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	02/14/2025

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 48830 Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification at the time of transfer to the hospital for 2 of 2 sampled residents (#s 30 and 38) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 30 was admitted to the facility in 1/2023 with diagnoses including depression and diabetes. A review of Resident 30's health record revealed she/he was discharged to the hospital on three separate occasions: 3/19/24, 4/22/24, and 7/8/24. No evidence was found in Resident 30's health record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital on 3/19/24, 4/22/24, and 7/8/24. On 2/13/25 at 3:50 PM Staff 2 (DNS) confirmed a written bed hold policy was not provided to Resident 30 or their representative when the resident was transferred to the hospital on the identified dates. 2. Resident 38 was admitted to the facility in 8/2022 with diagnoses including anxiety and diabetes. A review of Resident 38's health record revealed she/he was discharged to the hospital on three separate occasions: 2/27/24, 3/7/24, and 8/14/24. No evidence was found in Resident 38's health record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital on the identified dates. On 2/13/25 at 3:50 PM Staff 2 (DNS) confirmed a written bed hold policy was not provided to Resident 38 or their representative when the resident was transferred to the hospital on the identified dates.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 34702 Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 1 of 6 sampled residents (#10) reviewed for medications. This placed residents at risk for adverse medication side effects. Findings include: Resident 10 readmitted to the facility in 2023 with diagnoses including dementia and schizoaffective disorder. a. The 3/6/24 medication error investigation indicated the following: -On 3/6/24 at 4:32 PM Staff 14 (RN) administered the following medications (in error) to Resident Resident 10: -clonazepam 0.5 mg (anticonvulsant medication) -Depakote 200 mg (anticonvulsant medication) -docusate sodium 100 mg (bowel medication) -gabapentin 400 mg (mood stabilizer medication) -metoprolol 12.5 mg (blood pressure medication) -levothyroxine 200 mcg (thyroid medication) -clozapine 100 mg (antipsychotic medication) On 3/6/24 the physician was notified of the medication error. On 2/13/25 at 10:18 AM Staff 14 stated she worked on 3/6/24. She stated she prepared another resident's medications and administered them to Resident 10 by mistake. Staff 14 was unable to recall the name of the resident whose medications were accidentally administered to Resident 10 and did not recall the medications that were administered. Staff 14 stated the physician was notified of the medication error. On 2/13/25 at 12:21 PM Staff 16 (RNCM) acknowledged on 3/6/24 Staff 14 administered the identified medications to Resident 10 in error. b. The 10/5/24 medication error investigation indicated the following: -On 10/5/24 at 11:26 AM Staff 15 (LPN) administered the following medications (in error) to Resident Resident 10. -clonazepam 2 mg (anticonvulsant medication) (continued on next page)

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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	-Clozaril 100 mg (antipsychotic medication) -lamotrigine 200 mg (anticonvuslant medication) -furosemide 40 mg (diuretic medication) -levothyroxine 200 mcg (thyroid medication) On 10/5/24 the physician was notified of the medication error. On 2/13/25 at 10:04 AM Staff 15 acknowledged she administered the identified medications to Resident 10 on 10/5/24 and the medication was intended for Resident 23. On 2/13/25 12:21 PM Staff 16 (RNCM) acknowledged on 10/5/24 Staff 15 administered the identified medications to Resident 10 in error.