STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385072	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corvallis Manor	160 NE Conifer Blvd Corvallis, OR 97330

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 40774 Based on observation, interview and record review the facility failed to assess a resident for safe self-administration of medication for 1 of 1 sampled resident (#50) reviewed for anticoagulant medications. This placed resident at risk for adverse side affects. Findings include: Resident 50 was admitted to the facility in 12/2023 with diagnoses including somatization disorder (a form of mental illness that caused one or more bodily symptoms, including pain. They cause excessive and disproportionate levels of distress) and PTSD. A 1/27/25 Self-Administration of Medication indicated Resident 50 offered her/his medications to others. Staff determined the resident was not a candidate for self-administration. A 1/27/25 Nursing Note indicated Staff 2 (DNS) informed Resident 50 regarding her/his cogitative testing results which indicated she/he had cognitive impairment which suggested it was unsafe for her/him to self-administer medications without supervision. A 2/6/25 Risk Versus Benefit indicated Resident 50 was allowed access to one over the counter medication daily from the medication cart. Staff were to review the instructions with the resident and document she/he acknowledged the instructions. The 2/24/25 Care Plan indicated the resident could check out one medication per day to keep in her/his room. Staff were to review the administration instructions with her/him each time and document the resident acknowledged. No documentation was found in the clinical record to indicate the resident checked out her/his medication or staff reviewed administration instructions with the resident. On 3/10/25 at 4:00 PM Resident 50 was observed in her/his bedroom which included nasal sprays and supplements on her/his bedside table and in a large plastic tote sitting on the floor. Resident 50 stated she/he was allowed to keep the medications in her/his room as long as she/he kept them organized. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1:45 PM Staff 18 (LPN) was asked about the medications in resident 50's room but did not remove them. Staff 18 stated the resident was allowed to keep certain medications at her/his bedside during the day and was required to return them at the end of the day. Staff 18 added staff did not monitor which medications the resident took to her/his room or whether the resident returned them. Staff 18 confirmed there were multiple unsecured medications in the resident's room and was unable to determine which medications the resident accessed on any given day. On 3/14/25 at 12:27 PM Staff 2 (DNS) acknowledged Resident 50 was not capable of safe self-administration of medications. Staff 2 stated staff were expected to follow the care plan, provide appropriate instructions to Resident 50 and ensure her/his medications were properly secured at the end of each shift.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 26991 Based on interview and record review it was determined the facility failed to provide a clean environment as well as functioning phones and lights for 2 of 6 sampled residents (#s 33 and 174) reviewed for environment. This placed residents at risk for an unclean, unsafe, and unhomelike environment. Findings include: 1. Resident 33 was admitted to the facility in 12/2024 with a diagnosis of heart disease. A care plan initiated 1/24/25 indicated Resident 33's goal was to discharge to an Assisted Living Facility. On 3/10/25 at 11:07 AM a white portable fan was observed on top of Resident 33's night stand. The fan blades were coated with a brown layer of dust. On 3/14/25 at 3:05 PM Staff 28 (Maintenance Director) acknowledged the fan blades were dusty and was not sure who cleaned the blades. On 3/17/25 at 9:15 AM Staff 11 (Housekeeping Manager) stated the outside of the fans were cleaned with daily dusting and and the blades were cleaned when residents moved out of a room. 41455 2. Resident 174 was admitted in 12/2024 with diagnoses including diabetes and a surgical site infection. On 12/26/24 a State Agency public complaint was received which indicated Resident 174 voiced concerns about broken equipment in her/his room which were still unaddressed. On 12/18/24 the resident's phone stopped working and on 12/21/24 the room's light failed to operate. The following work orders for Resident 174's room were obtained from the facility's building management reporting system: -A 12/23/25 order indicated the room's light not working and reported by Staff 21 (IP). -A 12/23/25 order indicated the phone did not ring. -A 12/24/25 order indicated the pull light was not working and was completed on 12/27/25. -A 12/26/25 order indicated the light was not working and the repair was a high priority. A 12/25/24 Nursing Note indicated Resident 174's family attempted to call her/his room and used 911 dispatch in order to call the resident because the room phone did not work. Staff 52 (LPN) replaced Resident 174's phone with a phone from an empty room which fixed the issue. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 10:41 AM Staff 21 stated in 12/2024 maintenance work orders were not completed timely and staff were told to follow-up on repair requests verbally. On 3/14/25 at 8:59 AM Staff 8 (LPN) stated she was aware of the repair concerns in Resident 174's room especially when Staff 8 required a light from her cell phone to provide care to the resident's wound. Staff 8 stated Resident 174 liked to read and the room light did not work for three days. On 3/17/25 at 3:05 PM Staff 1 (Administrator) acknowledged work orders were expected to be completed within 24 hours.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41455 Based on interview and record review it was determined the facility failed to ensure grievances were acted upon timely for 1 of 5 sampled residents (#14) reviewed for dignity and missing property. This placed residents at risk for unresolved needs. Findings include: An undated facility Grievance Process Guide indicated all staff may complete grievances on behalf of residents and to provide a paper copy to residents who declined to file grievances online. Resident 14 was admitted to the facility in 2/2025 with diagnoses including fractures of the spine and pelvis. A 2/17/25 Admission MDS indicated Resident 14 was cognitively intact. Facility Grievances from 2/2025 through 3/10/25 were reviewed, but no grievance form for Resident 14 was found. On 3/10/25 at 11:23 AM and 3/12/25 at 4:08 PM Resident 14 indicated her/his red cell phone was missing. Resident 14 stated staff were aware her/his phone was missing and no staff offered assistance to file a grievance. Resident 14 stated she/he purchased a new blue cell phone to replace the missing one; however, no follow-up was conducted concerning the the original issue. On 3/11/25 at 3:28 PM Staff 26 (Social Service Director) stated the facility offered multiple options to submit grievances and confirmed no grievance was submitted by staff or Resident 14 for a missing phone. On 3/12/25 at 12:02 PM Staff 30 (CNA) stated she was aware of Resident 14's missing red phone, had informed nursing about the issue, and did not know where to locate a paper copy of a grievance form to assist Resident 14 with the grievance process. Staff 30 acknowledged no grievance form was completed for Resident 14.

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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. 40774 Based on observation, interview and record review it was determined the facility failed to incorporate PASARR (Preadmission Screening and Resident Review) Level II recommendations for 1 of 1 sampled resident (# 50) 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 50 was admitted to the facility in 12/2023 with diagnoses including anxiety and post-traumatic stress disorder (PTSD). A 1/25/25 PASARR Level II Mental Health Evaluation was conducted for Resident 50. The assessment included the following non-pharmacological recommendations: Resident 50 expressed interest in having a recliner-style chair placed in her/his room, stating that they spent most hours of the day and night in a wheelchair and experienced significant discomfort. On 3/10/25 at 4:00 PM Resident 50 reported prior to admission, she/he slept in a recliner chair. The resident stated several months earlier, psychological evaluation had been conducted, during which she/he was informed a recliner chair could be provided; however no further updated regarding this request had been received. On 3/14/25 at 9:32 AM Staff 26 (SSD) stated she was responsible for reviewing PASARR Level II results but was unaware of recommendations. Upon reviewing the PASARR Level II documentation, Staff 26 acknowledged the PASARR Level II recommendations was overlooked. On 3/14/25 at 12:27 PM Staff 2 (DNS) reviewed the PASARR II recommendation, acknowledged the recommendation was overlooked and stated staff were expected to follow up on the recommendations.

