STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385104	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hood River Post Acute	729 Henderson Road Hood River, OR 97031

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 43690 Based on interview and record review it was determined the facility failed to ensure a consent was obtained prior to administering antidepressant medications to residents for 1 of 5 sampled residents (#21) reviewed for unnecessary medications. This placed residents at risk for being uninformed about their medications. Findings include: Resident 21 was admitted to the facility in 8/2023 with diagnoses including fracture and dementia. Resident 21's 8/25/23 Physician Order indicated the resident was prescribed mirtazapine (antidepressant) for major depressive disorder. Resident 21's 8/2023 through 9/2024 MARs revealed the resident received mirtazapine daily. Review of Resident 21's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of mirtazapine. On 9/25/24 at 10:57 AM Staff 2 (DNS) and Staff 3 (Regional Nurse Consultant) reviewed Resident 21's health record, acknowledged there was no documentation to indicate the resident was informed of the risks and benefits of mirtazapine and confirmed a consent was not obtained from Resident 21 or her/his representative prior to the resident starting the medication.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 41453 Based on interview and record review it was determined the facility failed to ensure a safe system for a resident's self-administration of medication for 1 of 2 sampled residents (#6) reviewed for care planning. This placed residents at risk for adverse medication reactions. Findings include: Resident 6 admitted to the facility in 2022 with a diagnosis of multiple sclerosis. An 6/25/24 quarterly MDS revealed Resident 6 was cognitively intact. A 3/10/22 Self-Administration of Medication form revealed Resident 6 was assessed to be capable of self-administration of multiple medications. The form also indicated Resident was 6 was not to be left unattended while medication was being administered. A 4/1/24 Self-Administration of Medication form revealed Resident 6 was assessed to be capable of self-administration of Ventolin (respiratory medication) only. On 9/23/24 at 12:56 PM Staff 18 (RN) was observed to leave four unidentified medications at Resident 6's bedside and then left the room. When questioned Staff 18 stated she believed Resident 6 had a medication administration assessment completed that allowed Resident 6 to take her/his medications independently. Staff 18 confirmed she left medications with Resident 6 while she/he was unattended. On 9/24/24 at 2:27 PM staff 27 (CNA) stated in the evenings she observed medications left at Resident 6's bedside while she/he was unattended. On 9/25/24 at 2:31 PM Staff 2 (DNS) was made aware of the details of the medication self administration assessment as well as the observation of medications being left in resident 6's room while she/he was unattended. As of 9/27/24 at 9:57 AM no further information had been provided.

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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. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents were allowed to retain personal possessions for 1 of 1 sampled resident (#9) reviewed for choices. This placed residents at risk for diminished quality of life. Findings include: Resident 9 was admitted to the facility in 7/2024 with diagnoses including Schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania). Resident 9's 8/6/24 Admission MDS indicated the resident was cognitively intact and did not exhibit any mood symptoms or behaviors. The MDS also indicated it was very important to the resident to take care of her/his personal belongings. On 9/23/24 at 12:15 PM Resident 9 was observed in her/his wheelchair in the dining room. Resident 9 stated she/he wanted to speak with the State Surveyor but wanted Witness 1 (Family Member) to be present for the conversation via her/his cell phone. Resident 9 stated she/he would check out her/his cell phone from the office and then meet in her/his room. On 9/23/24 at 1:05 PM the State Surveyor spoke with Resident 9 in her/his room with Witness 1 available on the resident's cell phone. Resident 9 stated she/he was allowed to have her/his cell phone between the hours of 9:00 AM to 7:00 PM when she/he had to return it to the office. Resident 9 and Witness 1 stated the facility restricted Resident 9's access to her/his cell phone at night since admission. They were told Resident 9 needed to learn to depend on [the facility] and felt as if they could not fight the restriction. Resident 9 further stated she/he did not like it and felt upset [she/he] could not call [her/his] mom when [she/he] wanted to. On 9/24/24 at 1:18 PM Staff 22 (CNA) and at 1:30 PM Staff 21 (CNA) stated they did not know why Resident 9 was not allowed to maintain her/his cell phone. On 9/24/24 at 2:33 PM Staff 23 (Enhanced Care Unit Program Supervisor) stated she would not be surprised if [Resident 9] wanted it [her/his cell phone] all the time. Staff 23 further stated staff were concerned Resident 9's roommate would take the phone so it was brought into the office to charge. No evidence was found in Resident 9's clinical record to indicate why the resident was not allowed to maintain her/his cell phone. On 9/24/24 at 3:47 PM Staff 1 (Administrator) acknowledged the findings of this investigation and stated she expected residents to be able to maintain their own cell phones unless a behavior care plan was in place to indicate otherwise.