

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Avamere Health Services of Rogue Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Stevens Street Medford, OR 97504	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were treated with dignity for 1 of 4 sampled residents (#52) reviewed for dignity. This placed residents at risk for lack of self-worth. Findings include:</p> <p>Resident 52 was admitted to the facility in 2024 with a diagnosis of pernicious anemia (inability of the body to absorb vitamin B12; left untreated it can cause irreversible damage to the nervous system).</p> <p>A 3/23/24 admission MDS revealed Resident 52 was cognitively intact.</p> <p>On 4/15/24 at 1:17 PM and 4/17/24 at 11:47 AM Resident 52 stated she/he took medication which was required to prevent her/his health from significantly declining. The side affects of the medication made her/him feel ill for up to four hours after it was administered and she/he preferred to take the medication in the morning. One Thursday morning Resident 52 asked the nurse when her/his medication could be administered. The nurse's response was that she had the medication in her pocket and would administer the medication when the nurse wanted to administer it. Resident 52 stated the nurse's response hurt her/his feelings.</p> <p>On 4/16/24 at 6:42 PM Staff 26 (LPN) stated she worked with Resident 52 but denied any verbal interactions with the resident about administering the medication on her time and not the resident's preferred time.</p> <p>On 4/16/24 at 7:04 PM Staff 42 (LPN) stated Resident 52 reported Staff 26 spoke to her/him in a manner which was not very nice. The resident reported she/he felt like she/he was an inconvenience to Staff 26. Staff 42 stated she did not report the resident's concern to management because she did not feel it was verbal abuse.</p> <p>On 4/17/24 at 8:04 AM and 10:26 AM Staff 2 (DNS) stated if a resident reported to staff they were not spoken to in a dignified manner it should be reported to management. Management should investigate the incident and educate staff as needed. Staff 2 stated she spoke to Staff 26 and Staff 26 acknowledged when Resident 52 requested her/his medication Staff 26 responded I'll get to it when I get to it.</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>34703</p> <p>Based on interview and record review it was determined the facility failed to treat residents with respect for 1 of 1 sampled resident (#63) reviewed for abuse and call lights. This placed residents at risk for lack of dignified treatment. Findings include:</p> <p>Resident 63 admitted to the facility in 2023 with diagnoses including kidney failure and difficulty walking.</p> <p>A 11/19/23 Admission MDS indicated Resident 63 was cognitively intact.</p> <p>A 12/15/23 FRI indicated staff yelled at Resident 63, and refused to assist her/him with cares. The FRI included the resident had significant care needs and depended on staff for assistance.</p> <p>On 4/18/24 at 11:23 AM Witness 5 (Complainant) indicated Resident 63 stated staff yelled at her/him all the time.</p> <p>An Incident report dated 12/15/23 included the following:</p> <p>-Staff 7 (CNA) and Staff 48 (CNA) were bathing Resident 63's roommate. Resident 63 asked Staff 7 if she/he could have a shower later in the day. Staff 7 stated he would try to do a shower for her/him in the afternoon.</p> <p>Resident 63 stated later she/he asked Staff 48 for a shower and Staff 48 stated you're going to have to wait, I'm here to take care of your roommate. You are not even elderly, you need to get your fat ass up, I don't even know why you are here. Resident 63 stated Staff 49 called her/him a bitch and she/he spoke with a nurse about it, but the nurse stated suck it up.</p> <p>On 12/15/23 Resident 63 left the facility for a dialysis appointment. When the resident returned from her/his appointment she/he stated to Staff 26 (LPN) she/he was going home and wanted her/his medications. Staff 26 explained if the resident left she/he would leave AMA (against medical advice) because there was not a physician order for discharge. Resident 63 stated Staff 26 told her/him I'm not giving you shit. Resident 63 responded she/he was concerned about dying if she/he did not have her/his medications and Staff 26 stated Go home and die. Resident 63 stated she/he left the facility. Staff 26 stated she returned with AMA paperwork but the resident left the facility.</p> <p>A Final Investigation dated 12/19/23 indicated management was notified of the 12/15/23 incident and staff involved were placed on suspension. Staff 10 (LPN Unit Manager) indicated the resident left AMA due to being yelled at by staff.</p> <p>On 4/18/24 at 8:09 AM Staff 26 stated she remembered the resident but did not remember her/him being yelled at by staff.</p> <p>On 4/18/24 at 8:05 AM Staff 49 (CNA) stated she did not yell at Resident 63.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to address with resident council grievances for 1 of 1 resident council reviewed for grievances. This placed residents at risk for unmet needs. Findings include:</p> <p>An 4/17/24 review of resident council notes revealed a Bi-Monthly Resident Counsel Questions form was completed on 4/10/24 which revealed the following concerns:</p> <ul style="list-style-type: none"> -Residents did not feel they were treated respectfully by staff. -Residents did not feel staff listened to their needs or responded timely. -Residents did not feel staff followed up with them when they had a concern or issue. -Residents felt staff retaliated when they expressed concerns. -Residents stated staff did not answer their call lights within 10 minutes. -Residents felt the noise level in the facility was unacceptable. -Residents stated the facility did not offer snacks at bedtime and when requested. -Residents stated the food did not taste good and it was cold. -Residents stated lost items were not replaced by the facility. -Residents did not feel there were enough activities to interest them. -Residents stated they did not receive showers timely. <p>During a resident council meeting on 4/17/24 at 11:00 AM residents stated the facility staff did not respond to concerns indicated on the 4/10/24 Bi-Monthly Resident Counsel Questions.</p> <p>On 4/19/24 at 8:34 AM Staff 21 (Activity Director) stated the Bi-Monthly Resident Counsel Questions form process was initiated on 4/10/24. Staff 21 stated she did not forward a completed copy of the Bi-Monthly Resident Counsel Questions to anyone.</p> <p>On 4/19/24 at 8:51 AM Staff 1 (Administrator) stated he did not receive a copy of the 4/10/24 Bi-Monthly Resident Counsel Questions. Staff 1 stated he should receive a copy of the form as soon as it is completed and grievances should be addressed within five days. Staff 1 acknowledged the grievances on the 4/10/24 Bi-Monthly Resident Counsel Questions form were not addressed.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690</p> <p>Based on observation and interview it was determined the facility failed to maintain a homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include:</p> <p>Observations of the facility's general environment and residents' rooms from 4/15/24 through 4/19/24 identified the following issues:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] had a missing floorboard in the center of the room. -room [ROOM NUMBER] had a large chunk of the bathroom door missing which exposed the inside material of the door and there was missing paint. -room [ROOM NUMBER]-B had wall damage with missing paint behind the bed and along the wall where the bathroom was located. -room [ROOM NUMBER]-A had wall damage with missing paint along the wall to the left of the residents bed. -Lights were not working on the 200 hall outside rooms [ROOM NUMBERS]. -A small round table in the smoking area had sharp and jagged edges that were approximately 18 inches long. -The double doors at the end of the 100 hall had multiple cobwebs, residual tape and splatter marks covering them. -A ceiling tile outside room [ROOM NUMBER] was damaged with a thick layer of what appeared to be different shades of brown mold. -The transition strip in the large dining room had corners that did not line up and sections of the strip were torn and peeling. -On Hall 100 where mechanical lifts were stored the carpet along the entryway was torn and tattered and there were gaps along the transition strip. -On Hall 100 there was approximately three to four feet of tattered carpet at the nurse's station. -On Hall 200 there were two areas near the fire doors with approximately 12 inches of black tape holding the carpet together. -On Hall 200 near the nurses' station there were two areas with approximately 12 inches of black tape holding the carpet together. <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The main entryway had a large section of carpet that was loose with waves/wrinkles in it.</p> <p>On 4/18/24 at 8:21 AM Staff 1 (Administrator) and Staff 44 (Maintenance Director) acknowledged the identified above concerns needed to be addressed.