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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. 35855 Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 2 of 4 sampled residents (#s 61 and 124) reviewed for ADLs. This placed residents at risk for lack of personal hygiene and skin injuries. Findings include: 1. Resident 61 was admitted to the facility in 12/2024 with diagnoses including stroke and muscle weakness. A 12/30/24 Admission MDS indicated Resident 61's BIMs score was 13, signifying cognitive intactness. Resident 61 required substantial to maximal assistance with personal hygiene. A revised care plan dated 1/26/25 indicated Resident 61 required a high level of caregiver support to have needs met. Resident 61 required extensive assistance from one staff member to provide bathing and limited assistance with personal hygiene. On 3/10/25 at 12:02 PM, Resident 61 was in her/his room and was observed to have facial hair on her/his chin and upper lip, approximately an inch long. Resident 61 stated she/he would like to have the facial hair removed on their shower days. On 3/12/25 at 9:56 AM, Resident 61 was observed in the main dining room and had facial hair on her/his chin and upper lip, approximately an inch long. On 3/17/25 at 7:54 AM, Resident 61 was in her/his room and was observed with facial hair on her/his chin and upper lip, approximately an inch long. Resident 61 stated she/he did not like having the facial hair, had requested staff to remove it, and did not know what to do to have the facial hair removed. Witness 2 (Staff) confirmed Resident 61's facial hair. On 3/17/25 at 1:58 PM, Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) stated they would expect staff to take care of a resident's facial hair if a resident did not want facial hair. 26991 2. Resident 124 was admitted to the facility in 3/2025 with a diagnosis of diabetes. A 3/5/25 nursing Admission/Readmission Evaluation form revealed Resident 124 was cognitively intact and required extensive assistance of one staff for bathing and hygiene. On 3/10/25 at 12:14 PM Resident 124 was observed to have long, dirty finger nails, and her/his right thumb nail was long and jagged. A 3/2025 TAR revealed diabetic nail care was to be completed every two weeks and was to be completed on 3/11/25 but was not documented as completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/11/25 CNA Skin Shower Review sheet revealed Staff 40 (Graduate Nurse Aide) assisted Resident 124 with bathing and indicated Resident 124 did not need her/his fingernails cut. A 3/12/25 Progress Note by Staff 18 (LPN) indicated nail care was not completed. On 3/12/25 at 1:00 PM with Staff 41 (CNA) Resident 124's nails were observed to be long and dirty. Staff 41 stated nail care was usually completed on shower days unless a resident had a diagnosis of diabetes, then the nurse completed nail care. On 3/12/25 at 1:03 PM and 3/15/25 at 4:52 PM Staff 18 stated on 3/11/25 a CNA provided Resident 124 a bath and the bath sheet indicated she/he did not require nail care. With Staff 18 Resident 124's nails were observed to be long and required a trim. Staff 18 stated on 3/11/25 she did not personally look at Resident 124's nails. On 3/14/25 at 11:40 AM Staff 40 stated she provided Resident 124 a bed bath on 3/11/25, washed her/his hands, but did not recall what her/his nails looked like. On 3/14/25 at 11:47 AM Staff 2 (DNS) stated diabetic nail care was done by the nurses and documented on the MAR or TAR. Nail care could be provided prior to the due date or after depending on the resident's preference of nail length preference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview and record reviewed it was determined the facility failed to follow physician orders, implement bowel care, treat and monitor skin conditions for 5 of 11 residents (#s 14, 29, 37,174, and 224) reviewed for skin conditions, tube feeding, bowel care, and dialysis. This placed residents at risk for unmet needs. Findings include: 1. Resident 29 was admitted to the facility in 2/2025 with diagnoses of diarrhea and UTI. A 2/17/25 Admission MDS indicated Resident 29 was rarely understood and had percutaneous endoscopic gastrostomy tube (PEG tube, also known as a feeding tube). a. A physician's order, signed on 2/20/25, indicated Resident 29 was to have nothing by mouth (NPO). A 2/22/25 Alert Note indicated Resident 29 was at risk of malnutrition and was evaluated by the registered dietitian to administer Juven (a nutritional supplement which supports wound healing, helps body build new tissue) twice daily through feeding tube. A 2/2025 and 3/2025 MARs instructed staff to administer Juven two times a day for wound healing and administer the medication via PEG tube. The MARs showed no documentation Juven was administered to Resident 29 on the following dates and shifts: - 2/20/25, 3/2/25, 3/4/25, 3/5/25, and 3/9/25 during the morning and evening shift. -2/22/25 and 3/8/25 during the evening shift. -3/7/25, with documented indicating to view Administration Notes for both the morning and evening shifts. A 3/7/25 at 8:22 AM and 5:00 PM Administration Notes revealed Juven was not available in the morning and could no longer receive the medication in the evening. No additional documentation was found in the clinical record explaining why Juven was not administered on the above-mentioned days. On 3/14/25 at 9:12 AM, Staff 13 (CMA) stated she believed the order for Juven was on both the TAR and the MAR and the nurse was required to administer the supplement. On 3/17/25 at 1:33 PM, Staff 1(Administrator), Staff 2 (DNS), and Staff 24(Regional Director of Care) stated no information was found explaining why Resident 29 did not receive physician-ordered Juven. Staff 2 expected staff to implement and follow physician orders. b. A 2/2025 Diabetic Administration Record (DAR) instructed staff to check Resident 29's blood sugar once daily for blood glucose monitoring. From 2/15/25 through 2/24/25, the document indicated blood sugar checks were performed, but no blood sugar values were documented on the DAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No documentation was found in Resident 29's clinical record physician-ordered blood sugar checks were completed on 2/15/25, 2/16/25, 2/20/25, 2/21/25, 2/22/25 and 2/23/25. On 3/17/25 at 1:33 PM, Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) were present. Staff 2 stated she expected staff to check Resident 29's blood sugars as ordered by the physician. c. A physician's order, signed on 2/20/25, indicated Resident 29 was to have nothing by mouth (NPO). A physician's order, dated 3/11/25, instructed staff to administer two loperamide (to treat diarrhea) capsules by mouth as needed for diarrhea, for three days after first loose stool. A 3/2025 MAR instructed staff to administer loperamide capsules by mouth as needed for diarrhea, with a start date of 3/11/25. On 3/13/25, documentation showed loperamide was administered. A 3/12/25 Skilled Nursing Note indicated Staff 14 (LPN) administered loperamide to Resident 29 on 3/11/25 and on the morning of 3/12/25. A 3/13/25 Administration Note indicated Staff 8 (Agency LPN) administered two loperamide capsules by mouth as needed for diarrhea, and the medication was effective. No documentation was found in the clinical record indicating the physician was notified to clarify the conflicting orders. On 3/14/25 at 10:39 AM, Staff 14 stated she was in training and on 3/12/25, she administered Resident 29's loperamide by crushing the pills, mixing them with water and administering the solution through Resident 29's gastrostomy tube (G-tube). Staff 14 stated because she obtained the medication from the medication technician, she did not document administration on the MAR, and instead documented the administration in the administration notes. On 3/14/25 at 12:22 PM, Staff 8 stated she did not follow physician's orders for loperamide by administering the medication through Resident 29's G-tube. On 3/17/25 at 1:33 PM, Staff 1 (Administrator) Staff 2 (DNS) and Staff 24 (Regional Director of Care) stated they expected staff to administer medications as prescribed by the physician. 