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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Hood River Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 729 Henderson Road Hood River, OR 97031 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 3 sampled residents (#101) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 101 was admitted to the facility in 7/2020 with diagnoses including alcohol-induced dementia.</p> <p>Resident 101's 3/18/22 Quarterly MDS indicated the resident was cognitively intact.</p> <p>Resident 100 was admitted to the facility in 7/2021 with diagnoses including Lewy body dementia (a brain disorder that can lead to problems with thinking, movement, behavior and mood).</p> <p>Resident 100's 8/8/21 Behavior Care Plan revealed the following:</p> <ul style="list-style-type: none"> -The resident experienced agitation and aggression. -Staff were to intervene as necessary to protect the rights and safety of others. <p>Resident 100's 2/4/22 Quarterly MDS indicated the resident was severely cognitively impaired and was able to walk independently.</p> <p>A 4/2/22 FRI and Investigation revealed the following:</p> <ul style="list-style-type: none"> -Staff 3 (Admission Director) heard yelling and cursing coming from Resident 100 and 101's shared room. -Staff 3 entered the room and observed Resident 101 on the ground. Resident 100 stood over Resident 101. -Resident 100 stated she/he hit Resident 101 in the face because the resident stole [her/his] shorts and food. -Resident 101 stated Resident 100 slapped her/him in the face which caused her/him to fall to the ground. <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Staff 5 (RN) entered the room and separated the residents.</p> <p>On 6/18/24 at 9:52 AM Staff 5 stated Resident 100 could be pleasant at times but angry and verbally aggressive at others. Staff 5 stated Resident 100 would yell and cuss at other residents. Staff 5 stated he was the nurse on duty when the altercation between Residents 100 and 101 occurred on 4/2/22. Staff 5 stated he recalled Resident 100 standing over Resident 101 with an angry look on her/his face and Resident 101 appeared shocked.</p> <p>On 6/18/24 at 10:46 AM Resident 101 was observed in her/his room in bed. Resident 101 stated she/he felt safe at the facility. Resident 101 was unable to recall any details about the incident that occurred on 4/2/22 and did not remember Resident 100.</p> <p>On 6/18/24 at 10:50 AM Resident 100 was observed to sit in her/his wheelchair in the doorway of her/his room. Resident 100 was unable to recall any details about the incident.</p> <p>On 6/18/24 at 12:03 PM Staff 2 (Social Services Director) stated she spoke with Resident 100 on 4/2/22 following the altercation and Resident 100 confirmed she/he hit Resident 101 because she/he thought the resident was a classmate and was going through her/his belongings. Staff 2 stated Resident 101 was shook up in the moment following the altercation but had forgotten about the altercation not long after it occurred because the resident's short term memory was so poor.</p> <p>On 6/18/24 at 12:45 PM Staff 3 stated she entered Resident 100 and 101's room on 4/2/22 because she heard yelling. Staff 3 stated when she arrived in the room, Resident 100 stood over Resident 101 who was on the ground. Staff 3 stated she helped remove Resident 100 from the room and stated Resident 101 was very scared after the incident.</p> <p>On 6/18/24 at 3:02 PM Staff 1 (Administrator) confirmed Resident 100 hit Resident 101 on 4/2/22.</p> | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47000</p> <p>Based on interview and record review it was determined the facility failed to ensure adequate supervision and a safe environment for 1 of 3 sampled residents (#100) reviewed for elopement. This placed residents at risk for injury from accidents. Findings include:</p> <p>Resident 100 was admitted to the facility in 7/2021 with diagnoses including Lewy body dementia (a brain disorder that can lead to problems with thinking, movement, behavior and mood).</p> <p>Resident 100's 7/29/21 At Risk for Falls and ADL Care Plans revealed the following:</p> <ul style="list-style-type: none"> -The resident was considered at high risk of falling. -The resident ambulated independently in the facility. -The resident used a front wheeled walker when ambulating on uneven surfaces. <p>Resident 100's 3/17/22 Elopement Risk/Wanderer Care Plan revealed the following:</p> <ul style="list-style-type: none"> -The resident was considered at risk to elope. -The resident wore a Wanderguard (a monitoring device that allows an alarm to be activated when a person attempts to leave a safe area). -The resident required frequent checks during routine rounds due to her/his dementia, independence with mobility and exit-seeking behaviors. -Staff were to distract the resident from wandering. <p>Resident 100's 10/28/22 Social Service Quarterly Assessment revealed the resident would regularly exit-see and got frustrated when staff did not open the doors and let her/him outside.</p> <p>Resident 100's 11/5/22 Quarterly MDS revealed the resident was severely cognitively impaired, exhibited wandering and experienced a fall with injury since her/his prior assessment.</p> <p>Resident 100's 11/15/22 Morse Fall Scale indicated the resident was at high risk of falling.</p> <p>Resident 100's 11/15/22 Elopement Risk Evaluation indicated the resident was at high risk to wander/elope.</p> <p>An 11/30/22 Incident Report and Summary revealed the following:</p> <ul style="list-style-type: none"> -Resident 100 was near the front door to the facility when a UPS (United Parcel Service) driver entered the facility. <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-The UPS driver dropped off parcels and exited the facility. Resident 100 followed the driver outside of the facility.</p> <p>-An unidentified nurse called out to Resident 100, requesting she/he return to the facility.</p> <p>-Resident 100 stepped on a snow-covered sidewalk and fell on her/his left side.</p> <p>-Resident 100 was assisted into a wheelchair and quickly returned to the facility.</p> <p>-Resident 100 experienced pain in her/his left hip and left arm following the fall.</p> <p>On 6/18/24 at 9:52 AM Staff 5 (RN) stated Resident 100 consistently hung out by the front door and repeatedly asked to go outside. Staff 5 stated Resident 100 had a Wanderguard on her/his ankle, and he would hear the alarm frequently going off because the resident was by the front or back door.</p> <p>On 6/18/22 at 3:22 PM Staff 1 (Administrator) stated Resident 100 had a Wanderguard due to a lot of exit-seeking behaviors. Staff 1 stated Resident 100 was constantly at the doors, trying to get out of the facility. Staff 1 stated Resident 100 was was nice and would make friends with people who would hold the door open for [her/him]. Staff 1 stated on 11/30/22 the weather conditions included snow and ice and acknowledged Resident 100 exited the facility behind a UPS driver and fell .</p> |