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 47000 Based on interview and record review it was determined the facility failed to ensure residents had access to their personal funds on an ongoing basis for 2 of 2 sampled residents (#s 1 and 9). This placed residents at risk for lack of access to personal funds. Findings include: 1. Resident 1 was admitted to the facility in 10/2017 with diagnoses including borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships). Resident 1's 7/18/24 Quarterly MDS indicated the resident was cognitively intact. On 9/24/24 at 9:22 AM Resident 1 stated she/he was only able to access her/his money during the day time. On 9/24/24 at 1:13 PM Staff 22 (CNA) stated if a resident wanted access to their money, she would direct the resident to wait for staff from the CFL (Center for Living, the community mental health program overseeing the facility's enhanced care unit). Staff 22 stated CFL staff were in the facility every day from approximately 9:00 AM to 7:00 PM. On 9/24/24 at 1:24 PM Staff 21 (CNA) stated she did not deal with any money things and the CFL was responsible for dealing with that. Staff 21 stated she told residents who wanted their money, you have to wait for CFL staff to get here. On 9/24/24 at 2:17 PM Staff 23 (Enhanced Care Unit Program Supervisor) stated residents did not get their money if CFL staff were not available. On 9/25/24 at 8:44 AM Staff 25 (LPN) stated she did not know how to access resident money when CFL staff were not available. On 9/25/24 at 10:53 AM Staff 1 (Administrator) acknowledged the findings of this investigation. Staff 1 stated residents should have access to their money all of the time. 2. Resident 9 was admitted to the facility in 7/2024 with diagnoses including Schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania). Resident 9's 8/6/24 Admission MDS indicated the resident was cognitively intact. On 9/23/24 at 1:03 PM the State Surveyor spoke with Resident 9 in her/his room with Witness 1 (Family Member) available on the resident's cell phone. Resident 9 and Witness 1 stated the resident was not able to access her/his money after 7:00 PM on weekdays and past 4:00 PM on the weekends. On 9/24/24 at 1:13 PM Staff 22 (CNA) stated if a resident wanted access to their money, she would direct the resident to wait for staff from the CFL (Center for Living, the community mental health program overseeing the facility's enhanced care unit). Staff 22 stated CFL staff were in the facility every day from approximately 9:00 AM to 7:00 PM. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1:24 PM Staff 21 (CNA) stated she did not deal with any money things and the CFL was responsible for dealing with that. Staff 21 stated she told residents who wanted their money, you have to wait for CFL staff to get here. On 9/24/24 at 2:17 PM Staff 23 (Enhanced Care Unit Program Supervisor) stated residents did not get their money if CFL staff were not available. On 9/25/24 at 8:44 AM Staff 25 (LPN) stated she did not know how to access resident money when CFL staff were not available. On 9/25/24 at 10:53 AM Staff 1 (Administrator) acknowledged the findings of this investigation. Staff 1 stated residents should have access to their money all of the time.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 47000 Based on observation and interview it was determined the facility failed to ensure contact information for pertinent State agencies and the required Long Term Care Ombudsman (LTCO) poster were accessible to residents for 1 of 2 units observed for required postings. This placed residents at risk for lack of information on how to file a complaint or how to report concerns. Findings include: On 9/23/24 at 11:00 AM the required postings to indicate how residents can contact the State Survey Agency, the State licensure office, adult protective services and LTCO were observed in a hallway outside of the facility's locked enhanced care unit (ECU). Neither posting was observed inside the ECU. On 9/25/24 at 3:30 PM Resident 1 stated she/he had no idea where to access the contact information for pertinent State agencies or the LTCO and she/he was interested to know this information. Resident 1 stated she/he was unable to leave the ECU without a staff escort. On 9/25/24 at 10:55 AM Staff 1 (Administrator) acknowledged the findings of this investigation and confirmed ECU residents could not access the required postings without staff assistance.

