STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385068	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health Care	3955 SE 182nd Avenue Gresham, OR 97030

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to comprehensively assess a resident for the use of an electric wheelchair and develop new interventions to reduce the risk of falls for 2 of 4 sampled residents (#s 3 and 73) reviewed for accidents. This failure resulted in Resident 73 sustaining a five-centimeter laceration (a jagged wound or cut in the flesh) to her/his right anterior (toward the front) lower leg, multiple leg fractures and a brief syncopal episode (fainting or passing out) secondary to blood loss. Findings include: The facility's 1/2025 Physical Restraints and Enablers/Devices Policy indicated a Device Evaluation was completed prior to a device being initiated. The resident and/or representative is provided risks/benefits of device use and consent obtained prior to its implementation. The individual service plan is updated to identify device use and identifies other interventions put into place addressing medical symptoms, environmental safety and psychosocial concerns. The facility's 1/2025 Fall Management Policy indicated the following:-The licensed nurse updates care plans reflecting individualized interventions in an attempt to reduce or prevent falls. -A systematic review of current interventions is completed post fall and a root cause is identified.-Should a new intervention be implemented, previous interventions are reviewed for discontinuation to determine if they were ineffective. 1. Resident 73 was admitted to the facility in 3/2025 with diagnoses including weakness and lymphedema (a chronic condition characterized by painful, long-lasting swelling caused by a buildup of lymph fluid in the body's soft tissues). Resident 73's 10/7/25 Care Plan revealed the following: -The resident required assistance for bed mobility, transferring and locomotion related to an above-the-knee amputation to her/his left leg. -The resident required one-to-two-person physical assistance from staff with a slide board (a medical mobility aid used to help people transfer between seated surfaces) for transfers. Resident 73's 2/23/26 Annual MDS revealed the resident was cognitively intact, experienced lower extremity impairment on one side, required supervision or touch assistance for bed-to-chair transfers and used a manual wheelchair for mobility. A 4/17/26 Equipment Related Incident Form revealed the following:-Resident 73 maneuvered a newly issued electric wheelchair in her/his room in a confined space near the bed.-At approximately 3:30 PM, the resident's assigned CNA responded to her/his call light and found the resident seated in her/his electric wheelchair with a large pool of blood on the floor beneath the resident. -A nurse was notified, entered the resident's room, noted active bleeding from the right anterior lower leg and applied pressure. -The resident was pale and lethargic. -The resident was sent to the emergency department, and she/he sustained a five-centimeter laceration to her/his right anterior lower leg, a (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture to her/his right tibia (the large, strong bone located in the front part of your lower leg, running from just below the knee to the ankle) and fibula (the slender long bone on the outer side of your lower leg, running parallel to the tibia from just below the knee to the ankle) and a brief syncopal episode secondary to blood loss. -The resident reported her/his thumb slipped off of the control, which caused the electric wheelchair to continue forward into the resident's bed where the resident's right leg hit the metal bed frame. -The resident received an anticoagulant (a medication that prevents or slows down the clotting of blood) which contributed to significant bleeding from the injury. A 4/19/26 Hospital Discharge Summary revealed the following:-Resident 73 required supplemental oxygen in the emergency department as she/he experienced acute hypoxemic respiratory failure (a sudden inability of the respiratory system to adequately oxygenate the blood) following a scooter accident. -The resident sustained fractures to her/his right tibia and fibula and required laceration repair. -The resident's oxycodone (a powerful, semi-synthetic opioid analgesic prescribed to treat moderate-to-severe chronic pain) was increased due to acute pain secondary to the fractures. No evidence was found in Resident 73's clinical