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>43690</p> <p>Based on interview and record review it was determined the facility failed to ensure grievances were resolved or resolutions sustained for 2 of 3 sampled residents (#s 7 and 29) reviewed for grievances and care planning. This placed residents at risk for unresolved concerns. Findings include:</p> <p>The facility's Grievance Policy dated 5/2000 stated: It is the policy of this facility to ensure that all residents and their family members are afforded the opportunity to express their concerns and suggest changes in facility policy formally, in writing if they desire without the fear of restraint, interference, coercion, discrimination or reprisal. Additionally, the nursing facility will listen to and act promptly upon grievances and recommendations received from resident, family and advocacy groups.</p> <p>1. Resident 7 admitted to the facility in 10/2017 with diagnoses including type 2 diabetes and major depressive disorder.</p> <p>On 10/12/23 a public complaint was received which indicated Resident 7 expressed concerns about nursing staff throwing her/his food away and the facility administration refusing to follow up on a grievance that was submitted.</p> <p>On 4/16/24 at 12:11 PM Staff 14 (Social Services Director) stated if a resident reported a concern a grievance was initiated within five days. Staff 14 stated she did not have a paper grievance for Resident 7 regarding staff throwing food away without the resident's permission, and Resident 7 submitted grievances often via emails to Staff 1 (Administrator).</p> <p>On 4/17/24 at 11:00 AM Staff 1 confirmed an email was sent to him from Resident 7 regarding her/his food being thrown away and a grievance was not started or completed related to Resident 7's concerns.</p> <p>26991</p> <p>2. Resident 29 admitted to the facility in 2024 with a diagnosis of dementia.</p> <p>A 1/25/24 Complaints/Grievances form revealed Witness 9 (Family Member) did not want Staff 43 (Night shift LPN) to work with Resident 29. The form indicated it would be difficult for the other nurse on the night shift to provide Resident 29 care if Staff 43 worked on the hall where Resident 29 resided. The form indicated a plan would be coordinated with Staff 2 (DNS) to ensure Resident 29 felt safe.</p> <p>A 1/27/24 Progress Note revealed Witness 9 requested Staff 43 not work with Resident 29. The note indicated the .nurse passed this message along.</p> <p>Resident 29's Progress Notes revealed Staff 43 documented the following:</p> <p>-1/27/24 Resident 29 walked in the hall with her/his walker without assistance.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-2/8/24 Staff 43 was called to Resident 29's room due to the resident's fall.</p> <p>-2/23/24 Resident 29 was on alert for a non-injury fall</p> <p>-3/8/24 Resident 29 was on alert for a non-injury fall and she/he did not report pain.</p> <p>-3/23/24 Resident 29 did not have a bowel movement and denied abdominal pain.</p> <p>-3/29/24 Resident 29 did not have a bowel movement and denied abdominal pain</p> <p>-4/5/24 Resident 29 was administered milk of magnesia (laxative)</p> <p>On 4/15/24 at 4:55 PM Witness 9 stated she filled out a Grievance form and spoke to staff and informed them she did not want Staff 43 to work with Resident 29 but Staff 43 continued to care for the resident.</p> <p>On 4/17/24 at 7:37 AM Staff 43 stated Resident 29 had dementia and was more confused when she/he first admitted to the facility. At the end of 1/2024 Resident 29 alleged she pushed the resident which caused her/him to fall. Staff 43 stated she tried to communicate with Resident 29, it agitated the resident, and then the resident reported to Witness 9 she/he was upset with Staff 43. Staff 43 stated she was told not to provide care to Resident 29 and the other night nurse would provide care to Resident 29. Staff 43 stated at times she still provided care and administered medications to Resident 29.</p> <p>On 4/17/24 at 11:47 AM Staff 10 (LPN Unit Manager) stated Staff 43 was to only work with Resident 29 on an emergency basis, but acknowledged Staff 43 continued to administer medications and provide routine care which was documented in Resident 29's clinical record.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47001</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 1 sampled resident (#19) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 19 was admitted to the facility in 8/2020 with diagnoses including post laminectomy syndrome (a condition in which a person continues to feel pain after back surgery).</p> <p>An 8/22/23 MDS indicated Resident 19 was cognitively intact.</p> <p>A 9/9/23 Progress Note stated Resident 19 was subjected to physical aggression when she/he ignored Resident 1. Resident 1 yanked on Resident 19's hair. Both residents were separated, and Resident 19 was placed on alert charting.</p> <p>A review of a 9/9/23 care plan revealed Resident 1 had a resolved care plan for physical aggression toward another resident.</p> <p>A 9/13/23 Brief Interview for Mental Status (BIMS) Evaluation indicated Resident 1 was cognitively intact.</p> <p>On 4/18/24 at 8:05 AM Resident 1 stated, when asked about the 9/2023 incident with another resident, I do not remember the incident, but it sounds like something I would do. I'm sorry, but I have a temper.</p> <p>Random observations from 4/15/24 through 4/18/24 revealed Resident 19 was either outside or sat in the hall in front of her/his room. Resident 19 and Resident 1 were not observed interacting.</p> <p>On 4/18/24 at 7:56 AM Resident 19 stated in 9/2023 she/he was sitting in Resident 1's spot in the hallway and Resident 1 went up to her/him and said she/he was in her/his spot. Resident 19 ignored Resident 1. Resident 19 stated Resident 1 scooted forward and yelled I know you can hear me, and then Resident 1 pulled Resident 19's hair. Resident 19 stated staff separated them. Per Resident 19 she/he had no pain or injuries related to the incident.</p> <p>On 4/19/24 at 8:41 AM Staff 1 (Administrator) and Staff 2 (DNS) agreed Resident 1 pulled Resident 19's hair. No further information was provided.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to assess a resident for a significant change in condition for 1 of 4 sampled residents (#6) reviewed for falls. This placed residents at risk for unmet care needs. Findings include:</p> <p>Resident 6 admitted to the facility in 8/2023 with diagnoses including infection and pressure ulcer of the lower spine.</p> <p>Resident 6's 12/14/23 Physician Order indicated the resident was referred to hospice services.</p> <p>Resident 6's Census log indicated the resident started hospice services on 12/20/23.</p> <p>A review of Resident 6's MDS records indicated a Significant Change MDS was not completed after the resident started hospice services.</p> <p>On 4/18/24 at 11:06 AM Staff 19 (LPN Unit Manager) reviewed Resident 6's MDS records. Staff 19 stated a Significant Change MDS was required if a resident started hospice services. Staff 19 confirmed a Significant Change MDS was not completed for Resident 6.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>43690</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 1 of 1 sampled resident (#7) reviewed for care plans. This placed residents at risk for unmet needs. Findings include:</p> <p>Resident 7 admitted to the facility in 10/2017 with diagnoses including diabetes and major depressive disorder.</p> <p>A Care Plan initiated on 9/20/23 revealed the resident was to use her/his call light, walkie talkie or to call the nurses' station by phone if staff assistance was needed.</p> <p>A 2/9/24 Quarterly MDS revealed Resident 7 was cognitively intact.</p> <p>A Kardex (brief overview of each resident) dated 4/15/24 revealed staff were to encourage Resident 7 to use her/his call light for her/his needs and to ensure all staff were able to attend to her/his needs.</p> <p>A 3/18/24 Alert Note revealed Resident 7 was reminded staff could not hear or see the call light from the hall the resident was on and for Resident 7 to use her/his call bell system or walkie talkie that was implemented.</p> <p>On 4/17/24 at 3:16 PM Staff 39 (CNA) stated Resident 7 used a call bell system or walkie talkie to request staff assistance as needed. Staff 39 stated she carried a walkie talkie in her pocket so Resident 7 could communicate with her at any time.</p> <p>An observation on 4/17/24 at 3:21 PM revealed Resident 7 used her/his walkie talkie to ask Staff 39 for assistance in her/his room.</p> <p>On 4/17/24 at 3:56 PM Staff 17 (LPN) stated Resident 7 used the call bell system or walkie talkie to communicate with staff for assistance. Staff 17 stated Resident 7 was aware to use her/his call bell system or walkie talkie because the call light could not be seen or heard from the location of Resident 7's room. Staff 17 stated he kept the walkie talkie with him during his shift so he could easily communicate with Resident 7.</p> <p>On 4/18/24 at 10:16 AM Staff 19 (LPN Unit Manager) reviewed Resident 7's care plan and stated it did not accurately reflect how the resident was to call for staff assistance. Staff 19 stated Resident 7 was aware staff could not hear or see her/his call light from her/his room location and she/he was to use the call bell system or walkie talkie the facility provided.</p> <p>On 4/18/24 at 10:34 AM Staff 2 (DNS) stated Resident 7 was instructed to not use her/his call light due to the location of her/his room and to use the other two devices that were provided to her/him for staff assistance. Staff 2 stated she expected care plans to be updated with any changes.