right shoulder. Staff 2 stated the fall was avoidable. Staff 2 stated during shift change, she expected CNAs to have a peer-to-peer report, review the care plan and communicate with the nurses regarding care needs for all residents.