26991 2. Resident 14 was admitted to the facility in 2/2025 with a diagnosis of diabetes. Per epocrates (online pharmacy resource) revealed insulin aspart (hormone to decrease blood sugars) was a fast acting insulin that started to work in about 15 minutes after injection, peaked in about one hour, and kept working for two to four hours. Instructions included you should eat a meal within 5 to 10 minutes. A 2/17/25 admission MDS revealed Resident 14 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/2025 Diabetic Administration Record (DAR) revealed on 3/13/25 Resident 14 received aspart at 12:00 PM. On 3/13/25 at 1:43 PM Resident 14 stated she/he just ate lunch at 1:20 PM. Resident 14 stated she/he did not have any symptoms of low blood sugars. On 3/14/25 at 8:48 AM Staff 8 (LPN) stated ideally residents should not receive fast acting insulin more than 30 minutes before they ate or they should be provided a snack at the time of the injection. Staff 8 stated on 3/14/25 she administered Resident 14 her/his insulin and lunch ended up being served really late. Resident 14 did not have a snack in her/his room and did not receive lunch for over one hour after the insulin was administered. Staff 8 stated she was in Resident 14's room reviewing her/his discharge medications and she/he did not have signs of low blood sugars. Staff 8 stated the kitchen staff did not notify the staff lunch was going to be late and she did not provide her/him a snack after the insulin was administered. 40774 3. Resident 37 admitted to the facility in 10/2024 with diagnosis including kidney failure. On 2/25/25 Labs were collected for suspected UTI. A 3/4/25 MD note indicated Resident 37 declined antibiotics and staff were to monitor the resident for signs and symptoms related to UTI complications. No evidence was found in the clinical record to indicate Resident 37 was monitored for signs and symptoms of a UTI. On 3/11/25 at 9:04 AM Staff 18 (LPN) stated nursing was expected to follow up with the residents physician in a timely manor requarding lab results, follow the reccomendations and monitor the resident for complications. Staff 18 confirmed staff did not follow physician orders. On 3/14/25 at 12:46 PM Staff 21 (Infection Preventionist) staff were expected to monitor residents daily for signs and symptoms of a UTI and confirmed no documentation was found to indicate the resident was monitored for UTI complications. Staff 21 further stated she did not know the process for when staff should follow up with the doctor. On 3/14/25 at 1:04 PM Staff 2 (DNS) and Staff 24 (Regional Director of Care) were interviewed. Staff 2 and Staff 24 reviewed Resident 37's clinical record and acknowledged Resident 37 was not monitored for signs and symptoms of her/his UTI. Staff stated she expected staff to monitor every shift for potential complications related to worsening symptoms of a UTI. 4. Resident 224 admitted to the facility in 2/26/25 with diagnoses including heart failure and end stage kidney disease. The facilities undated Bowel Program indicated the following: -To assess and track resident's bowel function and implement bowel protocols. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bowel movement frequency will be assessed daily by the nurse. -Absence of regular bowel movement in excess of three days will be assessed by the nurse. -The assessment will include: A physical assessment of G.I. system and signs/symptoms of constipation, impaction or obstruction. -When needed, a bowel protocol will be implemented as established by physician's orders: -If, after completion of bowl protocols orders, the resident has not had a bowel movement, the physician will be notified. A 2/26/25 NSG Bowel and Bladder Screener indicated the resident was alert and oriented, was incontinent of stool daily and required one person assistance with transfers to the toilet. A review of the Bowel Elimination Task from 3/1/25 through 3/8/25 indicated Resident 224 had no bowel movement for eight days. No documentation was found in the clinical record to indicate nursing staff monitored, assessed, or implemented bowel care. A 3/6/25 Progress Note indicated staff notified Resident 224's physician related to no bowel movement for six days. A 3/11/25 Alert Note indicated the resident had no bowel movement for six days. On 3/11/25 at 11:59 AM Staff 18 (LPN) stated it was standard for residents to have bowel care orders but confirmed Resident 224 had no orders and staff waited six days to notifiy her/his physician. Staff 18 further stated the resident did not have a bowel movement for six days and she/he was not monitored for bowel care. On 3/12/25 at 12:57 PM Staff 13 (CNA/CMA) stated residents were usually admitted with bowel care orders but Resident 224 did not have any bowel care orders. Staff 13 stated she notified the nurse and the CMA coming on the next shift. Staff 13 further stated the resident did not have a bowel movement for at least four days. On 3/13/25 at 5:17 PM Staff 2 (DNS) reviewed Resident 224 clinical record and confirmed the facility did not have bowel care orders upon Resident 224's admission. Staff 2 stated staff were expected ensure bowel care orders were in place and to implement bowel care protocol. 41455 5. Resident 174 was admitted on [DATE] with diagnoses including diabetes and a surgical site infection. The 12/17/24 hospital Orders and Discharge Instructions indicated Resident 174 required a wound vac (medical devise to assist in wound healing) applied to the resident's left groin and left foot amputation site wound which was to be changed three times weekly. (continued on next page)

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Corvallis Manor	160 NE Conifer Blvd Corvallis, OR 97330

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/17/24 care plan indicated Resident 174 had her/his wound vac in place and to monitor the wound daily. The 12/2024 TAR indicated Resident 174 received no wound vac treatment on 12/17/24 or on 12/25/24 when Staff 54 (LPN) worked. A 12/18/24 Nursing Note indicated Staff 8 (LPN) was unable to obtain a photo of Resident 174's left groin wound on 12/17/24. The resident required a dressing change due to the extended period of time the resident's wound vac was unhooked. On 3/14/25 at 8:59 AM Staff 8 stated on 12/17/24 the wound vac supplies were not available when Resident 174 was admitted which caused an issue for the resident's wound. Staff 8 indicated Resident 174's wound treatment did not occur on 12/17/24 and was delayed until 12/18/24. On 3/14/25 at 11:29 AM Staff 7 (LPN) stated in 12/2024 she had a misunderstanding regarding wound vacs and supplies. Staff 7 stated Resident 174 required her/his wound vac to remain in place at all times, except during wound vac changes. Staff 7 confirmed timely wound vac treatment for Resident 174 did not occur due to the lack of wound vac supplies. On 3/16/25 at 4:52 PM Staff 54 stated she did not complete Resident 174's treatment on 12/25/24 because she was unaware how to complete the wound vac process. On 3/17/25 at 3:05 PM Staff 2 (DNS) acknowledged staff did not implement and follow the care plan related to Resident 174's wound vac and wound vac supplies should have been in place.

