STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385031	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Crestview of Portland	6530 SW 30th Avenue Portland, OR 97239

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50928 Based on observation, interview and record review it was determined the facility failed to ensure dignity for 1 of 4 sampled residents (#23). This placed residents at risk for lack of dignity. Findings include: Resident 23 was admitted to the facility in 3/2022 with a diagnosis of dementia. Resident 23's Annual MDS completed on 3/14/2024 indicated Resident 23 was significantly cognitively impaired. Resident 23's revised 8/16/2024 Care Plan indicated Resident 23 had meals served on Styrofoam dishware. On 9/9/2024 through 9/11/2024 between the hours of 11:49 AM and 1:15 PM Resident 23 was obseved to eat meals off of Styrofoam dishware. On 9/12/2024 at 10:20 AM Staff 18 (LPN) stated the facility had not attempted to implement alternatives such as plasticware. Staff 18 confirmed the loss of dignity related to residents eating from Styrofoam dishware. On 9/12/2024 at 11:00 AM Staff 10 (Dietary Manager) acknowledged the use of Styrofoam dishware was a dignity concern. On 9/13/2024 at 2:06 PM Staff 1(Administrator) acknowledged the use of Styrofoam dishware was a dignity concern.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 43690 Based on interview and record review it was determined the facility failed to ensure a consent was obtained prior to administering antipsychotic medications to residents for 1 of 5 sampled residents(#24) reviewed for unnecessary medications. This placed residents at risk for being uninformed about their medications. Findings include: Resident 24 was admitted to the facility in 7/2024 with diagnoses including fracture and dementia. Resident 24's 7/30/24 Physician Order indicated the resident was prescribed valproic (antipsychotic) for schizoaffective disorder. Resident 24's 8/2024 and 9/2024 MARs revealed the resident received valproic daily. Review of Resident 24's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of valproic. On 9/11/24 at 9:57 AM Staff 13 (RNCM) reviewed Resident 24's health record, acknowledged there was no documentation to indicate the resident was informed of the risks and benefits of valproic and confirmed a consent was not obtained from Resident 24 or her/his representative prior to the resident starting the medication.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47000 Based on observation, interview and record review it was determined the facility failed to honor a resident's preference to get dressed for 1 of 4 sampled residents (#34) reviewed for ADLs. This placed residents at risk for lack of choices and self-determination. Findings include: Resident 34 was admitted to the facility in 10/2023 with diagnoses including blindness. Resident 34's 10/9/23 Admission MDS indicated she/he was severely visually impaired, usually able to make her/himself understood to others, required substantial-to-maximal assistance for upper body dressing and was dependent on staff for lower body dressing. The MDS also indicated it was somewhat important to the resident to be able to choose what clothes she/he wanted to wear. Resident 34's 7/15/24 ADL Self Performance Deficit Care Plan revealed the resident was totally dependent on staff to get dressed. On 9/9/24 at 12:24 PM and 9/10/24 at 1:21 PM Resident 34 was observed in bed and wore a hospital gown. Resident 34 stated it was not her/his preference to wear a hospital gown and staff did not offer to assist her/him to get dressed. On 9/11/24 at 9:19 AM Staff 14 (CNA) stated Resident 34 never refused when he offered to assist her/him to get dressed and the resident always wanted to wear pants. On 9/12/24 at 2:03 PM Staff 1 (Administrator) stated she expected staff to offer to assist residents to get dressed in the morning.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on observation and interview it was determined the facility failed to maintain a homelike environment for 4 of 7 facility halls reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include: Observations of the facility's general environment and residents' rooms from 9/9/24 through 9/13/24 identified the following issues: -Rooms 20, 23, 24, 27, 33, 35, 36, 38, 40, 45, 46, 49, 60, 61, 62, 64, 65, 66, 68 and 69 had resident doors with missing pieces of wood with sharp/jagged edges on the lower portions of the doors. -Rooms 61, 64, 65, 68, 69, 71 and 78 had walls where the in room sinks were with gouges along the walls, missing paint and exposed drywall. -room [ROOM NUMBER]-1 had a chunk of missing paint on the wall behind the resident bed. -room [ROOM NUMBER] had broken blinds and a jagged edge with missing paint and exposed drywall behind the resident door. -room [ROOM NUMBER]-1 had large scratches to the right of the head of bed and across the room from the foot of the bed. -room [ROOM NUMBER] had wall base peeling away from the wall next to the bathroom and the wall to the left of the resident door was gouged with missing paint, exposed drywall and had multiple missing chunks out of the blinds. -Carpet outside rooms [ROOM NUMBERS] was rippled approximately six feet by six feet causing a potential tripping hazard. -Carpet was pulled away from the wall base outside Rooms 17, 22, 23 and 46. -Carpet was pulled away from the wall base at nurses station 2 along with a sharp/jagged edges along the entryway with missing paint and exposed drywall. -Nurses station 1 had sharp/jagged edges along the lower portion of the entryway with pieces of wood that had separated. -The alcove adjacent to Hall 70 had two dirty light fixtures and two faux [NAME] chairs with exposed substrate fabric which was uncleanable and stained. -Blinds in the main dining room leading to the Activity Director's office had multiple missing and broken slats. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The entryway to the main dining room from the 300 Hall had a sharp/jagged wall edge with missing paint and exposed drywall approximately five feet up the wall. On 9/13/24 at 10:37 AM Staff 1 (Administrator) and Staff 8 (Maintenance Director) acknowledged the identified rooms were not homelike and the identified maintenance concerns needed to be repaired.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47001 Based on interview and record review it was determined the facility failed to report to the State Survey Agency an allegation of abuse for 1 of 4 sampled residents (#267) reviewed for dignity. This placed residents at risk for abuse and neglect. Findings include: Resident 267 was admitted to the facility in 9/2024 with diagnoses including malignant brain cancer. A 9/9/24 Grievance communication Form stated Resident 267 had concerns related to her/his night shift CNA not being responsive to the call light and not friendly during care. The DNS and LPN Resident Care Manager spoke with Resident 267 and her/his family about the concerns and determined Resident 267 can be overstimulated by noise and her/his care plan was updated. The conclusion of the grievance stated the CNA would not be working with Resident 267 anymore. On 9/10/24 at 10:00 AM Resident 267 stated on her/his first night in the facility there was a night shift CNA who did not take care of her/him and took her/his call light away. Resident 267 stated she/he called her/his brother to get assistance. Resident 267 was tearful when she/he described the night. A 9/10/24 Admission MDS indicated Resident 267 had mild cognitive impairment. On 9/12/24 at 10:17 AM Staff 12 (LPN Resident Care Manager) stated she became aware of Resident 267's concerns through his/her brother. Staff 12 stated she