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received medications as prescribed, were monitored for medication side effects and provide wound care as ordered for 4 of 14 sampled residents (#s 8, 52, 58 and 59) reviewed for dignity, medications, and pressure ulcers. This placed residents at risk for an ineffective medication regimen and worsening wounds. Findings include:</p> <p>1. Resident 8 admitted to the facility in 2018 with diagnoses including depression and irregular heartbeat.</p> <p>A 2/22/24 revised care plan indicated the following:</p> <p>-Resident 8 was on anticoagulant therapy and was at risk for bleeding. Interventions included monitoring, documenting, and reporting to the physician any anticoagulant complications.</p> <p>-Resident 8 was on antidepressant medications to reduce sexual behaviors toward staff. Interventions included monitoring the side effects of antidepressant medication and its effectiveness.</p> <p>An 4/2024 MAR instructed staff to administer Zoloft (for treating depression) every morning for depressive disorder and apixaban (an anticoagulant) for an irregular heartbeat.</p> <p>No documentation was found in clinical records Resident 8's anticoagulant and antidepressant medication side effects were monitored and documented daily.</p> <p>On 4/19/24 at 8:01 AM Staff 1 (Administrator) and Staff 2 (DNS) stated Resident 8's monitoring for anticoagulant and antidepressant medication should be in the physician's orders and monitored daily.</p> <p>26991</p> <p>2. Resident 52 was admitted to the facility in 2024 with a diagnosis of pernicious anemia (inability of the body to absorb vitamin B12; left untreated it can cause irreversible damage to the nervous system).</p> <p>An 4/2024 MAR revealed Resident 52 was to be administered Folic Acid 400 micrograms QD for vitamin B12 deficiency. The MAR indicated the Folic Acid was not administered from 4/13/24 through 4/16/24.</p> <p>Progress Notes revealed the following:</p> <p>-4/13/24 Folic Acid-dose on order</p> <p>-4/14/24 Folic Acid-waiting on pharmacy to deliver</p> <p>-4/15/24 Folic Acid-waiting on pharmacy to dispense</p> <p>-4/16/24 Folic Acid-waiting on pharmacy to dispense</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Avamere Health Services of Rogue Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Stevens Street Medford, OR 97504	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/24 at 3:50 PM Staff 10 (LPN Unit Manager) stated Folic Acid 400 micrograms was an over-the-counter medication which was available in the central supply closet and should have been administered.</p> <p>47001</p> <p>3. Resident 58 admitted to the facility in 4/2023 with diagnoses including an infection in a right foot wound.</p> <p>On 9/11/23 a public complaint was received alleging Staff 15 (LPN) failed to complete wound care and falsified records by signing the wound care as complete.</p> <p>A review of Resident 58's 8/2023 TAR indicated her/his dressing change to the right great toe was not completed on 8/24/23 and 8/25/23.</p> <p>A review of Resident 58's 8/2023 Progress Notes revealed the dressing change to the right great toes was passed to the next shift on 8/24/23 and 8/25/23. No evidence was located which indicated Resident 58's dressing was changed on 8/24/23 and 8/25/23.</p> <p>A review of Resident 58's 8/2023 Progress notes revealed on 8/26/23 it was discovered Resident 58's right great toe dressing was not changed for two days, 8/24/23 and 8/25/23, and it was noted there were maggots found in the wound and the wound had increased redness around it.</p> <p>A review of Resident 58's 8/28/23 Wound Evaluation indicated there was increased redness around the wound.</p> <p>A review of Resident 58's 8/2023 MAR revealed on 8/30/23 Resident 58 began Keflex (an antibiotic) for her/his wound.</p> <p>An 8/30/24 Order Note stated new orders for an antibiotic were received due to redness around the wound.</p> <p>On 4/15/24 at 6:34 PM Witness 4 (Complainant) stated she was unable to complete Resident 58's wound care on 8/24/23 and 8/25/23 and she notified the next shift. Witness 4 stated Staff 15 did not complete Resident 58's wound care the days before 8/24/23 but signed it as completed.</p> <p>On 4/16/24 at 6:15 PM Witness 3 (Complainant) stated they were informed Resident 58's wound care was not completed for two days which resulted in maggots being in the wound and a wound infection.</p> <p>On 4/17/24 at 9:04 AM Staff 15 stated she changed Resident 58's dressing to her/his right great toe on 8/23/24 and there were no maggots present. Staff 15 denied signing wound care was completed when it was not.</p> <p>On 4/19/24 at 8:41 AM Staff 2 (DNS) stated she was aware maggots were found in Resident 58's right great toe wound on 8/26/24. Staff 2 acknowledged Resident 58's wound care was not completed on 8/24/23 and 8/25/23 and Resident 58 was started on antibiotics on 8/30/24 related to her/his right great toe wound. Staff 2 denied any increased redness around the wound and stated the wound did not worsen.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident 59 admitted to the facility in 7/2018 with diagnoses including a pressure injury (wound caused by pressure) to the sacrum region (the large, triangle-shaped bone in the lower spine that forms part of the pelvis).</p> <p>On 9/11/23 a public complaint was received alleging Staff 15 (LPN) failed to complete wound care and falsified records by signing the wound care was completed in 5/2023.</p> <p>A review of Resident 59's 5/2023 TAR revealed blank entries related to Resident 59's sacral wound care on 5/19/23 and 5/20/23.</p> <p>A review of Resident 59's 5/2023 Progress Notes revealed no evidence her/his sacral wound dressing was changed on 5/19/23 and 5/20/23.</p> <p>On 4/15/24 at 6:34 PM Witness 4 (Complainant) stated Staff 15 did not complete Resident 59's wound care in 5/2023, but Staff 15 signed on the TAR the wound care was completed.</p> <p>On 4/17/24 at 9:04 AM Staff 15 stated if she was unable to complete wound care she passed the wound care task to the next shift and informed management. Staff 15 denied signing wound care as completed when it was not.</p> <p>On 4/19/24 at 8:41 AM Staff 2 (DNS) stated she expected wound care to completed as ordered. Staff 2 acknowledged missed documentation on 5/19/23 and 5/20/23 for Resident 59's sacral wound care. Staff 2 and Staff 35 (Regional Nurse Consultant) acknowledged there was no indication wound care was completed for Resident 59's sacrum wound on 5/19/23 and 5/20/23.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991</p> <p>Based on observation, interview, and record review it was determined the facility failed to maintain water temperatures below 120 F for 3 of 4 resident bathrooms (room [ROOM NUMBER], 108, 111) reviewed for hot water and follow care plan interventions, assess for care plan effectiveness, identify and implement new fall interventions and provide adequate supervision needed to prevent falls for 1 of 4 sampled residents (#6) reviewed for falls. This placed residents at risk for injury. Findings include:</p> <p>1. On 4/17/24 from 10:55 AM through 12:02 PM with Staff 44 (Maintenance Lead) the following bathroom water temperatures were obtained:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] 123 F -room [ROOM NUMBER] 125 F -room [ROOM NUMBER] 121 F <p>Resident 26 and Resident 29 resided in room [ROOM NUMBER] and both required staff assistance for toileting transfers.</p> <p>Resident 20 and Resident 52 resided in room [ROOM NUMBER], both were cognitively intact. Resident 52 was independent for toileting and Resident 20 required one staff assistance for toileting transfers.</p> <p>room [ROOM NUMBER] was currently empty.</p> <p>On 4/17/24 at 12:30 PM Staff 1 (Administrator) indicated the water heater was new, acknowledged the water temperature was greater than 120 F in rooms [ROOM NUMBER], and Staff 44 would adjust and monitor the water temperatures.</p> <p>41458</p> <p>2. Resident 6 admitted to the facility in 8/2023 with diagnoses including infection and pressure ulcer of the lower spine.</p> <p>Resident 6's 8/28/23 Admission MDS revealed the resident had no cognitive impairments and required extensive assistance of two or more persons for transferring and toileting. Resident 6 had no falls within the last two to six months (prior to admission) and no falls since her/his admission.</p> <p>Resident 6's Fall CAA indicated Resident 6 was at risk for falls due to prescribed psychotropic medications (medications affecting a person's mental state), the need for staff assistance with balance and mobility and the need for staff to monitor Resident 6 for safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 6's 11/28/23 Quarterly MDS revealed the resident had no cognitive impairments and required supervision or touch assistance for transferring and toileting. Resident 6 had two or more falls since admission.</p> <p>Resident 6's 2/28/24 Quarterly MDS revealed the resident had moderate cognitive impairments and required substantial/maximal assistance for transferring and toileting. The resident was frequently incontinent of urine and occasionally incontinent of bowel and was not on a toileting program. Resident 6 had two or more falls since the last assessment.</p> <p>From 8/24/23 through 4/15/24 31 fall risk evaluations were completed. Resident 6 was identified to be at a moderate to high fall risk.