record to indicate she/he had been assessed to safely operate an electric wheelchair. On 6/1/26 at 11:03 AM and 6/2/26 at 1:33 PM, Resident 73 was observed in her/his room in bed. Resident 73 stated she/he was informed by Staff 27 (Former Director of Rehabilitation) she/he was to receive an electric wheelchair on 4/17/26 between 2:00 PM to 2:30 PM. Resident 73 stated the electric wheelchair arrived as scheduled accompanied by Witness 4 (Electric Wheelchair Representative). Resident 73 stated Staff 29 (CNA) helped transfer her/him from a manual wheelchair into the electric wheelchair, following which she/he went around the facility in the electric wheelchair with Witness 4 walking alongside. Resident 73 stated Witness 4 showed her/him how things worked on the chair, but not as much as he should have. Resident 73 stated she/he did not know how to use that chair, including how to stop it. After Witness 4 left the facility, Resident 73 stated she/he returned to her/his room, could not stop the electric wheelchair, and as a result, bumped into the metal part of the bed and kept pushing. Resident 73 stated blood was gushing out of my leg, she/he activated her/his call light and went to sleep. Resident 73 stated, I thought I was going to die. On 6/2/26 at 1:13 PM, Witness 5 (Family) stated he was informed by Resident 73 she/he was going to receive her/his new electric wheelchair on 4/17/26. Witness 5 stated he was informed by Staff 1 (Administrator) that residents were to receive training on operating an electric wheelchair prior to receiving one in order to ensure the resident knew how to operate it, but Resident 73 did not receive training by therapy services. Witness 5 stated the electric wheelchair incident that occurred on 4/17/26 was near fatal and derailed the resident's life. On 6/2/26 at 2:06 PM and 2:38 PM, Staff 27 stated it was the facility's policy a resident did not use an electric wheelchair independently until therapy completed an assessment, which included the residents' ability to transfer on-and-off the electric wheelchair, use the controls to safely navigate their environment and to prove they were safe. Staff 27 stated Resident 73's electric wheelchair was to be delivered to the facility by the end of 4/2026, but she did not know the exact date of delivery. Staff 27 stated Resident 73's electric wheelchair arrived on 4/17/26 but after she had left the facility. Staff 27 stated Staff 30 (Physical Therapist) was in the facility when the resident's electric wheelchair arrived, but because the therapy department was located in the back of the facility, there was no way for a therapist to know the electric wheelchair arrived unless someone let them know. Staff 27 stated nurses usually let the therapy department know when an electric wheelchair arrived, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and the resident had passed out. Staff 13 stated the resident was drowsy when she entered the room, Staff 2 (DNS) applied pressure to the resident's leg because she/he was bleeding a lot, and she called 911. On 6/3/26 at 10:13 AM, Staff 2 stated she expected the therapy department to be notified as soon as an electric wheelchair arrived at the facility so an assessment and training could be completed to ensure the resident was safe to use the device. Staff 2 stated she expected staff to inform therapy or management staff that Resident 73's electric wheelchair had arrived on 4/17/26 and prior to her/him being transferred into the chair, and they were not notified until after the incident occurred. On 6/3/26 at 10:25 AM, Staff 30 (Physical Therapist) stated she worked on 4/17/26 but was not notified Resident 73's electric wheelchair was delivered. Staff 30 stated she was unsure of the process of what to do if an electric wheelchair showed up for a resident, but stated if she was notified, she would not leave the electric wheelchair with the resident and would talk to someone at the facility to find out the process. On 6/3/26 at 10:32 AM, Staff 1 (Administrator) stated he expected staff to notify the therapy team that an electric wheelchair arrived at the facility prior to a resident getting into the device so a safety evaluation could be completed. Staff 1 stated he was unaware Resident 73 and other staff were aware of the exact delivery date and time for the electric wheelchair. Staff 1 further stated he expected any staff who were aware Resident 73's electric wheelchair was in the facility to have notified the therapy team, and they did not. 2. Resident 