spoke with Resident 267 with Staff 2 (DNS). Resident 267 stated the CNA was slow to respond to her/his call light and was not friendly. Staff 12 stated Resident 267's care plan was updated after talking with the family and the CNA was not coming back to the facility. When asked about the CNA taking Resident 267's call light, Staff 12 replied she thought the call light was taken away to provide care and then given back to Resident 267. On 9/12/24 at 11:03 AM Staff 2 (DNS) stated Resident 267 made a compliant about the night shift CNA on 9/6/24. Staff 2 stated she and Staff 12 spoke with Resident 267 and her/his family and she/he stated the CNA made her/him feel uncomfortable. Staff 2 stated Resident 267 likes interactions to be quiet and soft and this CNA was not quiet and soft. Staff 2 stated Resident 267's care plan was updated. When asked about Resident 267's call light being taken away, Staff 2 stated Resident 267 informed her the CNA removed the call light form her/his hands and she/he had to call her/his brother to get assistance. Staff 2 stated the CNA was not coming back to the facility due to the allegation of taking away Resident 267's call light. Staff 2 stated the incident could have been abuse depending upon why the CNA took away the call light and for how long. Staff 2 denied interviewing the CNA and stated the compliant should have been investigated to rule out abuse. On 9/12/24 at 11:47 AM Staff 16 (RNCM) stated if abuse is suspected, a Facility Incident Report should have been completed and sent to the State Survey Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47001 Based on interview and record review it was determined the facility failed to investigate an allegation of abuse for 1 of 4 sampled residents (#267) reviewed for dignity. This placed residents at risk for abuse and neglect. Findings include: Resident 267 was admitted to the facility in 9/2024 with diagnoses including malignant brain cancer. A 9/9/24 Grievance communication Form stated Resident 267 had concerns related to her/his night shift CNA not being responsive to the call light and not friendly during care. The DNS and LPN Resident Care Manager spoke with Resident 267 and her/his family about the concerns and determined Resident 267 can be overstimulated by noise, her/his care plan was updated. The conclusion of the grievance stated the CNA would not be working with Resident 267 anymore. On 9/10/24 at 10:00 AM Resident 267 stated on her/his first night in the facility there was a night shift CNA who did not take care of her/him and took her/his call light away. Resident 267 stated she/he called her/his brother to get assistance. Resident 267 was tearful when she/he described the night. A 9/10/24 Admission MDS indicated Resident 267 had mild cognitive impairment. On 9/12/24 at 10:17 AM Staff 12 (LPN Resident Care Manager) stated she became aware of Resident 267's concerns through his/her brother. Staff 12 stated she spoke with Resident 267 with Staff 2 (DNS). Resident 267 stated the CNA was slow to respond to her/his call light and was not friendly. Staff 12 stated Resident 267's care plan was updated after talking with the family and the CNA was not coming back to the facility. When asked about the CNA taking Resident 267's call light, Staff 12 replied she thought the call light was taken away to provide care and then given back to Resident 267. On 9/12/24 at 11:03 AM Staff 2 (DNS) stated Resident 267 made a compliant about the night shift CNA on 9/6/24. Staff 2 stated she and Staff 12 spoke with Resident 267 and her/his family and she/he stated the CNA made her/him feel uncomfortable. Staff 2 stated Resident 267 like interactions to be quiet and soft and this CNA was not quiet and soft. Staff 2 stated Resident 267's care plan was updated. When asked about Resident 267's call light being taken away, Staff 2 stated Resident 267 informed her the CNA removed the call light form her/his hands and she/he had to call her/his brother to get assistance. Staff 2 stated the CNA was not coming back to the facility due to the allegation of taking away Resident 267's call light. Staff 2 stated the incident could have been abuse depending upon why the CNA took away the call light and for how long. Staff 2 denied interviewing the CNA and stated the compliant should have been investigated to rule out abuse.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46053 Based on observation, interview and record review it was determined the facility failed to ensure accurate assessments for 2 of 12 sampled residents (#s 11 and 20) reviewed for communication, dental, and activities. This placed residents at risk for inaccurate assessments. Findings include: 1. Resident 11 was admitted to the facility in 6/2023 with diagnoses including chronic diastolic (congestive) heart failure (a condition where the left heart ventricle becomes stiff and does not pump blood efficiently) and chronic respiratory failure with hypoxia (a condition where there is not enough oxygen or there is too much carbon dioxide in the blood). A review of resident 11's 6/25/24 annual MDS revealed she/he was cognitively intact and had no oral or dental issues. On 9/9/24 at 11:03 AM Resident 11 was observed to have teeth that were gray and jagged. Resident 11 stated she/he needed dental care and she/he had tooth decay, missing and broken teeth. Resident 11 stated she/he used a medicated mouthwash prescribed by her/his doctor to treat the infections in her/his teeth. She/he also said no facility staff ever looked in her/his mouth. A review of Resident 11's active orders revealed the following prescription: Chlorhexidine Gluconate Mouth/Throat Solution 0.12%; Give 15 ml by mouth every 12 hours as needed for prevention of oral infections. Resident 11's 6/24/24 Quarterly Dental Assessment indicated she/he refused to let the licensed nurse who completed the assessment to visually inspect her/his oral cavity. On 9/13/24 at 11:04 AM Staff 11 (MDS Coordinator) stated she completed Resident 11's annual MDS based on her/his 6/24/24 Dental Assessment. She stated she did not look in Resident 11's mouth and should have coded the entry as unable to assess. Staff 11 confirmed Resident 11 had the order for Chlorhexidine Gluconate since 2023 and added she would have reapproached her/him if she knew she/he had orders for the mouthwash. Staff 11 stated she did not accurately capture Resident 11's dental needs which, in turn, did not trigger dental care on the MDS. On 9/13/24 at 2:06 PM Staff 1 stated she expected Staff 11 to reapproach Resident 11 to accurately assess her/his dental status and needs. 50928 2. Resident 20 was admitted to the facility in 7/2016 with diagnosis of dementia. Resident 20's Annual MDS 6/19/24 indicated the primary language for Resident 20 was English and she/he needed or preferred an interpreter to communicate with a doctor and health care staff. Resident 20's Social Determinant of Health Assessment on 6/19/2024 indicated the primary language for Resident 20 had been Laotian or Thai and the resident preferred to have an interpreter when communicating with physicians and health care staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/2024 at 2:17 PM Staff 14 (CNA) entered Resident 20's room and asked if she/he needed assistance. Staff 14 asked yes-or-no questions in English to identify the resident's needs. The resident did not respond to the questions being asked. On 9/12/24 between 10:40 AM and 12:23 PM Staff 9 (Activities Director), Staff 5 (Social Services) and Staff 13 (LPN Care Manager) confirmed the assessments found in Resident 20's MDS had not been completed using an interpreter. On 9/13/2024 at 2:06 PM Staff 1 (Administrator) acknowledged interpretative services were not used to complete assessments for Resident 20.