</p> <p>Resident 6's current Care Plan indicated the resident was at risk for falls related to impaired mobility, muscle weakness, wasting, atrophy and pain. The following fall prevention measures were in place:</p> <ul style="list-style-type: none"> -Call light within reach at all times; initiated 8/25/23. -Notify family/responsible party of any fall; initiated 8/25/23. -Notify Resident 6's physician of any fall; initiated 8/25/23. -Keep bed in lowest position except during care; initiated 8/29/23. -Physical Therapy/Occupational Therapy evaluation and/or treatment as needed; initiated 8/29/23. -Mobility bed canes to bilateral sides of the bed; initiated 8/30/23, revised 3/19/24. -Monitor for decline or improvement; initiated 8/30/23. -Frequently remind Resident 6 to use the call light for any assistance; initiated 9/1/23, revised 1/1/24. -Education given to therapy staff to come to the nursing station to report any falls; initiated 9/21/23. -Keep the wheelchair in a locked position, centered on Resident 6's left side; initiated 9/21/23. -Resident 6 was to wear non-skid foot wear at all times; initiated 10/2/23. -Frequent rounding; initiated 10/13/23. -Nightstand moved closer to Resident 6's bed with all personal items within reach; initiated 10/28/23. -Continue to remind and encourage the resident to ask for assistance multiple times during the shift; initiated 10/14/23, revised 1/31/24. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff to remind Resident 6 frequently to ask for assistance and use her/his call light to transfer out of bed; initiated 11/10/23.</p> <p>-Keep Resident 6's door open at all times except during care; initiated 11/13/23.</p> <p>-Ensure Resident 6 had her/his soda pop and snacks within wheelchair accessibility so she/he could reach them; initiated 11/15/23.</p> <p>-Therapy to evaluate cushion in electric wheelchair; initiated 12/30/23.</p> <p>-Fall mats on both sides of the bed for safety; initiated 2/5/24.</p> <p>-Staff to anticipate Resident 6's needs; initiated 2/5/24.</p> <p>From 10/12/23 through 4/19/24 Resident 6 experienced 30 falls in the facility. Fall investigations revealed the following:</p> <p>-10/12/23 at 8:30 PM: Resident 6 had an unwitnessed fall in her/his bathroom due to self-transferring without assistance. New fall care plan intervention: staff to educate Resident 6 on self-transferring and need to ask for assistance.</p> <p>-10/26/23 at 2:42 PM: Resident 6 had an unwitnessed fall in her/his room due to self-transferring without assistance. Interventions: continue to educate and encourage Resident 6 to use the call light for assistance with transferring and to keep her/his non-skid socks on at all times.</p> <p>No new fall care plan interventions were put into place.</p> <p>-10/28/23 at 9:30 PM: Resident 6 had an unwitnessed fall in her/his room due to reaching for something on her/his nightstand and falling. The resident did not ask for help when self-transferring. New fall care plan intervention: Resident 6's nightstand was moved closer to her/his bed so all personal items were within reach.</p> <p>-11/10/23 at 3:55 AM: Resident 6 had an unwitnessed fall in her/his room while getting up to reach for a can of soda pop. New fall care plan intervention: ensure Resident 6 had her/his soda pop and snacks within wheelchair accessibility so she/he could reach them.</p> <p>-11/12/23 at 4:35 PM: Resident 6 fell when being transferred by two CNA staff due the resident's legs being weak and giving out. New fall care plan intervention: Resident 6 was changed to a two person mechanical lift until Physical Therapy evaluated the resident.</p> <p>-11/19/23 at 1:15 PM: Resident 6 had an unwitnessed fall in her/his room and was found at the end of her/his bed. No interventions were documented.</p> <p>No new fall care plan interventions were put into place.</p> <p>-12/25/23 at 10:17 PM: Resident 6 had an unwitnessed fall while self-transferring to her/his power wheelchair. Interventions: Continue to remind Resident 6 to use the call light. New fall care plan intervention: therapy to look at Resident 6's wheelchair cushion.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1/1/24 at 3:00 AM: Resident 6 had an unwitnessed fall while self-transferring into her/his power wheelchair. Interventions: continue to encourage Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-1/25/24 at 9:33 PM: Resident 6 had a fall while her/his family member assisted the resident with a transfer from the toilet. Interventions: education given to family to let staff transfer resident.</p> <p>No new fall care plan interventions were put into place.</p> <p>-1/26/24 at 5:23 PM: Resident 6 had an unwitnessed fall while attempting to self-transfer to the bathroom. Interventions: continue to encourage Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-1/28/24 at 7:01 PM: Resident 6 had an unwitnessed fall in her/his bathroom. Interventions: continue to remind and encourage Resident 6 to ask for assistance, multiple times during the shift.</p> <p>No new fall care plan interventions were put into place.</p> <p>-2/4/24 at 3:20 AM: Resident 6 had an unwitnessed fall in her/his room while standing up and self-ambulating to reach her/his soda pop. Interventions: education provided to Resident 6 to use her/his call light for assistance, ensure call light remained within reach and bed was in lowest position.</p> <p>Resident 6's care plan was not followed as the resident's soda pop was not within reach. No new fall care plan interventions were put into place.</p> <p>-2/5/24 2:30 AM: Resident 6 had an unwitnessed fall and was found on her/his back on the floor at the foot of her/his bed. Interventions: encourage Resident 6 to use the call light for assistance and place the bed in the lowest position. New fall care plan intervention: Fall mats to be placed on both sides of the bed for safety.</p> <p>-2/10/24 at 3:00 PM: Resident 6 had an witnessed fall while self-transferring from her/his wheelchair to the bed. Interventions: continue to remind and encourage Resident 6 to ask for assistance, multiple times during the shift.</p> <p>No new fall care plan interventions were put into place.</p> <p>-2/13/24 at 5:51 PM: Resident 6 had an unwitnessed fall while she/he attempted to walk to her/his bathroom. Interventions: encourage Resident 6 to ask for assistance for transfers and other care needs. Continue to regularly round on Resident 6.</p> <p>No new fall care plan interventions were put into place.</p> <p>-2/16/24 at 5:00 PM: Resident 6 had an unwitnessed fall while she/he attempted to self-transfer from her/his bed to her/his wheelchair. Interventions: education provided to Resident 6 to use her/his call light to ask for assistance, ensure call light remained within reach, the bed was in the lowest position and continue frequent rounding on Resident 6.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No new fall care plan interventions were put into place.</p> <p>-2/25/24 2:00 PM: Resident 6 had an unwitnessed fall in her/his room and was found on the floor leaning on her/his wheelchair. Interventions: continue encouragement and reminders for Resident 6 to use the call light for assistance and the resident to be rounded on when up in a chair.</p> <p>No new fall care plan interventions were put into place.</p> <p>-3/9/24 6:00 AM: Resident 6 had an unwitnessed fall and was found on her/his right side on the floor by her/his bed. At the time of the incident there was no fall mat in place. Interventions: ensure fall mats were in place, education was provided to the nurse regarding facility protocols when a fall occurred, continue to educate and encourage Resident 6 to use the call light.</p> <p>Resident 6's care plan was not followed as no fall mats were in place. No new fall care plan interventions were put into place.</p> <p>-3/16/24 12:42 PM: Resident 6 had an unwitnessed fall in her/his room and was found on the floor leaning on her/his wheelchair after self-transferring. Interventions: encouragement provided to Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-3/18/24 9:35 AM: Resident 6 had an unwitnessed fall in her/his bathroom while she/he attempted to look in the bathroom mirror to trim her/his beard. Interventions: encouragement provided to Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-3/18/24 10:45 AM: Resident 6 had an unwitnessed fall due to self-transferring. The resident was found on the ground between the foot of the bed and a table and appeared to be sleeping. Interventions: encouragement provided to Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-3/18/24 9:53 PM: Resident 6 had an unwitnessed fall in front of her/his bathroom. Interventions: encourage Resident 6 to use the call light for assistance.</p> <p>No new fall care plan interventions were put into place.</p> <p>-3/30/24 11:45 PM: Resident 6 had an unwitnessed fall and was found in her/his room on the floor next to her/his bed due to self-transferring. Interventions: encouragement provided to Resident 6 to use the call light for assistance and ensure fall mats were in place.</p> <p>No new fall care plan interventions were put into place.</p> <p>-4/2/24 3:51 AM: Resident 6 had an unwitnessed fall and was found on the floor next to her/his bed due to self-transferring. Interventions: encourage Resident 6 to call for assistance and continue to place fall mats to the sides of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No new fall care plan interventions were put into place.</p> <p>-4/5/24 1:44 PM:Resident 6 had an unwitnessed fall and was found in the bathroom in the hallway near Staff 19's (LPN Unit Manager) office due to self-transferring. Interventions: encourage Resident 6 to use the call light for assistance and round on Resident 6 frequently.