3 was admitted to the facility in 3/2026 with diagnoses including a right total hip replacement with deep hardware removal and post-traumatic osteoarthritis of right hip. Review of Resident 3's Morse Fall Scale assessments dated 3/16/26 and 4/7/26 revealed Resident 3 was a high risk for falls. Review of Resident 3's Occupational Therapy (OT) evaluation dated 3/13/26 revealed the resident's SLUMS (a test to assess an individual's cognition) score was 16 out 30 which indicated the resident had cognitive impairment. The resident required maximal assistance with toileting and moderate assist with transfers. Review of Resident 3's 3/14/26 Physical Therapy (PT) evaluation revealed Resident 3's Short Physical Performance Battery (an objective tool designed to measure balance, lower limb strength, and functional mobility) score was zero which indicated the resident was at high risk for falls and increased risk of mobility disability. The resident required touch assistance when walking using a front wheeled walker (FWW). A progress note dated 3/29/26 indicated Resident 3 required one to two staff to assist with transfers using a FWW and indicated the resident had been transferring and toileting themselves without assistance. The progress note indicated Resident 3 was reminded she/he had not been cleared to be independent and needed to use her/his call light for assistance. Review of Resident 3's Fall incident reports revealed the following: - On 3/31/26 Resident 3 fell after getting up on her/his own. Resident 3 requested to be sent to the hospital and was found to have a right femur fracture which required surgical repair. The incident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	report indicated the facility had been providing Resident 3 with education to ask for assistance due to getting up on her/his own. No new interventions were listed but the resident was encouraged to ask for assistance. - On 5/12/26 Resident 3 fell after getting up on her/his own and sustained a skin tear on her/his right elbow. The resident had not used her/his call light and was re-educated to call for assistance to prevent re-injury. Resident 3's care plan dated 3/24/26 revealed the resident was at risk for falls and instructed facility staff to encourage the resident to use the call light for assistance, to ensure the resident wore non-skid socks when up, and to provide one person to assist with toileting and transferring. The care plan was revised on 3/25/26, 4/25/26, and 6/2/26 but did not include new or amended fall prevention interventions. On 6/1/26 at 11:00 AM Resident 3 stated she/he did not know why she/he fell but believed she/he was approved to walk and transfer independently. Observations made on 6/1/26 at 11:00 AM, 6/2/26 at 8:15 AM, 6/3/26 at 8:53 AM, and 6/4/26 at 8:52 AM revealed Resident 3 was not wearing non-skid socks. On 6/3/26 at 8:53 AM Resident 3 was observed to push her/his call light and observed the bedside commode had crumpled toilet paper and yellow liquid in the bowl. The resident stated she/he wanted staff to empty the bedside commode and confirmed she/he had used the commode without assistance because she/he believed she/he was cleared to do so independently. On 6/3/26 at 9:33 AM Staff 22 (CNA) stated she believed Resident 3 was independent to transfer and use the toilet on her/his own and was not at risk for falls. Staff 22 confirmed Resident 3 had not asked for assistance before using the bedside commode earlier. Staff 22 stated she had not reviewed Resident 3's Kardex (a quick, easy-to-read care plan for CNAs) before working with Resident 3. After reviewing the Kardex, Staff 22 confirmed Resident 3 was not cleared to complete her/his cares independently. On 6/4/26 at 10:09 AM Staff 20 (RN) stated staff educated Resident 3 to use the call light to ask for assistance, but the education did not prevent Resident 3 from self-transferring and falling. On 6/4/26 at 11:04 AM Staff 24 (Former Director of Rehabilitation) confirmed Resident 3 was at high risk for falls and was often non-compliance with asking for assistance. Staff 24 stated the facility discussed Resident 3's non-compliance multiple times during morning department manager meetings and weekly skilled services review meetings. Staff 24 stated she did not recall what interventions were put in place but would have recommended frequent checks and moving Resident 3 closer to the nursing station. On 6/5/26 at 8:36 AM Staff 2 (DNS) stated she determined the effectiveness of fall interventions by