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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. 41455 Based on interview and record review it was determined the facility failed to follow physician orders for treatment of a resident's pressure ulcer for 1 of 5 sampled residents (#20) reviewed for medications. This placed residents at risk for worsening pressure ulcers. Findings include: Resident 20 was admitted to the facility in 1/2025 with diagnoses including chronic pain and a Stage 3 pressure ulcer (full-thickness skin loss). The 2/4/25 Admission MDS indicated Resident had frequent pain and a Stage 3 pressure ulcer on admission. The 3/10/25 revised care plan indicated staff were to observe Resident 20's wound dressing every shift. A wound dressing change and documented observation of the wound was to occur three days per week. The 3/2025 TAR revealed a 3/13/25 revised order for wound care to Resident 20's sacrum which was to occur three times per week on Tuesday, Thursday and Saturdays. Staff were to first cleanse and prep the wound. A black foam was to cover the wound before the wound vac (medical devise to promote wound healing) was attached. On 3/16/25 a 9 (to see progress note) was indicated by Staff 47 (LPN). No progress note related to Resident 20's wound was found. On 3/17/25 at 7:54 AM Witness 2 (Staff) stated Resident 20 did not receive her/his wound treatment during the weekend. On 3/17/25 at 9:31 AM Staff 46 (Physician) stated he expected, but did not receive, communication related to a missing wound treatment for Resident 20. On 3/17/25 at 9:54 AM Staff 48 (RN) stated, during the weekend, Resident 20's wound was not treated and the wound vac was not changed due to the lack of black foam Staff 47 needed for the wound vac. On 3/17/25 at 10:11 AM an attempt to reach Staff 47 was unsuccessful. On 3/17/25 at 1:02 PM and 5:28 PM Staff 19 (LPN-Unit Manager) confirmed during the weekend the black foam for Resident 20's wound vac was in stock and acknowledged Resident 20's wound treatment was not provided as ordered.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 35855 Based on interview, and record review it was determined the facility failed to provide appropriate foot care for 1 of 2 sampled residents (#s 22) reviewed for skin. This placed residents at risk for infections. Findings include: Resident 22 was admitted to the facility in 10/2024 with diagnoses of diabetes and vascular dementia. A 10/24/24 Admission MDS indicated Resident 22's BIMS was 10, signifying moderate cognitive impact. A 2/25/25 Alert Note revealed Resident 22's left big toe appeared red and swollen, with no drainage noted. The affected area was cleansed. Resident 22 denied pain but reported tenderness upon touch. No open wound or ulceration was observed. The physician was notified and awaiting further recommendations. A 2/25/25 Order Request Response indicated Resident 22 had redness and swelling of the left big toenail with no visible drainage. The physician response recommended continued monitoring and supportive care. Resident 22 was placed on physician's schedule to be evaluated on 2/28/25. No documentation was found in the clinical record for monitoring or evaluation of Resident 22's left big toe. On 3/14/25 at 11:16 AM, Staff 16 (LPN) stated she received information during Resident 22's update she/he had an ingrown toenail. Staff 16 stated she received a physician order to soak the toe in Epsom salt daily for seven days. No documentation was found in Resident 22's clinical record for an Epsom salt soak physician order or a wound evaluation for the left big toe. Resident 22 discharged from the facility on 3/13/24 and admitted to another nursing facility. On 3/14/25 at 2:02 PM, Witness 12 (DNS at Resident 22's facility she admitted to on 3/13/25) stated it appeared Resident 22 had an ingrown toenail which appeared to be infected. On 3/14/25 at 2:26 PM, Staff 2 (DNS) stated the physician evaluated Resident 22's toe on 3/13/25 and there were no concerns. A 3/14/25 Wound Evaluation (From the facility Resident 22 admitted to on 3/13/25) revealed Resident 22 had an ingrown toenail which was present on admission. The size of the wound was 3.05 centimeters in area, 2. 21 centimeters in length, and 1.94 centimeters in width, with 40 percent eschar (dead tissue). The wound had evidence of infection with increased drainage, increased pain, redness, and inflammation. The wound has scabbing which was possible dried drainage, increased pain redness, and inflammation. Pain score was five on a scale of one to 10 with 10 being the worst pain. Suspected infection, and the physician was notified. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 3:14 PM, Staff 50 (Physician) stated they were notified of the redness on the left big toe on 2/25/25. It was ordered to continue to monitor and to have it evaluated on 2/28/25. Staff 50 stated the left big toe was not evaluated on 2/28/25 as the physician's schedule changed. Staff 50 stated when she completed Resident 22's discharge evaluation, she did not address the toe as Resident 22 did not complain about the toe. Staff 50 stated she continued to be Resident 22's physician at her/his new nursing facility. On 3/17/25 at 1:58 PM, Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) confirmed Resident 22 should have had treatment, monitoring and the physician should have observed the wound before Resident 22's discharge.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure resident water temperatures were safe for 3 of 6 sampled residents (#s 2, 10, and 17) and 1 of 1 therapy gym reviewed for water temperatures. This placed residents at risk for burns. Finding include: 1. Resident 2 was admitted to the facility in 8/2024 with a diagnosis of heart disease. A care plan initiated 6/2022 revealed Resident 2 was incontinent and required the assistance of two staff and a mechanical device for transfers. On 3/12/25 at 11:16 AM Staff 42 (Maintenance) stated water temperatures were checked weekly. On 3/14/25 at 3:33 PM Staff 30 (CNA) stated Residents did not report concerns with hot water. On 3/14/24 at 3:09 PM with Staff 28 (Maintenance Director) Resident 2's bathroom water was observed to be 122 degrees F and the boiler was set at 114 degrees F. Staff 28 was not sure the reason the water was so hot with the boiler set at 114 degrees F. On 3/17/24 at 3:00 PM Staff 1 (Administrator), Staff 2 (DNS) Staff 24 (Regional Director of Care) were present for an interview. Staff 1 stated Resident 2 did not use the bathroom but the water was too hot in the residents' shared bathroom. 2. Resident 10 was admitted to the facility in 5/2024 with a diagnosis of diabetes. A care plan initiated 5/2024 indicated Resident 10 was incontinent and dependent on staff for incontinent care. On 3/12/25 at 11:16 AM Staff 42 (Maintenance) stated the water temperatures were checked weekly. On 3/14/25 03:33 PM Staff 30 (CNA) stated Residents did not report concerns with hot water. On 3/14/24 at 3:09 PM with Staff 28 (Maintenance Director) Resident 2's bathroom water was observed to be 122 degrees F and the boiler was set at 114 degrees F. Staff 28 was not sure the reason the water was so hot with the boiler set at 114 degrees F. On 3/17/24 at 3:00 PM Staff 1 (Administrator), Staff 2 (DNS) Staff 24 (Regional Director of Care) were present for an interview. Staff 1 stated Resident 2 did not use the bathroom but the water was too hot in the residents' shared bathroom. 3. Resident 17 was admitted to the facility in 10/2022 with a diagnosis of cancer. A care plan revised 10/2024 revealed Resident 24 required the assistance of one staff for toileting and mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 11:16 AM Staff 42 (Maintenance) stated the water temperatures were checked weekly. On 3/14/25 03:33 PM Staff 30 (CNA) stated Residents did not report concerns with hot water. On 3/14/24 at 3:09 PM with Staff 28 (Maintenance Director) Resident 2's bathroom water was observed to be 122 degrees F and the boiler was set at 114 degrees F. Staff 28 was not sure the reason the water was so hot with the boiler set at 114 degrees F. On 3/17/24 at 3:00 PM Staff 1 (Administrator), Staff 2 (DNS) Staff 24 (Regional Director of Care) were present for an interview. Staff 1 stated Resident 2 did not use the bathroom but the water was too hot in the residents' shared bathroom. 