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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. 41453 Based on observation and interview it was determined the facility failed to maintain a homelike environment and adequate hot water temperatures for 1 of 1 facility shower room reviewed for a homelike environment. This placed residents at risk for a cluttered and damaged shower environment as well as cold showers. Findings include: On 9/23/24 at 10:23 AM Resident 32 stated the water in main shower room was too cold. On 9/26/24 at 7:43 AM Resident 100 stated the water would go hot for a bit and then suddenly get cold. On 9/26/24 at 7:01 AM Staff 11 (CNA) stated she started the shower way ahead of time so the water could warm up. Staff 11 stated sometimes the water was too cold. On 9/26/24 at 7:56 AM staff 19 (maintenance director) tested the shower water temp after five or more minutes and it was 87 degrees F. Staff 19 indicated which hot water heater supplied the shower and the temperature gauge read 99 degrees F. On 9/27/24 at 7:26 AM Staff 1 (Administrator) tested the shower water temperature and it reached 94 degrees Fahrenheit. On 9/27/24 at 7:26 AM the main shower room was observed with sections of baseboard missing from the three partition walls on the left side of the shower room leaving exposed unfinished, uncleanable sheetrock. The partition wall furthest from the door had significant chunks and gouges near the base. The ceiling above the non-functioning side of the shower room appeared torn and potentially damaged by water. The vent above the non-functioning shower was observed to be dirty and the light bulb was exposed. The drain cover was also missing in the functional shower resulting in an approximately three inch hole in the floor and was a potential source of injury. 09/27/24 10:17 AM Staff 1 (Administrator) confirmed the damage and un-homelike state of the shower room as well as the hot water temperatures being out of the aceptable range.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47000 Based on interview and record review it was determined the facility failed to ensure a PASARR Level II (Preadmission Screening for individuals with a mental disorder and/or individuals with intellectual disability) was completed for 2 of 2 sampled residents (#s 9 and 26) reviewed for PASARR. This placed residents at risk for not receiving specialized services. Findings include: The facility's 9/2024 PASARR Policy and Procedure directed the following: -If a Level II evaluation was indicated, the social worker would ensure a LMPH (licensed mental health professional) was scheduled to evaluate within a timely period. -If there was a significant change of condition that could affect a resident's diagnosed need for a PASARR Level II, staff should refer for a new PASARR Level II. -Follow up as needed per federal PASARR rules. 1. Resident 9 was admitted to the facility in 7/2024 with diagnoses including Schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania) and cerebral palsy (a group of conditions that affect movement and posture and caused by damage that occurs to the developing brain, most often before birth). Resident 9's 7/31/24 PASARR Level I indicated the resident experienced indicators of both serious mental illness and a developmental disability. A review of Resident 9's Social Service Notes from 8/1/24 through 8/13/24 revealed a PASARR Level II was requested to address the resident's indicators of developmental disability but not her/his indicators of serious mental illness. On 9/25/24 at 9:39 AM Staff 4 (Social Services Director) stated PASARR Level IIs for serious mental illness were completed by the Center for Life (CFL), the organization who managed the facility's enhanced care unit, and she was not sure why the PASARR Level II for Resident 9 for her/his diagnosed serious mental illness had not been completed. On 9/25/24 at 10:56 AM Staff 1 (Administrator) acknowledged the findings of this investigation and provided no additional information. 2. Resident 26 was admitted to the facility in 1/2021 with diagnoses including anxiety and depression. Resident 26's 1/21/21 PASARR Level I indicated the resident did not have indicators of either serious mental illness or a developmental disability. A 6/21/23 PASARR Level II revealed Staff 4 (Social Services Director) requested a Level II evaluation for Resident 26 as the resident experienced a dramatic increase in paranoid delusions. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 26's clinical record revealed the resident was hospitalized from 3/3/24 to 3/6/24. Resident 26 readmitted to the facility with a new PASARR Level I which indicated the resident had indicators of serious mental illness. No evidence was found in Resident 26's clinical record to indicate an additional PASARR Level II was requested to address the resident's new onset of serious mental illness indicators. On 9/26/24 at 3:47 PM Staff 4 (Social Services Director) stated Resident 26 was not physically aggressive in 6/2023 when the resident received her/his initial PASARR Level II. Staff 4 stated the resident had experienced a significant change of condition in 3/2024 on account of worsening behaviors and she should have requested an additional PASARR Level II following the resident's hospitalization but she did not. On 9/27/24 at 9:37 AM Staff 1 (Administrator) was informed of the findings and provided no additional information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43690 Based on observation, interview, and record review it was determined the facility failed to ensure care plans were revised to accurately to reflect the needs of residents for 2 of 4 sampled residents (#s 14 and 35) reviewed for weights and assistive devices. This placed residents at risk for unmet needs. Findings include: 1. Resident 14 was admitted to the facility in 6/2020 with diagnoses including dementia and parkinsonism (difficulty with movement). Resident 14's 7/2/24 Annual MDS revealed the resident was moderately cognitively impaired. A Care Plan dated 7/11/24 revealed Resident 14 used a mobility bar on the left side of the bed for inhanced bed mobility. Observations from 9/23/24 through 9/27/24 revealed Resident 14 did not have a mobility bar in place while the resident was in bed. On 9/26/24 at 9:51 AM Staff 11 (CNA) stated Resident 14 should have a bed mobility bar on her/his bed to help her/him with positioning while in bed. On 9/26/24 at 10:59 AM Staff 9 (LPN Resident Care Manager) stated Resident 14 had a mobility bed assist rail on her/his bed to assist with positioning and movement. On 9/27/24 at 9:10 AM Staff 2 (DNS) confirmed Resident 14's care plan had not been updated to reflect the resident no longer needed the mobility bar. 2. Resident 35 was admitted to the facility in 3/2023 with diagnoses including delusional disorders, depression and edema. Resident 35's Quarterly MDS revealed the resident was cognitively intact. A Care Plan dated 9/21/24 revealed Resident 35 used bilateral 1/4 inch rails on her/his bed due to a self-performance deficit. Observations from 9/23/24 through 9/27/24 revealed Resident 35 did not have bilateral 1/4 inch rails on her/his bed while the resident was in bed. On 9/24/24 at 3:01 PM Staff 24 (CNA) stated Resident 35 did not use any bed mobility devices. On 9/24/24 at 3:31 PM Staff 5 (RNCM) stated Resident 35 did not use bilateral bars and stated the care plan had not been updated. On 9/27/24 at 9:10 AM Staff 2 (DNS) confirmed Resident 35's care plan had not been updated to reflect the resident no longer needed the bilateral 1/4 inch rails while in bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 35 was admitted to the facility in 3/2023 with diagnoses including delusional disorders, depression and edema. A Care Plan dated 9/21/24 revealed Resident 35 was to have her/his weight obtained daily due to diuretic therapy from edema. Resident 35's Quarterly MDS revealed the resident was cognitively intact. Review of Resident 35's clinical record revealed a 4/5/24 physician order for the resident to be weighed weekly. On 9/24/24 at 3:01 PM Staff 24 (CNA) stated Resident 35 was to be weighed everyday in the mornings. On 9/24/24 at 3:31 PM Staff 5 acknowledged Resident 35's care plan had not been revised to reflect Resident 35 was to be weighed weekly. On 9/24/24 at 3:52 PM Staff 2 (DNS) was informed of the findings. No additional information was provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 50927 Based on observation, interview and record review it was determined the facility failed to provide an on-going program to support individual activity interests and preferences for 1 of 2 sampled residents (#25) reviewed for activities. This placed residents at risk for lack of social interaction and isolation. Findings include: The facility's 3/2019 Activities Policy and Procedure indicated the following: -Each resident's physical, mental, spiritual, psychosocial and leisure choices as well as preferences for participation in activities will be assessed. This assessment will occur on admission, annually and with condition changes. -A monthly calendar shall be posted in designated areas of the facility. The scheduled