monitoring for the absences of no new falls and the team would discuss alternative strategies. Staff 2 stated she was aware of Resident 3's falls and stated the resident's confirmed current fall preventions interventions were ineffective and no new interventions were not discussed or implemented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview and record review it was determined the facility failed to monitor temperatures in the medication refrigerators for 3 of 3 medication refrigerators. This places residents at risk for receiving ineffective medications or vaccinations. Findings include:On 6/5/26, the CDC requires facilities to monitor temperatures in medication refrigerators to maintain a temperature between 36 and 46 degrees Fahrenheit (F).On 6/4/26 at 1:13PM, Staff 3 (Regional Director of Clinical Operations) provided the temperature logs for three medication refrigerators.A review of Station 1's medication temperature log for 5/2026 revealed missing temperatures on 5/1/26, 5/2/26, 5/8/26, 5/11/26, 5/14/26, 5/15/26, 5/16/26, 5/17/26, 5/22/26, and 5/29/26 (10 days).A review of Station 2's medication temperature log for 5/2026 revealed missing temperatures on 5/1/26, 5/2/26, 5/3/26, 5/4/26, 5/5/26, 5/9/26, 5/10/26, 5/16/26, and 5/17/26 (nine days).A review of Station 3's medication temperature log for 5/2026 revealed missing temperatures on 5/1/26, 5/2/26, 5/3/26, 5/4/26, 5/5/26, 5/6/26, 5/8/26, 5/9/26, 5/10/26, 5/16/26, 5/17/26, and 5/24/26 (12 days).On 6/5/2026 at 8:43 AM, Staff 1 (Administrator) stated staff were expected to check the medication refrigerators daily. Staff 1 confirmed the missing temperatures and stated the facility did not have a back-up temperature monitoring system on the days with blank temperatures.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview and record review it was determined the facility failed to ensure residents were allowed to retain and use personal possessions for 1 of 1 sampled resident (#50) reviewed for edema. This placed residents at risk for diminished quality of life. Findings include:The facility's Notice of Resident Rights Under Oregon State Law policy, dated 7/2025 indicated residents had the right to keep and use personal clothing and possessions as space permitted unless to do so infringed on other residents' rights and unless medically contraindicated. Resident 50 was admitted to the facility in 9/2025 with diagnoses including chronic respiratory failure with hypoxia (an ongoing long-term condition where the respiratory system cannot adequately oxygenate the blood), COPD (a group of progressive long-term lung conditions that cause irreversible damage to the airways), dependence on oxygen, anxiety and insomnia. Resident 50's 9/5/25 Social Services admission and History Evaluation indicated the resident slept in a wheelchair because it helped her/him to breathe better. Resident 50's 9/8/25 admission MDS indicated the resident was cognitively intact, had shortness of breath or trouble breathing when lying flat and Resident 50 was at risk for pressure ulcers. Resident 50's 9/29/25 Cardiology follow-up note indicated the resident's legs continued to be swollen and the resident had not received her/his recliner chair but was supposed to receive it today. Resident 50's 2/17/26 Care Conference indicated the resident and her/his daughter inquired about needing a reclining chair, the business office would follow-up with Staff 1 (Administrator) and Staff 1 and Staff 2 (DNS) would look into purchasing a reclining chair for the resident. Resident 50's 4/2026, 5/2026 and 6/2026 TARs indicated the resident consistently became short of breath when lying flat or avoided lying flat to prevent shortness of breath. Multiple observations from 6/1/26 through 6/5/26 between the hours of 8:00 AM and 4:30 PM revealed Resident 50 sat in a non-reclining, manual wheelchair when awake and while sleeping. On 6/1/26 at 9:43 AM, 6/2/26 at 2:42 PM and 6/4/26 at 3:26 PM, Resident 50 stated she/he slept in a manual wheelchair since her/his admission to the facility and was in a wheelchair 24 hours a day, seven days a week. Resident 50 stated she/he did not sleep in her/his bed because she/he was unable to breathe when in bed and was afraid because her/his oxygen levels dropped into the 70's (severe hypoxia) when in bed. Resident 50 stated she/he was supposed to elevate her/his legs, but it was difficult to do while sitting in a wheelchair. Resident 50 stated she/he asked to bring her/his own recliner chair from home but was