</p> <p>No new fall care plan interventions were put into place.</p> <p>-4/10/24 6:38 AM: Resident 6 had an unwitnessed fall and was found laying on the floor mat next to her/his bed due to self-transferring. Interventions: fall mats placed to both sides of Resident 6's bed and call light placed within reach.</p> <p>No new fall care plan interventions were put into place.</p> <p>Resident 6's Progress Notes from 4/10/24 through 4/19/24 revealed the resident experienced additional falls on 4/12/24, twice on 4/14/24 and once on 4/19/24. None of Resident 6's 30 falls resulted in injuries.</p> <p>Observations from 4/15/24 through 4/19/24 between the hours of 8:07 AM and 4:06 PM revealed the following concerns:</p> <ul style="list-style-type: none"> -Resident 6's room was the last room at the end of the unit with minimal staff activity or traffic. -Resident 6 did not use her/his call light to call for assistance. -Resident 6 was often up in her/his wheelchair and alone in her/his room. -Resident 6 attempted to stand up while in her/his wheelchair, at times, while no staff were around. -Resident 6 was not checked on by staff for up to one hour at times. <p>The facility failed to follow care plan interventions, re-assess current interventions and develop new interventions to ensure Resident 6 was adequately supervised.</p> <p>On 4/15/24 at 1:39 PM Witness 6 (Family) stated Resident 6 fell all of the time, every day and sometimes several times a day. Witness 6 stated Resident 6 was usually found on her/his floor or in her/his bathroom. Witness 6 reported staff talked about moving Resident 6 by the nurses' station over a month ago but nothing happened.</p> <p>On 4/16/24 at 2:38 PM Staff 17 (LPN) stated Resident 6 was a high fall risk. Staff 17 reported Resident 6 would benefit from being closer to the nurses' station but there were no appropriate beds to accommodate Resident 6 at the current time. Staff 17 stated the resident fell frequently due to self-transferring and he checked on Resident 6 when he did his rounds. Staff 17 stated on 3/28/24, Resident 6 left the facility without being seen by staff and was located at a restaurant near the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/24 at 2:54 PM Staff 38 (CNA) stated Resident 6 was confused, unpredictable and unable to use her/his call light. Staff 38 stated Resident 6 had many falls due to self-transferring and he checked on her/him a minimum of every two hours. Staff 38 stated staff tried to remind Resident 6 not to get up but she/he did not remember. Staff 38 stated Resident 6 continued to fall despite fall preventions being in place.</p> <p>On 4/17/24 at 2:32 PM Staff 4 (CNA) stated Resident 6 was unsuccessful using the call light so she/he required checks at least every two hours. Staff 4 stated Resident 6 was a high fall risk and fell a lot and she worried about her/him. Staff 4 stated Resident 6 would benefit from being closer to the nurses' station where there was more staff activity.</p> <p>On 4/18/24 at 10:52 AM Staff 19 (LPN Unit Manager) reported Resident 6 had many falls because she/he self-transferred. Staff 19 stated Resident 6 needed to have round-the-clock rounding, all of the time, as frequently as possible. Staff 19 stated Resident 6 did not use her/his call light and had many falls, often on evening or night shift, because she/he was not being rounded on frequently enough and her/his room was at the end of the unit where she/he could not be seen. Staff 19 reviewed Resident 6's current fall care plan interventions and confirmed there were no new fall interventions attempted for several months and the team needed to reassess Resident 6 and determine other fall interventions to try because she did not want to see the resident continue to fall and get injured.</p>

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NAME OF PROVIDER OR SUPPLIER Avamere Health Services of Rogue Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Stevens Street Medford, OR 97504	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>35855</p> <p>Based on observation, interview, and record review the facility failed to maintain healthy parameters of nutritional status for 3 of 6 residents (#s 32, 60 and 358) reviewed for nutrition. This placed residents at risk for weight loss. Findings include:</p> <p>1. Resident 32 admitted to the facility in 2023 with diagnoses including stroke and dementia.</p> <p>An 10/3/23 MDS indicated Resident 32 had moderate cognitive impairment. No dietary issues were noted, and she/he was working with ST and currently weighed 142 pounds.</p> <p>An 10/20/23 MAR instructed staff to administer a nutritional supplement three times a day with a discontinuation date of 10/30/23.</p> <p>An 10/28/23 Order Note indicated the supplement appeared to cause gastrointestinal upset.</p> <p>A Weight Summary Review revealed Resident 32 weighed 148 pounds on 9/29/23 and 135 pounds on 10/30/23. (Eight percent weight loss)</p> <p>No documentation was found in Resident 32's clinical record for a Nutritional Assessment after an eight percent weight loss.</p> <p>On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated there was usually a report which was created to review weight loss and Resident 32 should have been discussed by the Nutrition At Risk committee.</p> <p>2. Resident 60 admitted to the facility in 2023 with diagnoses including severe protein-calorie malnutrition.</p> <p>A 11/13/23 hospital Clinical Nutrition Follow-up indicated Resident 60 had a weight loss greater than 7.5 percent in the last three months with severe body fat and muscle mass depletion. Recommendations and interventions included changing the food supplement to a strawberry bene-protein shake three times a day with meals. Weight on 1/13/23 was 123 pounds.</p> <p>The MAR from 11/18/23 through 11/30/23 instructed staff to obtain weight daily on the day shift before breakfast and notify the physician of any weight gain. On 11/18/23 Resident 60's weight was documented at 135 pounds, on 11/20/23 her/his weight was documented at 114. On 11/24/23, 11/25/23, and 11/29/23 it was documented as NA. From 11/26/23 through 11/28/23 and 11/30/23 there was no documentation weights were obtained.</p> <p>The 12/2023 MAR instructed staff to obtain weight daily on the day shift before breakfast and notify the physician of any weight gain. On 12/1/23 and 12/30/23 there was no documentation of Resident 60's weight was obtained. On 12/10/23, 12/14/23, and 12/15/23 the MAR referred the reader to order notes.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician orders signed on 12/30/23 instructed staff to provide a nutritional supplement three times a day with a start date of 11/27/23 and to obtain weight daily on the day shift before breakfast with a start date of 11/18/23.</p> <p>Order Notes reviewed for 12/10/23, 12/14/23, and 12/15/23 did not have documentation of why Resident 60's weight was not obtained.</p> <p>On 4/19/24 at 7:51 AM Staff 1 (Administrator) and Staff 2 (DNS) stated when there was a large discrepancy in weight staff may be weighing in a wheelchair and not taking off the weight of the wheelchair. Staff 2 stated education may be needed for staff.</p> <p>47001</p> <p>3. Resident 358 admitted to the facility in 3/2024 with diagnoses including adult failure to thrive.</p> <p>A 3/26/24 Nutrition Assessment from the hospital stated Resident 358's eating was inadequate with an average intake of 33% of meals, and Resident 358's most recent weight on 2/29/24 was 220 lbs.</p> <p>An 4/4/24 Nutrition at Risk Assessment indicated Resident 358 was at risk for nutritional deficits due to malnutrition, inadequate intake and wounds.</p> <p>An 4/12/24 Nutrition at Risk Assessment indicated Resident 358's intake declined but she/he accepted 100% of the nutritional interventions.</p> <p>A review of Resident 358's 4/2024 MAR revealed 4/4/24 orders for a nutritional supplement, Med Pass 2.0, twice a day, and an 4/12/24 order to increase Med Pass 2.0 to three times a day.</p> <p>On 4/15/24 at 1:40 PM Resident 358 was observed sitting in bed with lunch on the tray table over her/his bed. Resident 358's food was untouched. The food tray was observed in front of Resident 358 until 2:58 PM. Resident 358's CNA Task charting indicated on 4/15/24 at 1:33 PM, Resident 358 consumed 0-25% of lunch.</p> <p>On 4/16/24 at 8:15 AM Resident 358 was observed sleeping in bed, her/his covered breakfast tray was located on the bedside table to the right side of the bed. Resident 358's CNA Task charting indicated she/he consumed 0-25% of breakfast.</p> <p>On 4/16/24 at 3:01 PM Staff 17 (LPN) stated Resident 358 often refused meals and alternate meals.</p> <p>An 4/16/24 review of Resident 358's weights revealed a weight of 142.8 lbs. on 3/29/24 and a weight of 191 lbs on 4/2/24. The 3/29/24 weight was struck out due to a technical error on 4/2/24.</p> <p>On 4/17/24 at 12:00 PM Resident 358's covered lunch tray was observed on the bedside table, Resident 358 was not observed in the room until 1:16 PM. At 1:16 PM staff set up Resident 358's lunch and left the room. Resident 358's CNA Task charting indicated at 1:00 PM Resident 358 consumed 0-25% of her/his lunch.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 7:53 AM Resident 358 was observed sitting in a wheelchair eating breakfast. At 8:00 AM Staff 18 (CNA) asked Resident 358 if she/he was done eating. Resident 358 replied she/he could not eat now. CNA Task charting indicated Resident 358 consumed 0-25% of breakfast.