4. Review of a logbook documentation form revealed on 3/7/24 the physical therapy gym water was tested and was 141.6 degrees F. On 3/14/25 at 3:28 PM Staff 43 (Physical Therapy Assistant) stated residents did not have access to the therapy gym unless staff were in the room. On 3/17/24 at 3:00 PM Staff 1 (Administrator), Staff 2 (DNS) Staff 24 (Regional Director of Care) were present for an interview. Staff 1 stated he was not aware the water was tested to be 141 degrees F in the therapy gym, it was too hot, but residents were not allowed in the gym with therapy staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 26991 Based on observation, interview, and record review it was determined the facility failed to assess a resident's ability to self-catheterize (sterile tube inserted into the bladder through the urethra [tube that goes from the bladder to the outside of the body] to drain the urine) for 1 of 1 sampled resident (#25) reviewed for UTI. This placed residents at risk for recurrent UTIs. Findings include: Resident 25 was admitted to the facility in 9/2024 with a diagnosis of incomplete quadriplegia (partial damage to the spinal cord resulting in varying degrees of weakness, paralysis, and loss of sensation in the legs and arms). A care plan initiated 1/20/22, from a former facility Resident 25 previously resided, revealed she/he had an ADL self care deficit due to quadriplegia, limited ROM, and weakness. Interventions included staff were to assist Resident 25 with hand washing. A 9/23/24 admission MDS revealed Resident 25 had impaired ROM, strength, and muscle coordination. Resident 25 was assessed to have more ability to use her/his arms and was able to straight catheterize her/himself after staff set up the equipment. Resident 25 had a history of multiple UTIs. A 11/19/24 Regulatory Visit Note revealed Resident 25 had range of motion of the arms but no fine motor function (ability to perform small, precise movements of the hands and fingers). A care plan initiated 1/11/25 revealed Resident 25 had a history of UTIs related to self-catheterization. Staff were to educate the resident on good hygiene practice, voiding at first urge, and to not hold her/his urine for extended amount of time. Resident 25's clinical record did not have an assessment to determine if she/he was observed to ensure she/he was able to self-catheterize in a manner to prevent UTIs including performing hand hygiene and keeping a clean environment. On 3/17/25 at 9:00 AM with Staff 20 (CNA) Resident 25's bedside table was observed to have catheter supplies, a urinal with urine in it, and a dry wash cloth. There was no hand sanitizer on the bedside table. Resident 25 was not in the room and Staff 20 stated Resident 25 would be out of the facility most of the day. Staff 20 stated Resident 25 was able to move her/his arms, needed staff to bring her/him catheter supplies, and she did not observe the resident's ability to perform catheterization. Staff 20 stated she would provide Resident 20 a wash cloth to clean her/his hands. On 3/17/25 at 9:06 AM Staff 3 (CNA) stated Resident 25 self-catheterized her/himself and she just set up the supplies. Staff 3 stated the resident was able to open packages and lubricants. Staff 3 stated she did not know if Resident 25 performed hand hygiene before she/he did catheterization. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 9:40 AM Staff 15 (RN) stated Resident 25 was able to move her/his arms and was able to grip her/his hands. Staff 15 stated she had not observed Resident 25 perform catheterization and was uncertain how effectively she/he had done it. Staff 15 stated the CNAs set the resident up with her/his supplies. On 3/17/25 at 11:02 AM Staff 19 (LPN Unit Manager) stated the facility ensured Resident 25 had catheter supplies and she/he did the catheterization. Staff 19 stated she never assessed the resident's ability to self-catheterize but indicated she provided education on hand hygiene. A request was made to Staff 19 to provide an assessment of Resident 25's ability to self-catheterize her/himself and education which staff provided the resident. Staff 19 did not provide the requested information. On 3/17/25 12:23 PM Staff 44 (LPN) stated she was not sure how long Resident 25 performed her/his own self-catheterization. The CNAs set up the supplies and the resident did the task. Staff 44 stated she never observed Resident 25 perform the catheterization or observed her/him wash her/his hands. Staff 25 stated she was not sure how clean of a procedure Resident 25 would be able to perform. On 3/17/24 at 3:00 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) were present for an interview. Staff 2 acknowledged Resident 25 self-catheterized after staff set up her/his supplies and the care plan did not direct the CNA staff to ensure the resident had a clean surface, or did hand hygiene prior to performing the task. A request was made for an assessment or education related to the prevention of UTIs which was provided to Resident 25. Staff 1, Staff 2, and Staff 24 did not provide the requested information.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40774 Based on interview and record review it was determined the facility failed to ensure accurate communication occurred between the facility and the dialysis provider and daily weight were obtained per physician orders for 1 of 1 sample resident's (#224) reviewed for dialysis. This placed residents at risk for potential complications and dialysis care and treatment. Findings include: Resident 224 admitted to the facility on [DATE] with diagnoses including heart failure and ESRD (end stage kidney disease). a. The 2/26/25 Admission MDS indicated Resident 224 was cognitively intact and had an active diagnosis of ESRD and received hemodialysis (treatment used to filter waste, excess fluids, and toxins from the blood when the kidneys are no longer able). A 3/3/25 physician order instructed staff to complete the Pre-Dialysis Assessment and Communication form and Post-Dialysis Assessment and Communication form. Staff were to ensure the form was sent to the dialysis center with the resident in the morning every Monday, Wednesday and Friday. A review of the Pre and Post Dialysis Assessment Communication form revealed the following: -3/3/25 indicated the resident had a AV (arteriovenous) shunt (a surgical connection between an artery and a vein usually created in the arm for hemodialysis access), the resident had a strong thrill (pronounced vibration or buzzing sensation felt over and AV shunt), and the resident had audible brunt presence (sound of blood flowing through the AV connection). The information did not include post dialysis vitals, additional comments or a signature from the dialysis nurse. -3/7/25 and 3/10/25 the forms were blank and no information was completed on the forms. On 3/11/25 at 11:59 AM Staff 18 (LPN) stated nurses were expected to fill the Pre-Dialysis Assessment and Communication form before the resident went to dialysis and to ensure the Post-Dialysis Assessment form was completed by the dialysis center. Staff 18 confirmed staff did not always complete the forms or follow up with the dialysis center. On 3/11/25 at 3:17 PM Staff 19 (LPN Unit Manager) stated nurses were expected to complete the Pre-Dialysis Assessment and Communication forms and send with the resident to dialysis. Staff 19 stated staff were expected to ensure the Post-Dialysis Assessment and Communication forms were complete after the resident returned from dialysis. Staff 19 confirmed the forms were incomplete. On 3/13/25 at 5:03 PM Staff 2 (DNS) reviewed the residents Pre and Post-Dialysis Assessments and Communication forms dated 3/5/25, 3/7/25 and 3/10/25 and acknowledged the forms were inaccurate or not completed appropriately. Staff 2 stated she expected staff to ensure the forms were completed and accurate. b. A 2/26/25 physician order directed staff to weigh the resident daily every day shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 224's weights were reviewed from 2/26/25 through 3/11/25. No weights were documented on 2/27/25, 3/2/25, 3/3/25, 3/5/25, 3/6/25, and 3/8/25. On 3/11/25 at 12:43 PM Staff 20 (CNA) stated the resident was already at dialysis when her shift began. Staff 20 stated when Resident 224 returned from dialysis, staff were supposed to weigh the resident and provide the information to the nurse. On 3/11/25 at 2:59 PM Staff 55 (CMA/CNA) stated she was unsure how many days per week the resident went to dialysis and was uncertain how often she/he was weighed throughout the day. On 3/11/25 at 3:17 PM Staff 19 (LPN Unit Manger) stated CNAs were expected to take the residents weights before and after dialysis and give the information to the nurse. Staff 19 confirmed the Resident 224's weights were not documented daily per the physician order. On 3/13/25 at 5:03 PM Staff 2 (DNS) confirmed Resident 224's weights were not obtained. Staff 2 stated she expected staff to ensure the resident weights were obtained daily per physician orders.