activities will be planned at an appropriate frequency to provide diverse activity/recreational programs that address various cognitive and functional levels and meet the needs of the residents. Resident 25 was admitted to the facility in 1/2021 with a diagnoses including dementia and depression. Resident 25's 1/17/24 Annual MDS indicated the resident experienced short and long term memory loss, was severely impaired for decision making and her/his activity preferences were listening to music, doing things with groups of people, participating in favorite activities and spending time outdoors. The 3/28/24 Care Plan indicated the following: -Resident 25 was dependent on staff to meet emotional, intellectual, physical and social needs, dementia and physical limitations. -The resident's activity goal was to attend/participate in activities of choice 2-4 times weekly by next review date. -Ensure the activities the resident is attending are compatible with known interests and preferences. -Ensure the activities the resident is attending are compatible with individual needs and abilities. -Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. -The resident needs one-to-one bedside/in-room visits and activities if unable to attend out of room events. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Activity Logs from 8/26/24 through 9/25/24 indicated Resident 25 received four one-to-one activities and did not participate in any group activities. Random observations of Resident 25 from 9/23/24 through 9/26/24 from 9:13 AM to 2:50 PM revealed the resident to be either in bed or in his/her wheelchair at the nurses station or in his/her room. No music was observed to play in the resident's room or at the nurses station. On 9/25/24 at 2:45 PM Staff 26 (CNA) stated Resident 25 was non-verbal, did not participate in activities and spent her/his day either sitting at the nurses station or sleeping in her/his room. On 9/26/24 at 9:28 AM Staff 11 (CNA) stated Resident 25 was non-verbal and was unable to make choices about activities or her/his rountine. Staff 11 stated the resident was in her/his room a lot and they were unaware of any activity interests outside of music. On 9/25/24 at 3:06 PM and 9/26/24 at 4:28 PM Staff 7 (Activities Director) indicated Resident 25 was non-verbal and unable to make activity choices. Staff 7 stated he did not do much one-on-one activites with the resident and was unable to articulate the resident's favorite activities outside of listening to music. Staff 7 stated he attempted a sensory mat with the resident at one point but had not attempted any additional sensory activities. On 9/27/24 at 10:04 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on interview and record review it was determined the facility failed to provide care in accordance with care planned interventions while transferring residents for 1 of 1 sampled resident (#31) reviewed for accidents. This failure resulted in avoidable skin tears to Resident 31's right arm. Findings include: Resident 31 was admitted to the facility in 9/2023 with diagnoses including stroke and kidney failure. Resident 31's Quarterly MDS dated [DATE] indicated the resident was moderately impaired in cognition. Resident 31's Care Plan dated 10/3/23 identified the resident was at risk for falls due to muscle weakness. Interventions on the care plan included: Two-person transfers with a hoyer lift, staff were to anticipate the resident's needs and to keep the call light and personal items within reach. A 12/6/23 Facility Reported Incident indicated Resident 31 was provided care by Staff 11 (CNA) and Staff 15 (CNA) during a transfer from bed to her/his wheelchair and sustained two skin tears to her/his right forearm. Staff 11 reported the injury happened while they assisted the resident with a transfer. Staff 18 (RN) assessed the resident and cleaned the skin tears which measured 1.5 cm each, and were horseshoe shaped. On 9/26/24 at 10:02 AM Staff 11 stated she recalled the incident on 12/5/23 when she was assisting Resident 31 with a transfer. Staff 11 stated she was not familiar with Resident 31 and the incident happened very quickly. Staff 11 acknowledged Resident 31 required two-person hoyer assistance with transfers and the care plan was not followed. On 9/26/24 at 5:16 PM Staff 2 (DNS) stated Resident 31 required two-person assistance with a hoyer for transfers at the time of the incident. Staff 2 stated the care plan was not followed by Staff 11 and Staff 15, a hoyer lift should have been used for the transfer. Staff 2 stated it was her expectation the care plans were always followed.