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 43690 Based on interview and record review it was determined the facility failed to incorporate PASARR (Preadmission Screening and Resident Review) Level II recommendations into residents' assessments and care plans for 1 of 1 sampled resident (# 51) reviewed for PASARR coordination of care. This placed residents who have a mental health disorder at risk for delayed care and services to attain their highest practicable level of well-being. Findings include: Resident 51 was admitted to the facility in 6/2024 with diagnoses including stroke, dysphasia, post traumatic stress disorder, depression and anxiety. On 7/3/24 a PASARR Level II Mental Health Evaluation was conducted for Resident 51. The reason for the referral was noted as .concern about mood-related symptoms and history of depression and anxiety symptoms . The evaluation included the following recommendations: -Participation in support groups for individuals who have suffered a stroke. -A daily plan for that would be helpful for the resident to deal with difficult situations. Resident 51's 9/2024 MAR included the following medications: -Sertraline 50 mg - 1 tablet QD -Zolpidem 5 mg - 1 tablet HS In an interview on 9/13/24 at 10:55 AM Staff 6 (Social Services Coordinator) confirmed Resident 51's PASARR Level II recommendations were not incorporated into the resident's assessments or care plan. In an interview on 9/13/24 at 11:46 AM Staff 1 (Administrator) and Staff 16 (Regional Nurse Consultant) were informed of Resident 51's PASARR Level II recommendations not being incorporated into the resident's assessments and care plan. Staff 1 acknowledged there was no follow-up on the recommendatons for Resident 51.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47001 Based on interview and record review it was determined the facility failed to comprehensively complete a baseline care plan within 48 hours of a resident's admission for 1 of 4 sampled residents (#267) reviewed for dignity. This placed residents at risk for unmet needs. Findings include: Resident 267 was admitted to the facility in 9/2024 with diagnoses including anxiety, depression and a history of mental and behavioral disorders. On 9/10/24 at 10:00 AM Resident 267 stated on her/his first night in the facility there was a night shift CNA who did not take care of her/him and took her/his call light away. Resident 267 stated she/he called her/his brother to get assistance. Resident 267 was tearful when she/he described the night. A 9/10/24 Admission MDS indicated Resident 267 had mild cognitive impairment. On 9/12/24 at 12:37 PM Resident 267 tearfully stated the incident that happened on her/his first night in the facility reminded her/him of the pain she/he had from childhood trauma related to her/his mother putting her/him in a dark room and being told to be quiet. A 9/12/24 review of Resident 267's chart revealed no evidence of an assessment of her/his history of mental health or behavioral concerns. On 9/13/24 at 8:08 AM Staff 1 (Administrator) stated Resident 267 has trauma related to feeling alone and left without the ability to call for help and she will have social services complete an assessment with Resident 267 for trauma and update to care plan as indicated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47000 Based on observation, interview, and record review it was determined the facility failed to revise care plans for 2 of 6 sampled residents (#s 19 and 28) reviewed for pressure ulcers and nutrition. This placed residents at risk for unmet needs. Findings include: 1. Resident 28 was readmitted to the facility in 7/2024 with diagnoses including dysphagia (difficulty swallowing foods or liquids). Resident 28's 7/7/24 Admission MDS revealed the resident was moderately cognitively impaired, had a feeding tube and required supervision or touching assistance with eating. Resident 28's 7/12/24 Dining Safety Care Plan revealed the following: -The resident was not to use straws. -The resident was to be in the atrium for meals. On 9/9/24 at 1:02 PM Resident 28 was observed in her/his room, in bed. Resident 28 ate from her/his lunch tray that was placed on an overbed table in front of the resident. A water pitcher with a straw was observed next to the lunch tray. On 9/10/24 at 9:59 AM and 9/11/24 at 9:14 AM a partially empty water pitcher with a straw was observed on Resident 28's overbed table and within the resident's reach. On 9/11/24 at 9:15 AM Staff 14 (CNA) stated Resident 28 preferred to eat meals in her/his room when the resident was drousy and liked to eat in the atrium when she/he had the strength. Staff 14 stated Resident 28 drank from a straw regularly and without issue. Staff 14 further stated he found information about where a resident was to have their meals and any dietary restrictions or needs in the resident's care plan. On 9/11/24 at 10:36 AM Staff 2 (DNS) and Staff 16 (Regional Nurse Consultant) acknowledged the findings of this investigation. Staff 2 confirmed Resident 28's care plan was in need of revision. 47001 2. Resident 19 was admitted to the facility in 2016 with diagnoses including a stroke. A 9/10/24 review of Resident 19's physician orders revealed an 8/23/24 order for her/his right ear to clean with normal saline, pat dry, leave open to air and monitor for signs of infection every day for a pressure sore. A 9/10/24 review of Resident 19's care plan revealed no evidence of a care plan for Resident 19's pressure ulcer on her/his right ear. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 9/11/24 at 10:04 AM Resident 19 was observed to have a wound on the front, external part of her/his right ear. The wound was red, raised and had a scab on it. The wound had the appearance of a stage 2 pressure ulcer (a wound with partial thickness loss of the first layer of skin caused by pressue). On 9/12/24 at 10:21 AM Staff 12 (LPN Resident Care Manager) stated Resident 19's wound on her/his right ear occurred due to Resident 19 not being able to reposition her/himself causing pressure on the right ear. Staff 12 stated Resident 19's wound should be but was not in her/his care plan. On 9/12/24 aat 10:30 AM Resident 19's wound was observed with Staff 12. Staff 12 stated the wound appeared to be a stage 2 pressure ulcer.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Crestview of Portland	6530 SW 30th Avenue Portland, OR 97239

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 47001 Based on interview and record review it was determined the facility failed to ensure a recapitulation of the resident's stay was completed accurately for 1 of 2 sampled residents (#261) reviewed for discharge. This placed residents at risk for unmet discharge needs. Findings include: Resident 261 was admitted to the facility in 12/2023 with diagnoses including hemiplegia (inability to move) of the right dominant side. A 1/1/24 Progress Note indicated Resident 261 had two pressure ulcers noted on her/his right and left buttock. A 2/8/24 Progress Note indicated Resident 261 had multiple superficial open areas and excoriation noted to buttocks. A review of Physician Orders indicated Resident 261 had a 2/28/24 order to apply calmoseptin barrier cream daily and as needed to Resident 261's buttocks. A 3/14/24 Discharge Skin Summary stated Resident 261 had no skin impairments at time of discharge. A 3/14/24 Discharge Summary stated Resident 261 had treatment orders for A&D cream to bilateral lower extremities with no evidence of any other treatment orders. A 3/19/24 Discharge MDS stated Resident 261 did not have any pressure ulcers. A 3/20/24 public complaint indicated Resident 261 was discharged to an adult foster home on 3/19/24 with a wound to her/his buttocks. A picture of the wound was sent with the complaint in an email dated 3/20/24 which shows open areas on the right and left buttock. On 9/9/24 at 6:27 PM Witness 1 (Complainant) stated the facility said Resident 261 had no skin issues. On 9/9/24 at 6:30 PM Witness 2 (Representative) identified herself as an RN and stated the nursing facility stated Resident 261 did not have any skin issues upon discharge. Witness 2 stated she observed Resident 261's coccyx on 3/19/24 at the adult foster home and Resident 261 had a stage 2 pressure ulcer to her/his coccyx. On 9/9/24 at 6:36 PM Witness 3 (Representative) stated Resident 261 was discharged to her adult foster home facility on 3/19/24. Witness 3 stated the nursing facility informed her Resident 261 did not have any skin issues. Witness 3 stated when Resident 261 admitted , she/he had wounds to her/his coccyx area. On 9/12/24 at 10:35 AM Staff 13 (RNCM) stated she did not remember if Resident 261 had any pressure wounds, she thought the resident may have had excoriation to her/his bottom. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:44 AM Staff 12 (LPN Resident Care Manager) stated Resident 261 had orders for barrier cream to her/his bottom upon discharge. Staff 12 stated she did not recall if Resident 261 had pressure ulcers. On 9/12/24 at 10:55 AM Staff 5 (Social Services) stated Resident 261 did not discharge with orders for home health wound care and the discharge instructions did not include wound care. Staff 5 stated home health nursing for wound care would have been ordered for Resident 261 if she had been aware of the need. On 9/12/24 at 2:22 PM Staff 23 (LPN) stated she assessed Resident 261's wounds in 1/2024 after the wounds were discovered. Staff 23 stated Resident 261 did not have a pressure ulcer at that time, but she/he had moisture associated damage to her/his buttocks. On 9/12/24 at 2:29 PM Staff 16 (RNCM) stated there was no wound assessment documentation for Resident 261's wounds.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 50928 Based on observation, interview, and record review it was determined the facility failed to provide appropriate treatment and services in communication for 1 of 1 sampled resident (#20) reviewed for communication. This placed residents at risk for diminished quality of life and potential decline in their ability to carry out activities of daily living. Findings include: Resident 20 was admitted to the facility in 7/2016 with diagnoses including dementia. Resident 20's 6/28/24 Care Plan indicated a language barrier due to the Resident's primary language being Laotian or Thai. Interventions indicated in the resident's Care Plan instructed staff to contact Optimal Interpreter Services for assistance in communication. Resident 20's 6/29/2024 Annual MDS revealed the primary language for Resident 20 was English and he/she needed or preferred to use an interpreter to communicate with a doctor and health care staff. The Communication CAA completed 6/19/2024 indicated language was a concern as the primary language for Resident 20 was Laotian or Thai. On 9/9/2024 at 2:17 PM Staff 14 (CNA) entered Resident 20's room and asked if she/he needed assistance. Staff 14 asked different yes-or-no questions in English to identify the resident's needs. It was unclear whether Resident 20 understood the questions asked by Staff 14 as the resident did not respond to the questions being asked. On 9/11/2024 at 11:25 AM and 9/12/2024 at 9:15 AM Resident 20 was asked in English how her/his morning was going. Both times Resident 20 responded in her/his native language. It was unclear if the resident understood the questions as the resident did not respond in English. On 9/11/2024 at 11:59 AM Staff 14 (CNA) stated staff communicated with Resident 20 by asking yes-or-no questions. Staff 14 stated he had not used interpretive interventions with Resident 20. On 9/13/2024 at 2:06 PM Staff 1 (Administrator) was nformed of these findings and did not provide any additional information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47000 Based on observation, interview and record review it was determined the facility failed to ensure dependent residents received ADL care for 1 of 4 residents (#33) reviewed for ADLs. This placed residents at risk for unmet care needs. Findings include: Resident 33 was readmitted to the facility in 6/2022 with diagnoses including dementia. Resident 33's 3/20/24 Annual MDS revealed the resident was severely cognitively impaired, required substantial/maximal assistance with upper body dressing and was dependent upon staff for lower body dressing. Resident 33's 4/12/24 ADL Self Care Performance Deficit Care Plan indicated the resident required assistance from one staff to get dressed. On 9/9/24 at 2:34 PM Resident 33 was observed in her/his room in bed and wore a hospital gown. Resident 33 was unable to answer any questions about her/his care or routine. On 9/11/24 at 11:50 AM and on 9/12/24 at 11:58 AM Resident 33 was observed in her/his room and sat in her/his wheelchair. The resident was dressed in a pink dress with yellow flowers. On 9/12/24 at 10:40 AM Staff 23 (CNA) and at 10:52 AM Staff 14 (CNA) stated Resident 33 did not resist or refuse to get dressed. On 9/12/24 at 1:29 PM Staff 25 (CNA) stated he was Resident 33's assigned CNA on this day and was responsible for getting the resident dressed. Staff 25 stated Resident 33 currently wore the dress she/he had on yesterday because she/he usually wore the same clothes for a couple of days and was changed only if [she/he] got dirty. On 9/12/24 at 2:03 PM Staff 1 (Administrator) acknowledged these findings and stated she expected staff to assist residents to get dressed each morning and in clean clothes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47000 Based on observation, interview, and record review it was determined the facility failed to provide a person-centered activity program for 3 of 3 sampled residents (#s 7, 20, and 33) reviewed for activities. This placed residents at risk for a diminished quality of life. Findings include: The facility's 2/2023 Activity Evaluation Policy indicated the following: -An activity evaluation was conducted as part of the comprehensive assessment to help develop an activities plan that reflected the choices and interests of the resident. -The resident's activity evaluation was conducted by activity department personnel, in conjunction with other staff who evaluate related factors such as functional level, cognition and medical conditions that may affect activities participation. -The resident's lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences were included in the evaluation. -The activity evaluation was used to develop an individual activities care plan that allowed the resident to participate in activities of his/her choice and interest. -Each resident's activities care plan related to her/his comprehensive assessment and reflected her/his individual needs. -Through the interdisciplinary process, the activity evaluation and activities care plan identified if a resident was capable of pursuing activities independently, or if supervision and assistance was needed. -The completed activity evaluation was part of the resident's medical record and was updated as necessary, but at least quarterly. 