told no because it was made of fabric and could be an infection control issue. Resident 50 stated she/he was provided with a Geri-chair (a medical chair for resident's requiring frequent assistance from a caregiver for daily activities and transport) approximately two months ago but she/he could not recline the chair, independently, and had to call for assistance thus did not want to use the Geri-chair. Resident 50 stated she/he wanted her/his own recliner chair because she/he could operate the recliner independently. On 6/2/26 at 1:46 PM, Witness 1 (Family) stated Resident 50 asked to bring her/his recliner chair to the facility and it was denied because it wasn't leather. Witness 1 stated Resident 50 never slept in a bed because the resident had too much trouble breathing and the resident needed a recliner chair so she/he could breathe better and elevate her/his legs. Witness 1 stated the facility brought the resident a Geri-chair but Resident 50 could not independently recline the chair and wanted her/his own recliner chair. Witness 1 stated the last she heard anything about Resident 50's recliner chair was at least two months ago. On 6/3/26 at 1:24 PM, Witness 2 (Friend) stated approximately two months ago, she spoke with Staff 1 about bringing Resident 50's recliner chair to the facility and she was told no. Witness 2 stated Resident 50 wanted her/his own recliner chair and I hate to see [her/him] sitting in the wheelchair all of the time. Witness 2 stated the facility brought the resident a Geri-chair but Resident 50 barely fit in it and was unable to independently operate the chair so the resident did not want to use it. On 6/4/26 at 8:32 AM, Staff 8 (CNA) stated Resident 50 always sat and slept in her/his wheelchair. Staff 8 stated one time Resident 50 tried to sleep in her/his bed, but (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was too hard for the resident to breathe, and she/he got scared so bad and would only sleep in her/his manual wheelchair. On 6/4/26 at 9:02 AM, Staff 10 (CNA) stated Resident 50 sat and slept in her/his wheelchair all of the time because the resident felt if she/he laid down, she/he would die. Staff 10 stated she tried to have Resident 50 lay in bed, but the resident was too afraid. On 6/4/26 at 9:38 AM, Staff 12 (CNA) stated Resident 50 had anxiety and she/he only sat in her/his wheelchair. Staff 12 stated Resident 50 reported if she/he got into bed, she/he would suffocate. On 6/4/26 at 12:58 PM, Staff 4 (LPN Care Manager) stated Resident 50 always sat in her/his wheelchair because she was not comfortable sleeping in her/his bed. Staff 4 stated Resident 50 had edema in her/his legs because the resident was not properly elevating her/his legs. Staff 4 stated Resident 50 wanted to bring her/his own recliner chair into the facility, but Staff 1 denied the request. On 6/4/26 at 1:14 PM and 2:51 PM, Staff 1 confirmed he denied Resident 50's request to bring her/his own recliner chair into the facility and acknowledged there was adequate space for the recliner chair in Resident 50's room and no residents' rights would be infringed upon unless the recliner chair became unsanitary. Staff 1 stated he did not feel the resident's own recliner chair was appropriate because it was, potentially, an infection control concern. Staff 1 stated he was aware the resident had been sitting and sleeping in her/his wheelchair since the resident admitted in 9/2025. Staff 1 stated around the end of 2/2026, he attempted to order a recliner chair for Resident 50 but accidently ordered a Geri-chair which did not work for the resident because she/he could not independently operate the chair. Staff 1 continued to state Resident 50 could not bring her/his recliner chair to the facility and no additional follow-up was conducted by Staff 1. On 6/5/26 at 11:33 AM, Staff 3 (Regional Director of Clinical Operations) stated it was her expectation the facility reviewed and offered all options to Resident 50 to ensure the resident had the accommodations she/he needed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure residents could access their closets independently for 1 of 1 sampled residents (#23) reviewed for accommodation of needs. This placed residents at risk for inability to access personal belongings. Findings include: Resident 23 was admitted to the facility in 12/2025 with diagnoses of right and left knee replacements and difficulty walking. Resident 23's quarterly MDS dated [DATE] identified the resident as having intact cognitive