</p> <p>On 4/18/24 at 12:06 PM Staff 19 (LPN Unit Manager) stated Resident 358 had a lot of missed weights due to refusals and Staff 19 confirmed the refusals were not documented. Staff 19 stated Resident 358's average meal intake was 33% and she/he should have been offered a replacement meal when she/he ate less than 50% of her/his meal. Staff 19 confirmed there was no documentation for meal replacements and Resident 358 lost weight since the last weight at the hospital prior to admission.</p> <p>On 4/18/24 at 12:38 PM Staff 20 (LPN) stated Resident 358 did not eat well during meals at times, but stated Resident 358 was offered snacks throughout the day. Staff 20 stated bedtime snacks were offered and charted in the CNA Tasks, but there was no documentation of the snacks offered throughout the day. Staff 20 confirmed bedtime snacks were charted once since Resident 358 admitted to the facility.</p> <p>An 4/19/24 review of CNA Task charting from 3/29/24 through 4/18/24 revealed Resident 358 consumed 76-100% of the meal eight times, consumed 51-75% of the meal 10 times, consumed 26-50% of the meal 20 times and consumed 0-25% of the meal 23 times.</p> <p>An 4/19/24 review of CNA Meal Replacement task charting revealed, from 3/29/24 through 4/18/24, Resident 358 consumed a meal replacement once on 4/16/24 at 1:00 PM and she/he consumed 50% of the meal replacement.</p> <p>An 4/19/24 review of Resident 358's weights revealed on 4/19/24 Resident 358 weighted 192 lbs.</p> <p>On 4/19/24 at 8:41 AM Staff 2 (DNS) confirmed Resident 358 had two weights since admission. Staff 35 (Regional Nurse Consultant) stated, per policy, weights should be obtained upon admission, then weekly for four weeks, and then monthly. Staff 2 stated if a resident consumed less than 50% of their meal she expected the alternate meal to be offered. Staff 2 confirmed Resident 358 ate on average less than 50% of meals with an alternate meal being offered once, and Resident 358 lost weight since admission.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>34703</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure ongoing communication with the dialysis center for 1 of 2 sampled residents (#63) reviewed for rehab. This placed residents at risk for dialysis complications. Findings include:</p> <p>Resident 63 admitted to the facility in 2023 with diagnoses including chronic kidney disease and was dependent on dialysis (a procedure to remove waste products from the blood when the kidneys stop working).</p> <p>Resident 63's care plan for renal failure dialysis, revised on 11/15/23, indicated the resident's scheduled dialysis days were Monday, Wednesday, and Friday.</p> <p>A review of the resident's clinical record revealed a 11/21/23 document related to dialysis communication. There were no forms from 11/22/23 through 12/15/23 between the facility and the dialysis provider.</p> <p>On 4/19/23 at 8:39 AM Staff 10 (LPN Unit Manager) indicated there was one dialysis communication form in Resident 63's clinical record. Staff 10 stated the form was an important document and used for communication between the dialysis center and the facility.</p> <p>On 4/19/23 at 9:34 AM Staff 2 (DNS) stated she would look for the missing dialysis communication documentation. No further information was provided.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>35855</p> <p>Based on observation, interview, and record review it was determined the facility failed to have adequate staff available to timely meet the needs of residents for 3 of 18 sampled residents (#s 32, 60 and 160) and for 2 of 3 wings (Wings 1 and 2). This placed residents at risk for unmet needs. Findings include:</p> <p>1. A 2/7/24 Quality Assurance Resident Council note indicated call light wait times were too long. The 2/12/24 Response Form indicated the facility followed the state minimum CNA staffing requirements.</p> <p>A 3/6/24 Resident Council Department Response Form indicated the residents felt they needed more nurses and there were not enough which affected their care. The facility's response was they staffed to meet the state minimum staffing requirements.</p> <p>An 4/10/24 Bi-Monthly Resident Counsel Questions form revealed the questions if residents felt staff answered call lights within a 10-minute time frame, and if the resident counsel felt the facility was staffed well enough to meet the needs of the residents, to which the answer to both was documented as no.</p> <p>An 4/10/24 Resident Council Department Response Form indicated the facility needed more CNAs on the evening shift because staff was working with residents who were sundowning (a neurological phenomenon associated with increased confusion and restlessness in people with delirium or dementia). The facility response was the facility staffed to meet or exceed the state minimum staffing requirements on all three shifts.</p> <p>On 4/15/24 interviews were conducted revealing the following:</p> <p>-11:28 AM Resident 1 stated she/he had to activate the call light long before she/he had to urinate as after 2:00 PM call light wait times were 10 minutes to an hour. Resident 1 stated she/he fell because she/he took herself/himself self to the bathroom. One night no CNAs ever came after activating the call light.</p> <p>-11:51 AM Resident 44 stated she/he was a dissatisfied consumer as she/he had chronic bowel issues, and she/he would be on the bedpan after activating the call light for up to 30 to 45 minutes. At times staff gathered and just gossiped and did not answer call lights.</p> <p>-1:21 PM Resident 31 stated she/he had to wait up to 30 minutes for her/his call light to be answered and stated the facility needed more staff.</p> <p>-1:26 PM Resident 52 stated the call light wait time was approximately one to one and a half hours for a response on all shifts.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1:35 PM Resident 37 stated it took an hour and a half to get assistance and on 4/15/24 she/he had to wait 40 minutes. At times staff came in to the room, turned off the call light, and then did not come back. Resident 37 stated at times she/he was in pain, and she/he had to wait an hour. Resident 37 stated it depended on who was working and not the time of day.</p> <p>-1:36 PM Resident 36 stated the facility was always short of staff. In the middle of the night she/he heard hear her/his roommate in pain and activated her/his call light, but waited an hour for a response.</p> <p>-1:42 PM Resident 6 stated it took forever for staff to respond to call lights. Resident 6 stated she/he would go down the hall to try and find someone to help but could not find anyone. Resident 6 stated it happened a lot on the evening shift around 7:00 PM and ,at times, she/he saw staff talking at the nurses' station and not answering call lights.</p> <p>-1:51 PM Resident 50 stated during the night she/he had to wait for care, she/he was a two-person assist and there were not always two staff members available to help. Resident 50 stated she/he, at times, had incontinent episodes because she/he could not wait any longer for assistance.</p> <p>-2:13 PM Resident 29 stated at night and on the weekends when she/he activated her/his call light it took a long time for staff to respond. Resident 29 stated at times she/he had incontinent episodes because she/he had to wait too long.</p> <p>-2:24 PM Resident 34 stated there was not enough staff on day and evening shifts, and residents had to wait a long time for their call lights to be answered.</p> <p>-2:25 PM Resident 308 stated she/he had to call out for help one night because her/his call light was not answered. Resident 308 stated she/he did not feel the facility had enough nurses.</p> <p>-5:24 PM Resident 26 stated call light wait times were over 15 minutes. Resident 26 stated the facility needed more CNAs and nurses during the day.</p> <p>On 4/16/24 at 7:35 AM Resident 8 stated her/his call light wait times were mostly over half an hour.</p> <p>On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 10/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes.</p> <p>On 4/18/24 at 9:30 AM Staff 8 (CNA) stated that call light wait times went over 20 minutes.</p> <p>On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she took lunch break, and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents activated their call light when on a bedpan and did not have timely follow up. Residents who were continent had incontinent episodes and their dignity was affected because of a long call light wait times.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/18/24 at 1:00 PM Staff 11 (CNA) stated residents complained of long call light wait times very much and she observed residents who were left on a bedside commode for long periods of time, and a couple of residents had incontinent episodes when they were continent because staff did not attend to timely.</p> <p>On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours.</p> <p>2. Resident 32 was admitted to the facility in 2023 with diagnoses including stroke and dementia.</p> <p>A 9/29/23 care plan indicated Resident 32 was incontinent of bowel and bladder with interventions including an incontinent program to toilet upon rising, before meals, after meals, at bedtime, and PRN.