1. Resident 7 was admitted to the facility in 9/2020 with diagnoses including dementia. Resident 7's 11/9/23 Annual MDS revealed the resident experienced short-and-long-term memory loss and was moderately impaired for decision making. The MDS also revealed having books, magazines and newspapers to read, listening to music and keeping up with the news were somewhat important activity preferences for the resident and doing her/his favorite activities was very important. Resident 7's 2/4/24 Activity Care Plan indicated the following: -The resident preferred to self-initiate/direct activities. -Self-directed pursuits included television (documentaries) and music (classical, opera and show tunes). -Provide the resident with a monthly calendar. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide the resident with one-to-three social visits per week for special updates on activities and provide/assist with self-directed material as needed/requested. -The resident's interests included animals, writing, music, television, being outside, reading and playing poker, cribbage and pinochle. -The resident got around on her/his scooter and went outside to smoke. A review of Resident 7's One-on-One Activity and Group Activity Tasks from 8/14/24 through 9/12/24 revealed the resident did not participate in any group activities and received four activity social visits. The facility's 9/2024 Activity Calendar revealed the following scheduled activities: 9/9/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO 9/10/24 -Outing to Hood River 9/11/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO 9/12/24 -Debbie's Rounds -Resident Council Random observations of Resident 7 from 9/9/24 through 9/12/24 from 9:11 AM to 4:12 PM revealed the resident to be either in bed or in her/his wheelchair in her/his room. No music was observed to play in the resident's room, three books were observed to sit in a stack on the far side of the resident's night stand underneath a figurine and the television was occasionally turned on and tuned to the FX channel. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 3:26 PM Resident 7 stated she/he enjoyed documentaries on television, listening to classical music and reading non-fiction books and the newspaper. When asked about the books stacked on her/his night stand, Resident 7 stated she/he was unaware she/he had any books and she/he had never been offered them. Resident 7 stated she/he enjoyed going outside but did not think staff would let her/him go outside. Resident 7 stated she/he enjoyed games but did not get to play them very often because there was no one to play with. Resident 7 was informed bingo was currently being played in the atrium, and the resident stated she/he would like to try to play but no one had invited her/him to join. On 9/11/24 at 4:10 PM Staff 24 (CNA) stated he had never seen Resident 7 read, use her/his scooter, smoke or participate in an activity out of her/his room, including going outside when the weather was nice. Staff 24 stated he was unsure of Resident 7's activity interests outside of watching television and talking about her/his time in the military. Staff 24 further stated Resident 7 did not make requests related to her/his routine and did not initiate any activities. On 9/12/24 at 10:27 AM Staff 23 (CNA) stated it had been years since [Resident 7] initiated conversations, questions or activities. Staff 23 stated she had never seen her/him read, write, go outside or participate in group activities and she/he had not smoked or rode her/his scooter in a long time. Staff 23 stated the only activity she saw Resident 7 do was watch television. On 9/12/24 at 10:55 AM Staff 14 (CNA) stated Resident 7 did not initiate activities. Staff 14 stated Resident 7 spent her/his time in her/his room and watched television. On 9/12/24 at 12:27 PM Staff 9 (Activity Director) stated Resident 7 was supposed to receive the newspaper on Wednesdays but did not receive one on 9/11/24 because the facility ran out. Staff 9 stated Resident 7 had tried Bingo in the past but the resident had difficulty participating on account of her/his hearing loss. Staff 9 stated she had involved the resident in Bingo prior to her/him receiving an assistive hearing device and had not reattempted the activity since. Staff 9 stated she missed the resident's interest of going outside and stated the resident had not participated in group activities in a month because she had been very busy. Staff 9 further stated the resident was no longer able to self-initiate activities. On 9/12/24 at 1:54 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 2. Resident 33 was readmitted to the facility in 6/2022 with diagnoses including dementia. Resident 33's 3/20/24 Annual MDS indicated the resident was severely cognitively impaired. The MDS also indicated listening to music, being around pets, doing her/his favorite activities and having books, newspapers and magazines to read were very important activities to the resident and doing things with groups of people, going outside and participating in religious services were somewhat important activities to the resident. Resident 33's 6/13/24 Activity Care Plan revealed the following: -The resident preferred to self-initiate/direct activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Self-directed pursuits included watching television, reading magazines and the newspaper, visiting with family, chatting and watching the birds at her/his window at the bird feeder. -The resident's other interests include pet visits and being outside. -The resident had occasionally come to activities and enjoyed her/himself. -Provide the resident with one-to-three social visits per week for special updates on activities and provide/assist with self-directed material as needed/requested. A review of Resident 33's Group Activity Task from 8/14/24 through 9/12/24 revealed the resident received three pet visits and participated in one musical activity. No evidence was found in the resident's clinical record to indicate the resident went outside or participated in any other group activity. The facility's 9/2024 Activity Calendar revealed the following scheduled activities: 9/9/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO 9/10/24 -Outing to Hood River 9/11/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO 9/12/24 -Debbie's Rounds -Resident Council Random observations of Resident 33 from 9/9/24 through 9/12/24 between 9:12 AM to 4:09 PM revealed the resident to be in her/his room either in bed or in her/his wheelchair. The resident's television was on low and she/he held her/his stuffed cat. No music was observed to play, no reading material was observed in her/his room and the bird feeder was not visible from the resident's window. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 4:17 PM Staff 24 (CNA) stated Resident 33 was usually very confused and had a problem communicating. Staff 24 stated the resident enjoyed holding her/his stuffed cat and watching television. Staff 24 stated the resident came out of her/his room for meals but not for activities. On 9/12/24 at 10:40 AM Staff 23 (CNA) stated Resident 33 spent her/his days in bed with her/his stuffed cat. Staff 23 stated the resident did not go outside, did not receive religious visits, did not listen to music and did not come out of her/his room for activities. On 9/12/24 at 10:52 AM Staff 14 (CNA) stated Resident 33 did not really go to activities and it had been a while since [he] had seen [her/him] go outside. Staff 14 further stated the resident spent her/his day in bed with her/his stuffed cat. On 9/12/24 at 12:50 PM Staff 9 (Activity Director) stated Resident 33 no longer self-initiated or directed her/his own activities and she had not attempted any sensory activities with her/him in a while because the resident was always in bed. Staff 9 stated the bird feeder outside of Resident 33's window was on the ground for the last week because she did not have a chance to hang it. Staff 9 further stated Resident 33 had not gone outside during