function, used a walker and wheelchair for mobility, and required set up and supervision with transfers and walking. A care plan dated 4/1/26 revealed Resident 23 utilized a wheelchair and required one person assistance with walking. Observations of Resident 23's room on 6/1/26 at 10:48 AM. 6/3/26 at 9:45 AM, and 6/4/26 at 3:02 PM revealed Resident 23 and the roommate's beds were positioned directly facing each other. Each bed was centered on its assigned wall beneath the overbed light. The headboards were pushed against the walls, and the footboards were approximately 20 to 24 inches apart from the other. The closets were located in the corner on the far wall. On 6/3/24 at 9:45 AM Resident 23 was observed attempting to maneuver her/his wheelchair between the two beds but the wheels caught against the foot boards preventing Resident 23 to access her/his closet.On 6/1/26 at 10:48 AM Resident 23 stated she/he could not access her/his closet when in her/his wheelchair because the wheels would become caught on the foot boards of the two beds because they were too close. Resident 23 stated she/he was not supposed to walk on her/his own yet but she/he did not want to have to ask staff and instead would hold onto the footboard to walk to the closet or use the bed remote to raise the bed all the way up to make more room for the wheelchair to fit between the two beds when attempting to get to her/his closet. Resident 23 stated staff were notified multiple times she/he could not access her/his closet, but no changes were made to the room. On 6/3/26 at 9:14 AM Staff 16 (CNA) stated Resident 23 only accessed her/his closet in the morning by transferring out of bed on the closet side of the bed and did not go to the closet after that to his knowledge. Staff 16 stated Resident 23 was independent with walking and thought she/he could probably get through the space between the beds if she/he wanted to.On 6/4/26 at 9:55 AM Staff 17 (CNA) stated Resident 23 was independent with walking in her/his room but also used a wheelchair. Staff 17 stated Resident 23's wheelchair did not fit between the two beds, so the resident would lock her/his wheelchair and walked on her/his own to access the closet. Staff 17 confirmed she was not aware Resident 23 was not yet cleared to walk unassisted and had not reported the wheelchair could not fit between the beds. On 6/4/26 at 10:09 AM Staff 20 (RN) stated he did know if Resident 23 had difficulty accessing her/his closet.On 6/4/26 at 3:02 PM Staff 1 (Administrator) and Staff 18 (Maintenance Director) entered Resident 23's room and confirmed the footboards were too close together and a wheelchair would not fit between them. Staff 1 stated he felt the current layout of Resident 23's room would not meet the required minimum square footage around beds and Resident 23 should not have been required to put her/himself at risk of falling to access her/his closet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385068	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health Care	3955 SE 182nd Avenue Gresham, OR 97030

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, it was determined the facility failed to provide a written bed-hold notice at the time of hospital transfer for 1 of 1 resident (#76), provide residents with the necessary written documentation related to hospital transfer and discharge and did not notify the Long-Term Care Ombudsman for 2 of 3 residents (#s76 and 78) reviewed for hospitalization and discharge. This placed residents at risk for lack of being informed, financial responsibilities and Ombudsman advocacy. Findings include: The facility's 5/2025 Bed Hold Policy indicated: The resident and/or representative is informed of the Bed Hold Policy in writing upon admission, transfer, or leave of absence. Upon transfer or discharge, the nursing department provides the resident and/or resident representative with a copy of the Notice of Bed Hold Policy. The facility's 5/2025 Transfer and Discharge Policy indicated: The facility sends a copy of the notice to the State Long-Term Ombudsman.1. Resident 76 was admitted in 4/2026 with diagnoses including streptococcal infection (bacterial infection) and respiratory failure.Resident 76's admission Profile indicated she/he was responsible for themselves.Review of Resident 76's clinical record revealed she/he was transferred to the hospital on 4/26/26. No evidence was found in Resident 76's clinical record to indicate the resident or resident representative was provided with a written