</p> <p>An 10/23/23 MDS indicated Resident 32 had moderate cognitive impairment and was occasionally incontinent of bowel and bladder. Resident 32 was normally aware of her/his need to go to the bathroom and staff assisted her/him with toileting and incontinent care needs.</p> <p>A review of the Direct Care Staff Daily Reports from 10/22/23 through 11/22/23 revealed the facility did not have sufficient CNA staff to meet the state minimum CNA staffing requirements on the following days: 10/28/23 day shift, 10/29/23 day shift, 11/12/23 day shift, and 11/24/23 night shift.</p> <p>On 11/22/23 a public complaint was received which indicated Resident 32 was left in a soiled brief for an extended period. A family member visited daily and observed Resident 32 sitting in wet brief because not enough staff were available to assist, and stated call light wait times were longer than 20 minutes.</p> <p>On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 10/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes.</p> <p>On 4/18/24 at 9:16 AM Witness 1 (Family Member) confirmed Resident 32 was left in a soiled brief for an extended period of time.</p> <p>On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she went on lunch break and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents activated their call light when on a bedpan and there was no timely response. Staff 4 stated she found Resident 32 in a soaked brief, and she/he complained to her about having to wait a long time for assistance.</p> <p>On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours.</p> <p>3. Resident 60 was admitted to the facility in 2023 with diagnoses including anxiety, a pressure ulcer to the right buttock, and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Direct Care Staff Daily Reports from 11/15/23 through 11/14/23 revealed the facility did not have sufficient CNA staff to meet the state minimum CNA staffing requirements on the following days: 11/24/23 night shift, 11/26/23 evening shift, 12/1/23 night shift, 12/3/23 evening shift, and 12/7/23 night shift.</p> <p>A 11/15/23 care plan indicated Resident 60 was incontinent of bowel and bladder and was at risk for skin impairment. Interventions included an incontinent program to toilet upon rising, before meals, after meals, at bedtime, and PRN. Resident 60 used briefs for dignity.</p> <p>A 11/18/23 Nursing Care Note indicated Resident 60 called the police for help. The note indicated Resident 60 wanted staff to always stay in her room. The note indicated Resident 60 used her/his call light multiple times and each time it was answered timely. The note indicated the facility would do frequent checks on the night of 11/18/23.</p> <p>A 11/19/23 MDS indicated Resident 60 had moderate cognitive impairment and was frequently incontinent of bladder and always incontinent of bowel. Resident 60 was at risk for skin impairment and was dependent on staff for assistance with toileting.</p> <p>A Documentation Survey Report for 11/2023 indicated no documentation of assistance with toileting hygiene for the day shift on 11/22/23 and the night shift on 11/23/23.</p> <p>A public complaint was received on 12/14/23 which indicated Resident 60 was lying in urine and she/he attempted to reach staff by phone, but no one answered. Resident 60 called Witness 2 (Family Member) and Witness 2 stayed on the phone with Resident 60 until staff came and assisted Resident 60. This occurred two nights in a row and Resident 60 ended up calling 911. Police came to the facility for a welfare check.</p> <p>On 4/16/24 at 12:03 PM Witness 2 confirmed call light wait times of up to an hour and staff standing around and talking with multiple lights on at the nurses' station.</p> <p>On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 11/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes.</p> <p>On 4/17/24 at 10:28 AM Staff 6 stated in 11/2023 the facility was short-staffed and she had to work very fast. Staff 6 stated it was overwhelming and stressful and residents thought staff were ignoring them.</p> <p>On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she would go on lunch and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents would activate their call light when on a bedpan and not have it answered timely. Staff 4 stated she had found Resident 60 in a soaked brief and if she/he would push her/his call light a lot it was because her/his needs were not met.</p> <p>On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours.</p> <p>34703</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>35855</p> <p>Based on interview, and record review, it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include:</p> <p>A review of the Direct Care Staff Daily Reports (DCSDR) from 11/23/23 through 12/15/23 revealed no staff hours were documented on eight days, census was documented only one day, and the number of staff was not documented two days out of 23 days reviewed.</p> <p>On 4/19/24 at 7:39 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they were not aware of the issues with the DCSDR reports. Staff 2 stated the Staffing Coordinator was newer to the facility during the above reviewed time period.</p>

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NAME OF PROVIDER OR SUPPLIER Avamere Health Services of Rogue Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Stevens Street Medford, OR 97504	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident's medication was available for administration for 1 of 4 sampled residents (#52) reviewed for dignity. This placed residents at risk for an ineffective medication regimen. Findings include:</p> <p>Resident 52 was admitted to the facility in 2024 with a diagnosis of pernicious anemia (inability of the body to absorb vitamin B12; left untreated it can cause irreversible damage to the nervous system).</p> <p>A 3/23/24 admission MDS revealed Resident 52 was cognitively intact. Resident 52 had a severe degeneration of her/his spinal cord due to a vitamin B12 deficiency.</p> <p>On 4/15/24 at 1:17 PM and 4/17/24 at 11:47 AM Resident 52 stated she/he took vitamin B12 daily, which was required to prevent her/his health from significantly declining. Resident 52 stated it was like life or death to her/him if she/he missed the medication. Resident 52 stated the facility did not have her/his vitamin B12 available to administer.</p> <p>An 4/2024 MAR revealed vitamin B12 was not administered on 4/15/24.</p> <p>An 4/15/24 Progress Note indicated staff waited for the pharmacy to dispense the medication.</p> <p>On 4/18/24 at 10:21 AM Staff 10 (LPN Unit Manager) stated the pharmacy did not send the resident her/his medication because it was not common to administer the medication daily. The order was initially clarified when Resident 52 was admitted to the facility but the pharmacy failed to document the clarification in the resident's record, and therefore there was another delay in sending the medication and Resident 52 missed a dose of her/his vitamin B12.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>26991</p> <p>Based on interview and record review it was it was determined the facility failed to ensure a medication error rate of less than 5%. The facility administration error rate was 7% with two errors in 27 opportunities. This placed residents at risk for an ineffective medication regimen. Findings include:</p> <p>1. Resident 303 admitted to the facility in 2024 with a diagnosis of a low functioning thyroid.</p> <p>Epocrates Online (web based pharmacy resource) revealed levothyroxine (hormone replacement) should be taken 15 to 60 minutes before breakfast with a full glass of water at the same time daily.</p> <p>Resident 303's 4/6/24 admission MDS indicated she/he was cognitively intact.</p> <p>On 4/16/24 at 7:30 AM Staff 15 (LPN) was observed to administer levothyroxine to Resident 303. Resident 303 was observed eating breakfast and stopped to take her/his medications including the levothyroxine.</p> <p>On 4/16/24 at 2:58 PM Resident 303 stated when she/he was at home, she usually did not take levothyroxine with food. Resident 303 stated she/he took the levothyroxine as soon as she/he woke up, even before she/he drank her/his coffee. Resident 303 stated since admission to the facility the staff administered the medication with food.</p> <p>On 4/17/24 at 10:00 AM Staff 10 (LPN Unit Manager) stated the medical director felt the benefits outweighed the risks if a resident took thyroid medications with food as long as the resident took the medication with food and the resident's labs were monitored. By providing the levothyroxine with breakfast it allowed the resident to sleep and not be woken at 6:00 AM. Staff 10 stated she reviewed medications with residents at the 72 hour conference but did not ask the residents about their medication administration time preferences for medications such as levothyroxine. Staff 10 acknowledged if a resident was a long-term resident, administering levothyroxine with food and monitoring labs could be effective, but for a resident on the skilled unit and only in the facility for a short period of time such as Resident 303, changing the resident's medication regimen might not be therapeutic. A request was made to Staff 10 to provide scientific data to support administering levothyroxine with food. No additional information was provided.</p> <p>2. Resident 30 admitted to the facility in 2024 with a diagnosis of diabetes</p> <p>On 4/16/24 at 7:54 AM Staff 45 (LPN) was observed to administer Resident 30 her/his medications. Cranberry D-Mannose (supplement to prevent UTIs) was not administered.