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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. 35855 Based on observation, interview and record review it was determined the facility failed to ensure a resident who was a history of trauma received trauma-informed care for 1 of 1 sampled resident (#22) reviewed for mood and behavior These placed residents at risk for unmet trauma needs and a decrease in their quality of life. Findings include: Resident 22 was admitted to the facility in 10/2024 with diagnoses of psychotic disturbance, mood disturbance and vascular dementia. A 10/24/24 Admission MDS and CAAs indicated Resident 22's BIMs was 10, signifying moderate cognitive impact. No behaviors were exhibited, and Resident 22 reported feeling down and depressed. A revised 11/4/24 care plan documented Resident 22 was cognitively impaired with altered thought process due to dementia and short-term memory loss. Interventions included addressing Resident 22 by name, facing Resident 22 when speaking, and make eye contact. The care plan did not address trauma. A 11/7/24 Social Services note revealed Resident 22 was suspected of experiencing financial, sexual, verbal, emotional and physical abuse. A 2/13/25 External Visit physician note, indicated based on chart review, Resident 22 had a history of trauma. During the last visit, Resident 22 voiced interested in behavioral health support. Resident 22 stated she/he had not yet seen a provider. On 3/10/25 at 2:42 PM, Resident 22 was observed sitting in her/his wheelchair in her/his room. Resident 22's eyes were wide, and they seemed concerned. Staff 49 (CNA) stated Resident 22 had PTSD and was jumpy. Staff 49 also stated Resident 22 had a form of dementia. On 3/14/25 at 7:41 AM, Staff 6 (NA) stated Resident 22 could be touchy on certain days. Resident 22 would express a fear of falling when the bed was being raised or lowered. On 3/17/25 at 12:52 AM, Staff 26 (Director of Social Services) stated she had not received any updates on the 11/7/24 investigation concerning the potential financial, sexual, verbal, emotional, and physical abuse of Resident 22. Staff 26 stated she did not feel Resident 22 was appropriate for counseling. On 3/17/25 at 1:58 PM, Staff 1 (Administrator) Staff 2 (DNS), and Staff 24 (Regional Director of Care) confirmed Resident 22's care plan should be personalized to address her/his potential history of trauma.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident's use of bed rails was assessed for 1 of 1 sampled resident (#124) reviewed for side rails. Findings include: Resident 124 was admitted to the facility in 3/2025 with a diagnosis of cancer. A 3/5/25 nursing Admission/Readmission Evaluation form revealed Resident 124 was admitted on hospice services, was cognitively intact, and required extensive assistance for bed mobility. On 3/10/25 at 12:16 PM Resident 124's bed was observed to have bilateral half rails. Resident 124 stated she/he did not use the rails to turn. Resident 124's clinical record did not have an assessment of the use of bed rails to ensure the rails did not place her/him at risk for entrapment. On 3/12/25 at 10:11 AM Staff 13 (CMA) stated Resident 124 did not turn on her/his own and did not have uncontrolled movements while in bed. On 3/12/25 11:01 AM at 3/12/25 Staff 1 (DNS) and Staff 19 (LPN Unit Manager) were present for an interview. Staff 1 stated prior to implementing bed rails staff were to do an evaluation. The evaluation needed to ensure the rails were not a restraint, did not restrict movement, and did not place residents at risk for entrapment. If rails were placed, risk and benefits were reviewed with the resident and or resident representative. The facility attempted to use the least restrictive device for mobility aides. Staff 1 stated if hospice applied a rail there would still need to be an evaluation completed. On 3/12/25 at 11:16 AM Staff 42 (Maintenance Assistant) stated maintenance did not apply the rails on Resident 124's bed and was not aware she/he had rails. Staff 124 checked the rails and the rails were observed to be secure. On 3/12/25 at 12:18 PM Witness 7 (Hospice) stated Resident 124 had orders for the rails since 3/4/25 but there was no assessment. Witness 7 stated the facility did not request a side rail assessment until 3/12/25.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 50897 Based on interview and record review it was determined the facility failed to ensure recommended mental health services were provided for 1 of 5 sampled residents (#18) reviewed for unnecessary medications. This placed residents at risk for unmet needs. Findings include: Resident 18 readmitted to the facility in 7/2021 with diagnoses including post-traumatic stress disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress, flashback and avoidance of similar situations), agoraphobia (a type of anxiety disorder characterized by fear of places or situations where a person might feel panicked, helpless, or trapped) and bipolar disorder (a mental health condition characterized by significant mood swings). Notes in the resident's 2/20/2025 Significant Change MDS assessment Cognitive loss/Dementia CAA described the resident as not liking to leave her/his room, yelling at staff and refusing care. A review of Physician Progress Note from 12/30/24 revealed the resident exhibited continued depressive symptoms and intermittent irritable mood. The note included consider referral for geropsych (sic) review. A review of the resident's clinical record revealed no evidence a referral for mental health evaluation was obtained. Random observations from 3/11/25 through 3/14/25 revealed Resident 18 remained in bed in her/his room with the lights off. On 3/12/25 at 9:18 Staff 20 (CNA) stated Resident 18 difficult with many of the staff due to her/his moodiness and irritability. Staff 20 stated Resident 18 rarely came out of her/his room and liked the room dark and the door closed. Staff 20 stated Resident 18 often refused personal care including showers and bed and brief changes. On 3/17/25 at 12:31 Staff 26 (Social Services Director) stated she did not review physician notes and was not aware of any practitioner recommendations for behavioral health for Resident 18. Staff 26 stated she thought Resident 18 was offered behavioral health services at some point but was not certain. Staff 26 acknowledged there was not documentation of any referrals for behavioral health services in Resident 18's electronic health record and stated Resident 18 should have been offered behavioral health evaluation and/or services. On 3/17/25 at 2:35 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Resident 18 was not provided a behavioral health evaluation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41455 Based on interview and record review it was determined the facility failed to provide timely pharmaceutical services for 1 of 1 sampled resident (#174) reviewed for insulin. This placed residents at risk for elevated blood sugars. Findings include: Resident 174 was admitted on [DATE] with diagnoses including diabetes and a surgical site infection. The 12/17/24 hospital Orders at Discharge revealed insulin orders for Resident 174 which were to be administered three times daily with meals. The 12/2024 Diabetic Administration Record for Resident 174 indicated a 9 (see progress notes) on 12/17/24 at noon and no meal time insulin was administered until 5:00 PM. A 12/17/24 at 12:14 PM Nursing Note indicated the facility's pharmacy received the request for Resident 174's prescriptions. On 12/26/24 a public complaint was received which indicated Resident 174 was admitted to the facility on [DATE] at 11:00 AM and did not receive her/his lunch time insulin as ordered. On 3/14/25 at 8:59 AM Staff 8 (LPN) stated there was an issue with the admission process and Resident 174's medications were not in place when she/he arrived to the facility on [DATE]. On 3/14/25 at 11:29 AM Staff 7 (LPN) confirmed in 12/2024 she arrived around 9:00 AM to address pharmacy orders. Staff 7 recalled Resident 174's need for insulin on 12/17/24 and stated there was no insulin available in the facility and the facility's pharmacy had specific times to receive and deliver medications. On 3/17/25 at 12:42 PM Witness 11 (Pharmacist) indicated on 12/17/24 the general request for Resident 174's orders were received at 12:30 PM and the deadline for immediate deliver was at 11:00 AM. Witness 11 stated on 12/17/24 at 3:07 PM an urgent request for insulin was received and delivered around 7:00 PM. On 3/17/25 at 3:05 PM Staff 2 (DNS) acknowledged residents' medications should be in place before they arrive.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to provide appropriate monitoring and dosing of medications for 3 of 5 sampled residents (#s 10, 18, and 20) reviewed for medications. This placed residents at risk for an adverse medication regimen. Findings include: 1. Resident 10 was admitted to the facility in ,d+[DATE] with a diagnosis of a mental health disorder. A [DATE] Note to Attending Physician/Prescriber revealed a recommendation to decease Resident 10's divalproex (treats seizures and bipolar) from 500 mg two times a day to 250 mg in the morning and 500 mg at night. Resident 10's ,d+[DATE] MAR and ,d+[DATE] MAR revealed divalproex was not decreased per orders until [DATE]. On [DATE] at 11:20 AM Staff 45 (Physician) and Staff 2 (DNS) Staff 45 verified the facility did not implement the decreased dose as ordered for approximately a month. 50897 2. Resident 18 admitted to the facility ,d+[DATE] with diagnoses including Type II diabetes mellitus with neuropathy (a condition that occurs when the body develops insulin resistance and no longer responds effectively to insulin and resultant nerve damage). The February 2025 MAR indicated Resident 18 was to receive tramadol 25 MG PRN 2 tablets every 6 hours for pain. A review of the resident's clinical record revealed an order from Resident 18's physician to stop administering PRN tramadol on [DATE]. A review of Resident 18's MAR for ,d+[DATE] and ,d+[DATE] revealed the following doses of tramadol were administered after [DATE]: - One dose per day administered on [DATE], [DATE], and [DATE]; - 2 doses per day administered on [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 2:35 PM Staff 2 (DNS) confirmed Resident 18 received tramadol after the [DATE] order to discontinue the medication. 41455 3. Resident 20 was admitted to the facility in ,d+[DATE] with diagnoses including heart disease and chronic pain. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] facility's Nursing Home Standing Orders indicated anti-hypertensive parameters which instructed staff to hold the medication for a systolic (top number) blood pressure reading below 100 or a diastolic (bottom number) blood pressure reading below 60. The ,d+[DATE] MAR revealed Resident 20 had orders to receive Metoprolol (anti-hypertensive mediation) twice daily, with no parameters indicated, and the following administrations occurred: -On [DATE] at 8:00 AM with a diastolic blood pressure of 59. -On [DATE] at 8:00 PM with a diastolic blood pressure of 57. -On [DATE] at 8:00 PM with a diastolic blood pressure of 50. On [DATE] at 12:28 PM Staff 34 (CMA) stated she was unaware of the facility's Nursing Home Standing Orders and normally did not administer a resident's Metoprolol if the diastolic blood pressure was below 60. Staff 34 acknowledged other CMAs indicated it was not necessary to hold a anti-hypertensive medication unless specified on the MAR. On [DATE] at 3:05 PM Staff 2 (DNS) acknowledged Resident 20's medication should not be administered when her/his diastolic blood pressure was below 60.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 40774 Based on observation, interview and record review it was determined the facility failed to promptly notify the ordering physician of laboratory results for 1 of 1 sampled residents (#37) reviewed for antibiotics. This placed residents at risk for unmet needs. Findings include: Resident 37 admitted to the facility in 10/2024 with diagnosis including kidney failure. On 2/25/25 Labs were collected for a suspected UTI. A 2/27/25 at 4:51 PM Nursing Note indicated staff notified MD regarding Resident 37's urinalysis results. A 3/4/25 Nursing Note indicated staff notified the physician of the final culture. Staff indicated the resident was not on any antibiotic therapy and requested new orders. On 3/11/25 at 9:04 AM Staff 18 (LPN) 3/11/25 stated nursing was expected to follow up with the residents physician in a timely manor with lab results. Staff 18 confirmed resident 37 had a UTI, staff did not monitor the resident for complications and the doctor was not notified until six days later. On 3/14/25 at 12:46 PM Staff 21 (Infection Preventionist/LPN) stated staff should not wait six days to follow up with abnormal lab result. On 3/14/25 at 3:12 PM Staff 2 (DNS) and Staff 24 (Regional Director of Care) acknowledged Resident 37's physician was not notified promptly regarding the laboratory results.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. 26991 Based on interview and record review it was determined the facility failed to ensure lab results were in the resident record for 1 of 5 sampled residents (#10) reviewed for medications. This placed residents at risk for incomplete records. Findings include: 1. Resident 10 was admitted to the facility in 5/2024 with a diagnosis of a stroke. A 5/31/24 prescriber written Order Details revealed staff were to obtain blood samples from Resident 10 for testing including thyroid hormone levels. Resident 10's clinical record did not have results of the 5/31/24 thyroid hormone test results. A 2/15/25 Consultant Pharmacist's Medication Regimen Review revealed labs were sent to the lab on 6/4/24 but the results were not in the record. Please follow up. On 3/14/25 at 10:13 AM Staff 19 (LPN Unit Manager) stated the staff collected the blood and sent the blood to the lab but she was unsure the reason the labs were not in the resident's record. Staff 19 stated she was unable to provide the reason the facility did not follow up to ensure the results were in the resident's clinical record.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35855 Based on observation, interview, and record review it was determined the facility failed to make reasonable efforts to deliver a menu based on resident requests and preferences for 2 of 2 residents (#s 7 and 61) during random observations. This placed residents at risk for unmet food preferences. Findings include: 1. Resident 7 was admitted to the facility in 2/2025 with diagnoses including anxiety and deficiency of specified B group vitamins. A 2/21/25 Admission MDS indicated Resident 7's BIMs was 15, which indicated she/he was cognitively intact. A 2/21/25 care plan indicated Resident 7 had a nutritional problem due to increased physical demand for participation in therapy and protein-calorie malnutrition (a state of malnutrition in which there is a deficiency of calories and protein). Staff were to provide and serve diet as ordered, monitor intake, and record every meal. On 3/13/25, the following occurred: -1:17 PM, Staff 35 (Agency CNA) was observed writing on a paper at the kitchen door to request pizza for Resident 7 per her/his request. -1:41 PM, the facility intercom system announced Resident 7's pizza was ready. -2:12 PM, Resident 7 stated she/he never received her/his pizza, and she/he stated it was now too late. Staff 36 (Agency CNA) stated she was assisting another resident to eat when she heard the facility announcement but could not go obtain Resident 7's pizza. -4:03 PM, Staff 32 (Dietary Manager) stated he communicated the expectation to place a request on the list outside of the kitchen and listen for the facility intercom system announcement at a recent all staff meeting. Staff 32 acknowledge agency staff may not have been at the meeting when he presented the process training. On 3/17/25 at 2:21 PM, Staff 1 (Administrator) Staff 2 (DNS) and Staff 24 (Regional Director of Care) stated they would expect residents to get their food. 2. Resident 61 was admitted to the facility in 12/2024 with diagnoses including diabetes and protein-calorie malnutrition. A 12/30/24 Admission MDS indicated Resident 61's BIMs score was 13, signifying cognitive intactness. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 7:54 AM, Resident 61 stated she/he did not receive her/his oatmeal. No bowl was observed on Resident 61's food tray. Witness 2 (Staff) confirmed there was no oatmeal on Resident 61's tray. Resident 61 stated it was too late for Witness 2 to obtain the oatmeal as she/he was done with eating her/his breakfast. A 3/17/25 Breakfast food ticket revealed Resident 61's list of breakfast items which included oatmeal cereal. On 3/17/25 at 8:43 AM, Staff 32 (Dietary Manager) stated the kitchen placed six to eight oatmeal bowls on top of each food cart for the halls. If CNA staff ran out of the oatmeal, they are supposed to return to the kitchen and obtain more for the residents. On 3/17/25 at 1:58 PM, Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) confirmed residents should receive what was listed on their food ticket.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41455 Based on observation, interview, and record review it was determined the facility failed to ensure food temperatures were maintained for meals served from 1 of 1 facility kitchen and 2 of 4 sampled residents (#s 56 and 61) reviewed for food. This placed residents at risk for food that was not palatable, safe, or appetizing. Findings include: 1. The 12/12/24 Dining Committee Minutes indicated meat quality was a concern for residents and Staff 32 (Dietary Manager) was working to improve results. On 3/13/25 at 1:21 PM the lunch meal service was observed in process and Staff 32 acknowledged the lunch was delayed. Staff 32 indicated the oven temperature to cook the pizza was not maintained, so the process took longer. On 3/13/25 at 1:32 PM a test tray requested by the survey team was completed and placed in an insulated cart. On 3/13/25 at 1:34 PM multiple undelivered lunch trays for resident rooms were observed in Hall 300, stacked on top of the insulated cart. Staff indicated there was insufficient space in the insulated cart to accommodate all the trays. On 3/13/25 at 1:52 PM the test tray was sampled by the survey team and included: pizza, beets, and a slice of cooked pork. The pizza, beets, and pork were not warm when eaten and the pork was tough to cut with a knife. On 3/13/25 at 4:03 PM Staff 32 and Staff 37 (Regional Dietary Manager) stated new kitchen equipment was ordered and acknowledged the kitchen required sufficient and working equipment to ensure foods were served hot and meats were not tough and overcooked. 40774 Resident 56 admitted to the facility in 9/2024 with diagnoses including cirrhosis of liver and high blood pressure. The 1/3/25 Quarterly MDS indicated resident 56 had a BIMS score of 15, which indicated the resident was cognitively intact. On 3/10/25 at 10:29 AM Resident 56 reported the mashed potatoes were soupy, the broth was overly salty and meals were served cold when they should be hot. The resident reported her/his concerns to staff, but they were not resolved. The resident further stated she/he was tired of going to bed hungry. On 3/10/25 at 12:30 PM staff 30 (CNA) removed moved resident 56's lunch tray and stated the resident expressed dissatisfaction with their lunch and requested an alternative and asked to speak to someone in the kitchen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25 at 12:39 PM staff 53 (Corporate Dietary Manager) stated she followed up on resident 56's dietary concerns. Staff confirmed the resident was not eating their meals because the food was cold, to salty, and, at times, the resident went to bed hungry due to poor quality of food. Surveyor: [NAME], [NAME] K. 35855 3. Resident 61 was admitted to the facility in 12/2024 with diagnoses including diabetes and protein-calorie malnutrition. On 3/10/24 at 12:02 PM Resident 61 stated the food which was supposed to be hot was cold sometimes. On 3/13/25 at 1:52 PM the lunch test tray was sampled by the survey team and included: pizza, beets, and a slice of cooked pork. The pizza, beets, and pork were not warm when eaten and the pork was tough to cut with a knife. On 3/13/25 at 4:03 PM Staff 32 and Staff 37 (Regional Dietary Manager) stated new kitchen equipment was ordered and acknowledged the kitchen required sufficient and working equipment to ensure foods were served hot. On 3/17/25 at 2:20 PM Staff 1 (Administrator) Staff 2 (DNS) and Staff 24 (Regional Director of Care) verified residents should receive their hot food hot.