Notice of Bed Hold Policy at the time of transfer and no evidence to indicate the State Long-Term Care Ombudsman was notified of the discharge. On 6/3/26 at 1:28 PM, Staff 24 (LPN) stated bed-hold information was provided to residents or resident representatives when residents were transferred to the hospital. On 6/5/26 at 12:26 PM, Staff 1 (Administrator) confirmed the facility did not provide a written Notice of Bed Hold Policy for Resident 76 at the time of the hospital transfer.2. Resident 78 was admitted in 3/2026 with diagnoses including surgical aftercare and morbid obesity.Resident 78's admission Profile indicated she/he was responsible for themselves.Review of Resident 78's clinical record revealed she/he was discharged from the facility following leaving against medical advice (AMA). No evidence was found in Resident 78's clinical record to indicate the State Long-Term Care Ombudsman was notified of the discharge.On 6/5/26 at 12:26 PM, Staff 1 (Administrator) verified the State Long-Term Care Ombudsman had not been notified of Resident 76 or Resident 78's transfer/discharge events.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 5 sampled residents (#7) reviewed for unnecessary medications. This placed residents at risk for adverse side effects to medications. Findings include:Resident 7 was admitted to the facility in 4/2024 with diagnoses including hypertension (high blood pressure) and heart failure.A 11/21/25 order for metoprolol succinate (a medication used to treat hypertension) indicated the medication was to be held if the pulse was less than 55 beats per minute (bpm).A review of the 5/2026 and 6/2026 MAR revealed no documentation on the MAR of Resident 7's pulse.A review of the pulse record revealed no pulse was taken on 5/1/26, 5/3/26, 5/11/26, 5/14/26, 5/24/26, 5/26/26, 5/27/26, 5/30/26, and 6/1/26.A review of the pulse record revealed Resident 7's pulse was taken after the medications were administered on 5/7/26, 5/8/26, 5/10/26, 5/15/26, and 5/31/26.A review of the pulse record revealed Resident 7's pulse was less than 55 and metoprolol succinate was administered on 5/12/26, 5/18/26, 5/22/26, 5/25/26, and 5/29/26.On 6/4/26 at 10:24 AM, Staff 14 (CMA) stated Resident 7 had orders for metoprolol succinate, hold if her/his pulse was less than 55. Staff 1 stated she should have checked Resident 7's pulse prior to administering the metoprolol, but Staff 7 stated she could not remember if she checked Resident 7's pulse prior to giving her/his medication.On 6/4/26 at 12:28 PM, Staff 2 (DNS) stated the MAR was not triggering for Resident 7's pulse to be taken prior to the metoprolol succinate being given. Staff 2 stated it was the expectation for staff to follow physician order, check Resident 7's pulse prior to administering the metoprolol succinate, and to hold the medication if resident 7's pulse was less than 55 bpm.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure a resident's ordered pain medication was available to the resident 17 out 186 dose administration opportunities for 1 of 1 sampled residents (#56) reviewed for pain management. This placed residents at risk for uncontrolled pain. Findings include: Resident 56 admitted to the facility in 11/2021 with diagnoses including chronic pain syndrome.Resident 56's Annual MDS dated [DATE] revealed the resident was cognitively intact, frequently experienced pain in the previous five days, and reported a nine out of ten on a pain scale (a scale indicating a person's pain level where zero equals no pain).Review of Resident 56's clinical records revealed a physician order for Aspercreme Lidocaine Cream 4%, which was active since 3/9/26, instructed the facility to administer the pain medication to the resident's neck and left shoulder two times per day for pain. Review of Resident 56's 3/2026 Treatment Administration Record (TAR), 4/2026 TAR, 5/2026 TAR, and 6/2026 TAR revealed the resident had not been administered Aspercreme Lidocaine Cream 4% on the following dates:- 3/5/26 AM Dose- 3/5/26 PM Dose- 3/6/26 AM Dose- 3/6/26 PM Dose- 4/21/26 AM Dose- 5/11/26 PM Dose- 5/20/26 AM Dose- 5/26/26 AM Dose- 5/27/26 AM Dose- 5/28/26 AM Dose- 5/29/26 AM Dose- 5/29/26 PM Dose- 5/30/26 AM Dose- 5/30/26 PM Dose- 5/31/26 AM Dose- 5/31/26 PM Dose- 6/1/26 AM Dose On 6/1/26 at 11:22 AM Resident 56 stated the facility had run out of the ordered lidocaine cream for her/his left shoulder pain multiple times with the most recent time occurring the week prior. Resident 23 stated she/he did not know why the