</p> <p>On 4/17/24 at 9:22 AM Staff 45 stated she/he did not administer Resident 30 her/his Cranberry D-Mannose because it was not available in the supply closet.</p> <p>On 4/17/24 at 9:22 AM with Staff 45 and staff 46 (Central Stores) one bottle of Cranberry D-Mannose was observed on the shelf. Staff 45 stated she looked in the supply closet and only saw plain cranberry supplement. Staff 45 stated she did not see the Cranberry D-Mannose on the higher shelf.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>35855</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure menus were followed for 2 of 4 sampled residents (#s 8 and 40) reviewed for food. This placed residents at risk for unmet food preferences. Findings include:</p> <p>1. Resident 8 admitted to the facility in 2018 with diagnoses including diabetes.</p> <p>An 4/17/24 breakfast menu ticket revealed poached eggs, toast, link sausage, cream of wheat, and two percent milk.</p> <p>On 4/17/24 at 7:51 AM Resident 8 stated she/he received scrambled eggs instead of poached eggs and did not receive any drinks.</p> <p>On 4/19/24 at 7:54 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they expected the kitchen to provide Resident 8 what was on her/his menu ticket.</p> <p>2. Resident 40 was admitted to the facility in 2023 with diagnoses including adult failure to thrive.</p> <p>An 4/17/24 breakfast menu ticket revealed Resident 40 circled hash brown patty, grapes, two eggs over easy, and coffee. The lunch menu ticket indicated a hamburger on a bun. The bun portion was crossed out and a handwritten English muffin was in place of the bun. Additionally, chopped tomatoes, chocolate ice cream, and a small apple juice were indicated.</p> <p>On 4/17/24 at 7:33 AM, 7:35 AM, and 7:36 AM Staff 9 (CNA) was in Resident 40's room assisting with breakfast set up, Resident 40 stated she/he wanted bacon, her/his roommate had bacon and her/his food was wrong. Staff 9 stated she could take the unwanted food off Resident 40's plate. Staff 9 stated Resident 40 wanted a hash brown patty and bacon, but bacon was not on the breakfast meal ticket. Resident 40 stated she/he was supposed to get a hash brown patty instead of tater tots.</p> <p>On 4/17/24 at 12:24 PM Resident 40 was observed with a hamburger and a hamburger bun, chopped tomatoes, and two English muffins with what appeared to be peanut butter spread in between the two pieces of English muffin. No chocolate ice cream was observed on the lunch tray. Resident 40 stated she/he did not get her/his ice cream.</p> <p>On 4/19/24 at 7:54 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they expected the kitchen to provide Resident 40 what was on the meal ticket. Staff 1 stated if the kitchen ran out of hashbrown patties it was simple to make them using tater tots.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>35855</p> <p>Based on observation, interview, and record review it was determined the facility failed to provide assistive devices for 1 of 5 sampled residents (#8) reviewed for nutrition. This placed residents at risk for unmet needs. Findings include:</p> <p>Resident 8 admitted to the facility in 2018 with diagnoses including diabetic neuropathy (damage or disease affecting the nerves).</p> <p>An 4/3/24 care plan indicated Resident 8 was at nutritional risk with interventions including adaptive equipment of a two-handle cup and a lip plate.</p> <p>An 4/17/24 breakfast menu ticket revealed the following adaptive equipment: a lip plate and a two-handle cup.</p> <p>On 4/17/24 the following occurred:</p> <p>-7:46 AM Staff 4 (CNA) brought out a small plastic cup with a white liquid out of Resident 8's room.</p> <p>-7:51 AM Resident 8 stated she/he did not know where her/his milk was, and she/he did not receive any drinks with breakfast.</p> <p>-7:55 AM Staff 4 stated she took Resident 8's milk because her/his cup did not have an adaptive handle on it.</p> <p>-7:58 AM Staff 4 came out of the kitchen with Resident 8's cup with adaptive handles on it.</p> <p>-12:43 PM Resident 8 was observed sitting in a wheelchair with a lunch tray in front of her/him with a cup of white liquid with no adaptive handles.</p> <p>-12:46 PM Staff 4 stated the kitchen neglected to provide Resident 8 with a cup with adaptive handles for lunch.</p> <p>On 4/19/24 at 8:00 AM Staff 1 (Administrator) and Staff 2 (DNS) stated it was expected for the kitchen to read the menu tickets and provide Resident 8 with her/his care planned adaptive meal equipment.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34703</p> <p>Based on observation, interview, and record review it was determined the facility failed to handle and prepare food in a sanitary manner for 1 of 1 kitchen reviewed for sanitary practices. This placed residents at risk for food-borne illness. Findings include:</p> <p>On 4/17/24 at 8:24 AM the beverage carts for Wing 1 and Wing 2 were observed with dirty coffee pots which were used for the residents. Staff 28 (Dietary Services Manager) acknowledged the coffee pots needed deep cleaning.</p> <p>On 4/17/24 at 11:45 AM the following was observed during preparing and plating food from the kitchen's steam table for lunch:</p> <ul style="list-style-type: none"> -Staff 31 (Dietary Aide) performed a temperature check on all food. The food was within normal limits except for the potato salad which was 51 degrees and needed to be 41 degrees. No further checking was performed for the potato salad. -Staff 31 was observed touching the food with utensils and his gloved hands, he then stepped away from the steam table to retrieve tongs and did not perform hand hygiene or don new gloves. Staff 31 left the steam table twice to retrieve food from the refrigerator and was observed to open the refrigerator with his gloved hand, retrieve a tote with ice, uncover bowls of potato salad and close the refrigerator door with his gloved hand. Staff 31 did not change his gloves or complete hand hygiene during the above observations. He then returned to the steam table, removed hamburger buns from a bag, placed them on a tray for delivery to a resident and then continued to handle food using utensils and his gloved hands. Staff 31 left the steam table to retrieve cheese slices from the refrigerator, touched his nose and watch, removed his gloves, and tossed one glove on top of the tote of ice with uncovered potato salad. -Staff 31 had a beard and mustache but only wore a surgical facemask which did not restrain all his beard or mustache. <p>On 4/17/24 at 12:56 PM Staff 31 acknowledged There was a break in infection control and he should have changed his gloves, performed hand hygiene, worn a beard restraint and checked the temperature again for the potato salad before it was served to residents.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure records were accurate for 1 of 6 sampled residents (#44) reviewed for unnecessary medications. This placed residents at risk for inaccurate treatment. Findings include:</p> <p>Resident 44 was admitted to the facility in 12/2023 with diagnoses including high blood pressure.</p> <p>Resident 44's 12/19/23 Physician Order indicated the resident was to receive lisinopril (medication to treat high blood pressure) one time a day and the medication was to be held for systolic blood pressure (pressure in the arteries when the heart beats) below 110 and diastolic blood pressure (pressure in the arteries when the heart rests between beats) below 60.</p> <p>Resident 44's 3/2024 and 4/2024 MARs indicated the resident's blood pressure was documented as NA on 3/27/24, 4/1/24, 4/5/24, 4/8/24, 4/9/24, 4/15/24 and 4/16/24.</p> <p>On 4/18/24 at 10:32 AM Staff 19 (LPN Unit Manager) and Staff 22 (CMA) reviewed Resident 44's physician order and 3/2024 and 4/2024 MARs. Staff 19 stated Resident 44's blood pressure readings needed to be documented on the MAR where NA was marked. Staff 22 stated he took Resident 44's blood pressure readings prior to administering her/his lisinopril on the dates marked NA, but did not document the readings as required. Staff 19 stated her expectation was Resident 44's blood pressure readings were documented as instructed.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to monitor antibiotic use for 1 of 1 resident (#1) reviewed for antibiotic stewardship. This placed residents at risk for unnecessary medications. Findings include:</p> <p>Resident 1 admitted to the facility in 7/2013 with diagnoses including infection due to urinary catheter, and a history of multi-drug-resistant organisms (MDRO).</p> <p>An 4/16/24 review of Resident 1's care plan revealed a 2/9/23 care plan for enhanced barrier precautions related to a history of MDRO infections and a 2/18/24 care plan for chronic urinary tract infections.</p> <p>A review of Resident 1's 2/2024 MAR revealed an order for cephalexin (an antibiotic) for a urinary tract infection which started on 2/17/24 and ended on 2/25/24.</p> <p>A 2/16/24 urine analysis lab indicated Resident 1 had a small number of bacteria in her/his urine.</p> <p>On 4/16/24 Staff 2 (DNS) acknowledged there was no culture and sensitivity completed with the urinalysis to determine the correct antibiotic for Resident 1.</p> <p>On 4/19/24 at 8:41 AM Staff 2 acknowledged Resident 1 completed the ordered antibiotic treatment from 2/17/24 through 2/25/24. Staff 2 stated an antibiotic time-out should have occurred but was not completed 48 hours after starting the antibiotic.</p>