this past year even when the weather was nice. On 9/12/24 at 1:54 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 50928 3. Resident 20 was admitted to the facility in 2016 with diagnoses including dementia. Resident 20's 6/28/2024 Care Plan indicated the resident's activity preferences were watching funny videos, listening to music, and participating in the facility's entertainment and music events. Resident 20's Annual MDS revised 6/19/24 indicated the primary language for Resident 20 was English and he/she needed or prefered an interpreter to communicate with a doctor and health care staff. Section F: Activities and Preferences indicated it is somewhat important for the resident to participate in group activities, go outside, listen to music, and have books to read. The Communication CAA completed 6/19/2024 stated language was a concern as the primary language for Resident 20 was Laotian or Thai. Review of Resident 20's 8/13/2024 through 9/13/2024 Group Activity Task and One to One Activity Task indicated the resident did not participate in any group or one-to-one activities. The facility's 9/2024 Activity Calendar revealed the following scheduled activities: 9/9/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/10/24 -Outing to Hood River 9/11/24 -Debbie's Rounds -2:30 PM Bingo -4:00 PM UNO 9/12/24 -Debbie's Rounds -Resident Council Observations of Resident 20 from 9/9/2024 to 9/12/2024 from 8:56 AM to 2:12 PM revealed the resident to be in bed with the television on with English language programming. On 9/11/2024 at 11:59 AM and on 9/12/2024 at 10:56 AM Staff 14 (CNA) and Staff 15 (CNA) stated Resident 20 spent most of her/his time in bed in her/his room. On 9/13/2024 at 2:06 PM Staff 1 (Administrator) acknowledged these findings and did not provde any additional information.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 47000 Based on observation, interview and record review it was determined the facility failed to ensure treatment and services to maintain hearing abilities were received for 1 of 6 sampled residents (#34) reviewed for communication and sensory care. This placed residents at risk for unmet hearing needs. Findings include: The facility's 2/2018 Care of Hearing Impaired Resident Policy revealed staff will assist the resident (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services. Resident 34 was admitted to the facility in 10/2023 with diagnoses including blindness. Resident 34's 10/17/23 Communication Care Plan revealed the following: -The resident had a hearing deficit. -The resident's family visited daily and could help answer specific questions for the resident. Resident 34's 7/11/24 Quarterly MDS revealed the resident was moderately cognitively impaired, experienced moderate difficulty hearing and was able to make her/himself understood. Resident 34's 9/2024 Physician Orders directed auditory consults as indicated. No evidence was found in the resident's clinical record to indicate an auditory consult or resources to obtain hearing aid or hearing appliance were offered to the resident. On 9/9/24 at 12:28 Resident 34 was observed in her/his room in bed with the television on. The volume of the television was turned up loud enough to be heard from the hallway. Resident 34 stated her/his hearing was fair and she/he had never been offered the opportunity to have an auditory consult or resources to obtain a hearing device and stated she/he was interested in both. During the course of the interview, the State Surveyor spoke at an elevated volume and repeated most questions posed to the resident as she/he was unable to hear. On 9/11/24 at 11:06 AM Staff 5 (Social Services Director) stated she scheduled auditory consults for residents when she was informed to do so by nursing staff. Staff 5 further stated she had never received a request to schedule an auditory consult for Resident 34. On 9/11/24 at 11:18 AM Staff 2 (DNS) and Staff 12 (LPN-Resident Care Manager) acknowledged the findings of this investigation. Staff 12 confirmed Resident 34's hearing was impaired and she had not offered the resident the opportunity to have an auditory consult and she should have.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47001 Based on observation, interview, and record review it was determined the facility failed to assess pressure ulcers and update care plans for 1 of 2 sampled residents (#19) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: 1. Resident 19 was admitted to the facility in 2016 with diagnoses including a stroke. A 9/10/24 review of Resident 19's physician orders revealed an 8/23/24 order for her/his right ear to clean with normal saline, pat dry, leave open to air and monitor for signs of infection every day for a pressure sore. A 9/10/24 review of Resident 19's care plan revealed no evidence of a care plan for Resident 19's pressure ulcer on her/his right ear. A 9/10/24 review of Resident 19's medical record revealed no evidence of a wound assessment of her/his right ear pressure ulcer. On 9/11/24 at 10:04 AM Resident 19 was observed to have a wound on the front, external part of her/his right ear. The wound was red, raised and had a scab on it. The wound had the appearance of a stage 2 pressure ulcer (a wound with partial thickness loss of the first layer of skin caused by pressure). On 9/12/24 at 10:21 AM Staff 12 (LPN Resident Care Manager) stated Resident 19's wound on her/his right ear occurred due to Resident 19 not being able to reposition her/himself causing pressure on the right ear. Staff 12 stated Resident 19's wound should be but was not in her/his care plan. Staff 12 stated wounds are assessed weekly but was unable to locate a wound assessment for Resident 19's right ear pressure wound. On 9/12/24 at 10:30 AM Resident 19's wound was observed with Staff 12. Staff 12 stated the wound appeared to be a stage 2 pressure ulcer and she was going to have the wound nurse assess the wound on 9/12/24 so weekly wound assessments and appropriate treatment will get done right away.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 3 of 3 sampled residents (#s 7, 34, and 51) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include: The facility's 8/2022 Trauma-Informed and Culturally Competent Care Policy and Procedure revealed the following: -Traumatic events included abuse, neglect, serious injury or illness, racism, war and historical trauma. -Universal screening of residents was to be performed, which included a brief, non-specialized identification of possible exposure to traumatic events. -Screening included information such as trauma history, trauma-related symptoms, concerns with sleep or intrusive behaviors, behavioral or interpersonal concerns, historical mental health diagnosis, substance abuse, protective factors and resources available and physical health concerns. -The initial screening identified the need for further assessment and care. -Individualized care plans were developed to address past trauma and identified triggers that could re-traumatize the resident. 1. Resident 7 was admitted to the facility in 9/2020 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 7's 9/24/20 Social History indicated the resident had a military history and she/he was exposed to Agent Orange (a chemical herbicide and defoliant) when she/he served in the Vietnam War. Resident 7's 8/11/24 Quarterly MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 7's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. On 9/11/24 at 11:13 AM Staff 2 (DNS) acknowledged the findings of this investigation and stated she expected a trauma screening to have been completed for Resident 7. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 34 was admitted to the facility in 10/2023 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 34's 10/5/24 Social History indicated the resident was a Vietnam War Veteran and had a diagnosis of PTSD. Resident 34's 7/11/24 Quarterly MDS revealed the resident was moderately cognitively impaired and able to make her/himself understood. On 9/9/24 at 12:36 PM Resident 34 was observed in her/his room in bed with the lights off. Resident 34 stated she/he suffered from PTSD as a result of her/his service in the Army. Resident 34 further stated no one at the facility had ever discussed with her/him the cause of her/his PTSD or potential triggers for re-traumatization and she/he was interested in talking to someone. No evidence was found in Resident 34's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. On 9/11/24 at 11:13 AM Staff 2 (DNS) acknowledged the findings of this investigation and stated she expected a trauma screening to have been completed for Resident 34. 43690 3. Resident 51 was admitted to the facility in 6/2024 with diagnoses including Post-traumatic stress disorder (PTSD) and anxiety. Resident 51's 6/18/24 Social History indicated the resident struggled to cope with change and changes in her/his environment. Resident 51's 6/17/24 Admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 51's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. On 9/13/24 at 11:46 AM Staff 1 (Administrator) and Staff 16 (Regional Nurse Consultant) acknowledged the findings of this investigation and stated Resident 51 should have had trauma informed screening completed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50928 Based on interview and record review it was determined the facility failed to provide staff with appropriate competencies and skills to attain and maintain the highest practicable well-being for 1 of 1 sampled resident (#20) reviewed for communications and activities. This placed residents at risk for unmet needs. Findings include: The facility's 2/2022 Trauma-Informed and Culturally Competent Care policy indicated all staff received orientation and in-service training regarding cultural competency as an aspect of resident-centered care. Resident 20 was admitted to the facility in 7/2016 with diagnoses including dementia. On 9/11/2024 at 11:59 AM Staff 14 (CNA) stated he had been an employee at the facility for over a year and had not received any cultural competency training. On 9/12/2024 at 10:56 AM Staff 15 (CNA) stated she had been an employee at the facility for over [AGE] years and had never participated or completed any cultural competency training. On 9/13/2024 at 12:42 PM Staff 4 (Staffing Coordinator) stated she was unaware of any cultural competency training program at the facility. On 9/13/2024 at 2:06 PM Staff 1 (Administrator) was unable to provide documentation to indicate Staff 14, Staff 15 or Staff 4 received training in cultural competency.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview, and record review it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for 5 of 14 sampled residents (#s 7, 20, 34, 46 and 51) reviewed for behaviors, communication and sensory care, dental and PASARR. This placed residents at risk for unmet needs and decreased dignity. Findings include: The facility's 9/2004 Social Services Program Policy and Procedure revealed the following: -The social services program shall assist facility staff, family and friends of the resident to help meet the resident's personal and emotional needs. -Duties of the social services department include assessing the psychosocial and emotional needs of each resident, developing interventions to address residents' needs and preferences to ensure or enhance quality of life and dignity, making referrals as needed and documenting the outcomes and assisting each resident in obtaining appropriate clothing. 1. Resident 7 was admitted to the facility in 9/2020 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 7's 9/24/20 Social History indicated the resident had a military history and she/he was exposed to Agent Orange (a chemical herbicide and defoliant) when she/he served in the Vietnam War. Resident 7's 8/11/24 Quarterly MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 7's clinical record to indicate the resident's mental and psychosocial needs were comprehensively assessed, including an assessment of the resident's trauma and potential trauma triggers. On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated she started completing trauma assessments for residents in 7/2024, and because Resident 7 admitted to the facility prior to this date, the resident's trauma was not assessed. On 9/13/24 at 12:45 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 2. Resident 34 was admitted to the facility in 10/2023 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 34's 10/5/24 Social History indicated the resident was a Vietnam War Veteran and had a diagnosis of PTSD. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 34's 10/9/23 Admission MDS indicated she/he was visually severely impaired, experienced moderate difficulty hearing, was usually able to make her/himself understood to others, required substantial-to-maximal assistance for upper body dressing and was dependent on staff for lower body dressing. The MDS also indicated it was somewhat important to the resident to be able to choose what clothes she/he wanted to wear. A 4/7/24 Personal Inventory Record revealed the resident had one hat, one gray t-shirt, one pair of red sweats and one pair of shoes. On 9/9/24 at 12:36 PM Resident 34 was observed in her/his room in bed with the lights off dressed in a hospital gown. Resident 34 stated she/he suffered from PTSD as a result of her/his service in the Army. Resident 34 stated no one at the facility had ever discussed with her/him the cause of her/his PTSD or potential triggers for re-traumatization and she/he was interested in talking to someone. Resident 34 stated her/his hearing was fair and she/he had never been offered the opportunity to have an auditory consult or obtain a hearing device and stated she/he was interested in both. Resident 34 further stated it was not her/his preference to wear a hospital gown, staff did not offer to assist her/him to get dressed, she/had been told that she/he did not have any clothes and no one at the facility had ever offered to assist her/him to obtain clothing. At this time, the only clothing items present in the resident's closet were two pairs of pants. No evidence was found in Resident 34's clinical record to indicate an assessment of the resident's trauma was completed, a care plan was developed to address the resident's potential trauma triggers, an auditory consult, or resources to obtain a hearing aid or hearing appliance were offered to the resident or any attempt had been made to assist the resident to obtain clothing items. On 9/11/24 at 10:58 AM and 12:18 PM Staff 5 (Social Services Director) stated resident trauma assessments were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. Staff 5 stated she started completing trauma assessments for residents in 7/2024, and because Resident 34 admitted to the facility prior to this date, she/he did not receive a trauma assessment. Staff 5 further stated she had not offered the resident an opportunity to have her/his hearing evaluated or assisted her/him to obtain clothing items. On 9/13/24 at 12:45 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 43690 3. Resident 51 was admitted to the facility in 6/2024 with diagnoses including Post-traumatic stress disorder (PTSD) and anxiety. Resident 51's 6/17/24 Admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 51's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. Staff 5 stated she started completing trauma screenings for residents in 7/2024, and because Resident 51 admitted to the facility prior to this date, she/he did not receive a trauma screening. On 9/13/24 at 11:46 AM Staff 1 (Administrator) and Staff 16 (Regional Nurse Consultant) acknowledged the findings of this investigation. 