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35855 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for contact and Enhanced Barrier Precautions for 3 of 7 sampled residents (#s 7, 20, and 274) reviewed for infection control. This placed residents at risk for exposure and contraction of infectious diseases. Finding include: 1. Resident 7 was admitted to the facility in 2/2025 with diagnoses including sepsis (a life-threatening condition caused by the body ' s overwhelming response to an infection) and a Foley catheter (a flexible tube inserted into the bladder to drain urine). A 2/19/25 physician order instructed staff to provide enhanced barrier precautions because of sepsis and Foley catheter. The 2/21/25 Admission MDS revealed Resident 7's BIMs 15, which indicated the resident was cognitively intact. Resident 7 was dependent on staff for toileting hygiene, and had a urinary catheter. A 3/3/25 care plan indicated Resident 7 was on enhanced barrier precautions related to a Foley catheter. Staff were to follow guidelines posted next to the door. On 3/12/25 at 11:21 AM, Witness 2 (Staff) stated prior to 3/10/25, staff were not wearing gowns in precaution rooms. On 3/13/25 at 1:45 PM, Resident 7 and Witness 6 (Family Member) stated gown use was not consistent during Resident 7's catheter care. On 3/17/25 at 1:58 PM, Staff 1 (Administrator) Staff 2 (DNS), and Staff 24 (Regional Director of Care) stated they would expect precautions to happen immediately for residents. 2. Resident 274 was admitted to the facility in 2/2025 with diagnoses of diarrhea and UTI. A 3/4/25 Admissions MDS revealed Resident 274's BIMS was 15, indicated the resident was cognitively intact. Resident 274 was occasionally incontinent of bowel and bladder. A 3/10/25 care plan revealed Resident 274 was on Doxycycline for UTI prophylaxis (an antibiotic) and was to be taught to practice good hand hygiene. On 3/12/25 at 11:21 AM, Witness 2 (Staff) stated the staff did not receive enough plastic bags to remove dirty linens from resident's rooms. Witness 2 stated the lack of bags had been ongoing for a long time. Witness 2 stated residents would have a bowel movement, and she was unable to remove the soiled briefs from the room because of the lack of bags. On 3/10/25 at 11:59 AM, Resident 274 stated the facility ran out of plastic bags and the paper towel dispenser in the resident's bathroom did not work. A cloth towel was observed in Resident 274's bathroom with no paper towels in the paper towel dispenser. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 9:58 AM, Staff 10 (Housekeeping) stated she runs out of paper towels about once a month. On 3/12/25 at 12:00 PM, Staff 30 (CNA) confirmed the paper towel dispenser was not functioning in Resident 274's bathroom. Staff 30 stated CNAs were not allowed to access plastic bags as they changed the door code. On 3/13/25 at 10:29 AM, Staff 4 (CNA) stated the facility was weird about the plastic bags. They count a specific number of bags for each resident room and when he attempted to remove garbage or dirty linens there may not be a bag to replace it. At times, he must go to the dirty linen room and bring the dirty laundry barrel back to the room to avoid carry dirty linens down the hall with no bag. On 3/14/25 at 9:26 AM, Witness 3 (Staff) stated there was a shortage of plastic bags. Staff were unable to find plastic bags, and CNA staff were observed walking down the hall with dirty briefs past the food cart. Witness 3 stated dirty briefs were also thrown into the garbage cans with no liners. Witness 3 stated there was also a shortage of paper towels and soap, so residents and staff could not wash and dry their hands appropriately. On 3/14/25 at 10:33 AM Witness 4 (Staff) stated the housekeeping department did not have enough plastic bags for staff to use for removing garbage and soiled linens. Witness 4 stated soap dispensers were also out of soap at times. On 3/17/25 at 8:58 AM, Staff 11 (Housekeeping Manager) confirmed housekeeping purchased the paper towels and plastic bags for the facility. Staff 11 stated when the housekeeping budget was low, the facility ran out of supplies faster, and she would have to travel to another facility and obtain them. Staff 11 stated bags were often hidden in various places by staff when the facility ran out, as staff tried to keep some on hand to prevent shortages. On 3/17/25 at 1:58 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) stated housekeeping was a contracted company and purchased their supplies once a month. Staff 1 stated CNA staff were putting plastic bags in their pockets and taking them home. Staff 2 stated there were different stories throughout the facility regarding supplies. 41455 3. Resident 20 was admitted to the facility in 1/2025 with diagnoses including chronic pain and a Stage 3 pressure ulcer (full-thickness skin loss). A 3/3/25 revised care plan indicated Resident 20 was on contact precautions due to a positive wound culture and staff were to follow the contact precautions posted next to the resident's door. On 3/14/25 at 9:53 AM a sign outside Resident 20's room indicated the resident was on contact precautions and staff were required to don (put on clothing) a gown and gloves before entering her/his room. Staff 13 (CMA) was observed to gather medications for Resident 20 and stated it was not necessary to wear a gown when medications were administered to Resident 20. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385072	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corvallis Manor	160 NE Conifer Blvd Corvallis, OR 97330

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 10:29 AM Staff 31 (CNA) was observed in Resident 20's room without a gown or gloves. Staff 31 was observed to removed Resident 20's personal clothing from her/his wheelchair. Staff 31 stated no gowns or gloves were required unless direct contact with the resident occurred. On 3/17/25 at 10:45 AM Staff 21 (IP) confirmed Resident 20 was on contact precautions and staff were required to don a gown and gloves when they were within three feet of the resident or touched the resident's personal belongings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385072	A. Building B. Wing	03/17/2025

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 26991 Based on interview and record review it was determined the facility failed to provide antibiotic stewardship for 1 of 1 sampled resident (#25) reviewed for UTIs. This placed residents at risk for drug resistant organisms. Findings include: Resident 25 was admitted to the facility in 9/2024 with a diagnosis of incomplete quadriplegia (partial damage to the spinal cord resulting in varying degrees of weakness, paralysis, and loss of sensation in the legs and arms). A 9/23/24 admission MDS revealed Resident 25 had incomplete quadriplegia and self-catheterized (sterile tube inserted into the bladder through the urethra [tube that goes fro the bladder to the outside of the body] after staff set up the supplies. Resident 25 had a history of UTIs and was on trimethoprim (antibiotic) for prophylaxis (antibiotics taken daily to prevent infection in high risk residents). a. A 11/1/24 UA culture (test to determine which antibiotics eliminate the organism identified to have caused the UTI) result revealed Resident 25 had a UTI and the organism was resistant to trimethoprim. A 11/4/24 order revealed Resident 25 was to receive amoxacillin (antibiotic) for seven days. A 11/2024 MAR revealed Resident 25 was administered trimethoprim daily from 11/1/24 through 11/30/24 and received amoxacillin for seven days from 11/4/24 through 11/11/24. The trimethoprim was not stopped despite not being effective against the UTI. On 3/17/24 at 3:00 PM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 24 (Regional Director of Care) Staff 2 acknowledged the Resident was on a prophylactic antibiotic which was found resistant on the 11/1/24 culture and the trimethoprim was not stopped. Staff 2 stated it was not stopped because it was used to prevent other organisms from growing. A request was made to Staff 2 to provide documentation to verify Resident 25's provider approved the continuation of the prophylactic antibiotic. Staff 2 did not provide any additional information. On 3/17/25 at 3:17 PM Witness 8 (Pharmacist) stated if a resident was on a prophylactic antibiotic and the culture indicated the organism was resistant to the antibiotic the prophylactic antibiotic should be held during an acute UTI unless the physician provided a rationale.