facility kept running out of medications and without it her/his left shoulder pain was not managed. On 6/4/26 at 10:05 AM Staff 19 (CMA) stated nurses administered creams. Staff 19 stated to ensure residents did not run out of medication the expectation was to check the supply regularly and submit a request to have the medication refilled when the supply started to become low. On 6/4/26 at 10:09 AM Staff 20 (RN) stated when Aspercreme Lidocaine 4% was running low the expectation was to notify Staff 21 (Central Supply) since it was an OTC cream. Staff 20 confirmed Resident 56 missed multiple doses of Aspercreme due to the medication running out but the medication running out but was unsure as to why the facility did not have any available for residents. On 6/4/26 at 3:09 AM Staff 21 stated he checked the medication supply room daily to verify available stock so he could order out of stock supplies. Staff 21 confirmed Aspercreme Lidocaine 4% had run out multiple times because the facility switched vendors and the new vender did not carry Aspercreme Lidocaine 4%, so he relied on Amazon.com and local stores to purchase the pain cream but the stores did not consistently have it in stock. Staff 2 stated Staff 21 was responsible for monitoring and tracking medications that required refills, including Aspercreme. Staff 21 stated she/he was unaware Resident 56 had missed doses of her/his Aspercreme and the medication should not have run out.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to offer pneumococcal immunizations for 2 of 5 sampled residents (#s 7 and 56) reviewed for immunizations. This placed residents at risk for pneumonia. Findings include:Review of the facility's Pneumococcal Vaccine policy, dated 6/19/25, instructed the facility to follow the Centers for Disease Control (CDC) Pneumococcal Vaccine Timing for Adults guide to determine appropriate vaccination and cadence. Review of the CDC's Pneumococcal Vaccine Timing for Adults, dated March 2025, revealed there were four types of pneumococcal vaccines available in the United States: pneumococcal conjugate vaccines (PCV15, PCV20, and PCV21) and pneumococcal polysaccharide vaccine (PPSV23). For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends you give 1 dose of PCV20 or PCV21. If PCV15 is used, this should be followed by a dose of PPSV23 at least one year later. For adults 65 years or older who have only received PPSV23, CDC recommended 1 dose of PCV20 or PCV21 one year after PPSV23. The PCV15 dose should be administered at least one year after the most recent PPSV23 vaccination. For adults 65 years or older who have only received PCV13, CDC recommended PCV20 or PCV21 one year after PCV13. For adults 65 years or older who have only received PCV13 or PPSV23 after age [AGE] years old, CDC recommended PCV20 or PCV21 at least five years after PCV13 or PPSV23. a. Resident 56 was admitted to the facility in 11/2021 with diagnoses including chronic obstructive pulmonary disease and asthma. Review of Resident 56's clinical records revealed the resident last received the PPSV23 on 2/27/23 with no documentation of pneumococcal consent after 2/23/24. There was no documented evidence that Resident 56 was offered or declined PCV15, PCV20, or PCV21.On 6/5/26 at 8:15 AM Resident 56 stated she would have wanted to have been offered the pneumococcal vaccination. b. Resident 7 was admitted to the facility in 4/2024 with diagnoses including chronic heart failure and diabetes.Review of Resident 7's clinical records revealed the resident last received the PCV13 on 7/17/17. There was no pneumococcal vaccination consent after 7/17/17. There was no documented evidence that Resident 7 was offered or declined PCV20 or PCV21.Resident 7's 4/30/26 Quarterly MDS indicated the resident had severe cognitive impairment. On 6/4/26 12:46 PM Staff 15 (Infection Preventionist) stated she developed a tracking system when she took over the position approximately ten months early and found residents were past due for vaccinations. Staff 15 was aware Resident 7 and Resident 56 were due for pneumococcal vaccinations but had not offered the vaccination. Staff 15 stated she struggled completing the past due vaccinations because of being pulled to other nursing and staffing coordination related tasks.On 6/5/26 at 8:36 AM Staff 2 (DNS) confirmed knowing Staff 15 was working on past due vaccinations but did not confirm knowing specific residents. Staff 15 stated her expectation was residents are offered pneumococcal vaccinations when due.