50928 4. Resident 20 was admitted to the facility in 2016 with diagnoses including dementia. Resident 20's Social Determinants of Health assessment dated [DATE] indicated the primary language for Resident 20 was Laotian or Thai and the resident preferred to have an interpreter when communicating with physicians and health care staff. On 9/12/2024 at 11:40 AM Staff 5 (Social Services Director) stated she had not arranged or assisted to provide for communication needs through Resident 20's primary language. 5. Resident 46 was admitted to the facility in 5/2024 with a diagnosis including severe protein calorie malnutrition. On 9/10/2024 Resident 46 stated he wanted new dentures because it would make eating easier. On 9/11/2024 at 2:57pm Staff 5 (Social Services Director) stated she had not arranged or offered services to Resident 46 regarding her/his dental needs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001 Based on observation and interview it was determined the facility failed to ensure proper storage of biologicals on 1 of 1 medication rooms during random observations for medication storage. This placed residents at risk of unsafe access to stored biologicals. Findings include: On [DATE] at 2:32 PM two Pfizer COVID 19 vaccines were observed in the medication refrigerator with an expiration date of [DATE]. On [DATE] at 2:33 PM Staff 24 (CMA) verified the two Pfizer COVID 19 vaccines were expired. On [DATE] at 2:45 PM Staff 2 (DNS) confirmed the two Pfizer COVID 19 vaccines expired on [DATE].

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50928 Based on interview and record review it was determined the facility failed to ensure routine dental services were provided for 1 of 3 sampled residents (#46) reviewed for dental care needs. This placed residents at risk for unmet dental needs. Findings include: Resident 46 was admitted to the facility on [DATE] with a diagnosis that includes severe protein calorie malnutrition. Resident 46's 5/10/2024 Admission Nursing Database assessment indicated the resident had no natural teeth, tooth fragments or missing teeth. An 8/13/2024 Physician Order instructed the facility to schedule dental, visionary, auditory, and podiatry consultations as indicated. No evidence was found in Resident 46's clinical record to indicate additional dental needs were offered to the resident. On 9/10/2024 at 2:30pm Resident 46 stated he had been interested in new dentures because it would make eating easier. On 9/11/2024 at 2:57pm Staff 5 (Social Services Director) stated that dental services were not offered to Resident 46. On 9/11/2024 at 3:22pm Staff 13 (LPN Resident Care Manager) indicated Resident 46 had not been offered dental services. On 9/13/2024 at 2:06pm Staff 1 (Administrator) was unable to provide additional information regarding Resident 46 and her/his being offered dental services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46053 Based on observation, interview and record review it was determined the facility failed to maintain a clean and sanitary environment in the facility's ice machine, dry storage, and dish drying area for 1 of 1 kitchen reviewed for sanitary conditions. This placed residents at risk of potential infections related to foodborne pathogens and cross contamination. Findings include: 1. On 9/6/24 at 9:43 AM, the facility's ice machine was observed to drain onto the floor approximately six inches from the in-floor drain underneath the ice machine. The linoleum flooring under the ice machine was disintegrated and pulled away from the concrete floor. A puddle of brown, moldy water formed on the concrete floor and flowed underneath the linoleum and onto the floor around the ice machine and in the direct path to the walk-in freezer. A chunk of an unknown brown porous substance the approximate size of a baked potato was observed under the ice machine. Staff 10 (Dietary Manager) observed this, donned exam gloves and removed the item. She stated it looked like wadded up paper towels to collect the water under the machine. On 9/9/24 at 9:54 AM Staff acknowledged the presence of what appeared to be mold in the puddle under and adjacent to the ice machine. She stated it needed to be cleaned and the ice machine needed to drip into the in-floor drain. Staff 10 acknowledged the current condition was unsanitary and stated she expected the kitchen to be cleaned regularly to avoid the potential contamination of items in the walk-in freezer, dry storage and food prep areas. 2. On 9/9/24 at 10:05 AM the ice machine was observed to have a holster containing an ice scoop mounted on its left side. The ice scoop rested in an accumulation of water and a brown slimy substance inside the holster. Staff 10 (Dietary Manager) acknowledge the holster was not clean and stated the holster was to be cleaned daily for food safety. 3. On 9/9/24 at 10:08 AM the exit door adjacent to the dry storage area was observed to have a half-inch gap between the floor and the bottom of the door. Staff 10 stated kitchen staff kept the compost bins outside of this door at night and acknowledged the gap was sufficient for pests to enter the facility. She requested, Write it up so we can get it fixed. 4. On 9/9/24 at 10:13 AM a large drum fan was observed to blow on a wire shelving unit adjacent to the dishwashing station. The shelving unit contained recently-washed dishes, cookware and utensils. The grate covering the front of the fan was observed to have a large accumulation of fuzz, grime and dust which was blowing toward the drying dishes. On 9/9/24 at 10:15 AM Staff 22 (Dietary Aide) stated the fan was used during all shifts because the kitchen and dishwashing area were very hot. On 9/9/24 at 10:18 AM Staff 10 (Dietary Manager) acknowledged the presence of the fuzz, grime and dust on the fan. She stated it was not sanitary and needed to be cleaned. She stated she expected the fan to be cleaned regularly to avoid transferring potential contaminants to the clean dishes and cook areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50928 Based on observation and interview it was determined the facility failed to follow proper infection control precautions for 1 of 1 sampled resident (#40) reviewed for catheter care and while handling clean laundry for 1 of 1 laundry areas. This placed residents at risk for cross contamination and risk of infection. Finds include: According to the Center for Disease Control and Prevention: Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (2009) III. B.2: -Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. 1. Resident 40 admitted to the facility in 9/2022 with diagnoses including a urinary tract infection. On 9/11/2024 at 12:14 PM Resident 40 was observed to ambulate independently in his/her wheelchair as his/her catheter bag dragged on the ground. On 9/11/2024 at 12:17 PM Staff 2 (DNS) confirmed catheter bags should not drag on the ground. 2. On 9/12/2024 at 2:06 PM Staff 19 (Housekeeping) was observed to push an uncovered rolling rack of clean resident clothing down the hall. The rack was left unattended in a crowded hallway as Staff 19 delivered clothing items to resident rooms. On 9/13/2024 at 1:00 PM Staff 19 stated the rolling rack used to deliver clean resident clothing did not have a cover. On 9/13/2024 at 1:00 PM Staff 20 (Regional Housekeeping Manager) stated rolling racks used to return clean resident clothing should be covered.