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	385104	A. Building B. Wing	09/27/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 2 sampled residents (#1) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include: Resident 1 was admitted to the facility in 10/2017 with diagnoses including borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships). The National Institute of Mental Health (NIMH) website section titled Borderline Personality Disorder indicated genetic, environmental and social factors may increase a person's risk of developing borderline personality disorder, and many people with borderline personality disorder report experiencing traumatic life events, such as abuse, abandonment or hardship during childhood. Resident 1's 7/18/24 Quarterly MDS indicated the resident was cognitively intact. On 9/24/24 at 9:17 AM Resident 1 was observed in her/his room in her/his wheelchair. Resident 1 stated she/he had a history of trauma as she/he was abused as a child and teenage years. Resident 1 stated she/he was diagnosed with multiple personality disorder about [AGE] years ago, and some of her/his personalities were not nice and still hurt [her/him]. No evidence was found in Resident 1's clinical record to indicate the resident's past history of trauma and/or triggers which could cause re-traumatization were identified or assessed. On 9/25/24 at 9:50 AM and 10:16 AM Staff 4 (Social Services Director) stated she screened residents for trauma and developed care plans for those residents who indicated they experienced trauma, which included possible triggers for re-traumatization. Staff 4 stated she did not have any documentation to indicate Resident 1 was ever screened for trauma. On 9/25/24 at 11:02 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43690 Based on observation and interview it was determined the facility failed to ensure medications and biologicals were secured and accessible only to authorized personnel for 1 of 1 facility observed for secure medication and treatment carts. This placed residents at risk for misappropriation of medications and adverse medication consequences. Findings include: The facility Medication Storage Policy dated 1/2024 stated: In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. On 9/23/24 at 1:27 PM the treatment cart near the 300 hall was unlocked and unattended by staff. On 9/23/24 at 1:32 PM Staff 2 (DNS) confirmed the cart was left unlocked and unattended. On 9/26/24 at 1:19 PM the medication cart on the 500 hall was unlocked and unattended by staff. On 9/26/24 at 1:23 PM Staff 10 (LPN) confirmed the cart was left unlocked and unattended by staff. On 9/26/24 at 1:32 PM Staff 2 stated it was her expectation for the medication and treatment carts to remain locked when unattended.

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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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43691 Based on observation, interview, and record review it was determined the facility failed to store foods at appropriate temperatures for 1 of 3 kitchen refrigerators reviewed for food safety. The facility's failure was determined to be an immediate jeopardy situation because raw meat stored outside of an acceptable temperature was planned to be used for an upcoming meal. Findings include: According to the U.S. Food and Drug Administration's Food Code 2022, (Chapter 3, Section 501.13), food shall be thawed under refrigeration that maintains the food temperature at 41 degrees F or less. Chapter 3, Section 501.13 goes on to say, improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. On 9/23/24 at 10:24 AM an initial inspection of the kitchen was performed. During this inspection an internal refrigerator thermometer read 45 degrees F. This refrigerator contained uncooked meat thawing, bacon, various salad dressings, cooked ham, cooked pulled pork, salami, pasteurized eggs, pasteurized cheeses and butter. On 9/25/24 at 11:20 AM the same refrigerator was inspected and the internal thermometer read 49 degrees F. This refrigerator contained the same items observed on 9/23/24 as well as uncooked beef being thawed. On 9/25/24 at 11:20 AM Staff 8 (Dietary Director) stated the fridge had problems staying cool for a few weeks. Staff 8 stated she thought this was either due to the location of the fridge or due to a problem with the door not fully closing and staying closed. Information was provided to Staff 8 regarding the temperature being at 49 degrees F and no action was taken by Staff 8. On 9/26/24 at 8:53 AM the Refrigerator Temperature Log for 9/2024 was reviewed and contained the following information: - 9/1: 50 F at 6:00 PM, - 9/2: 42 F at 6:00 PM, - 9/4: 43 F at 6:00 PM, - 9/5: 44 F at 6:00 PM, - 9/6: 46 F at 6:00 PM, - 9/7: 47 F at 6:00 PM, - 9/10: 42 F at 6:00 PM, - 9/15: 46 F at 6:00 PM, (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 9/18: 43 F at 7:00 AM, - 9/18: 42 F at 6:00 PM, - 9/19: 42 F at 6:00 PM, - 9/22: 42 F at 9:00 AM, - 9/22: 42 F at 3:00 PM, - 9/23: 42 F at 7:00 AM, - 9/23: 43 F at 7:00 PM and - 9/24: 43 F at 2:00 PM. On 9/26/24 at 10:54 AM Staff 8 repeated she thought the problem was just the door not fully closing and checked to ensure the door was fully closed. Staff 8 repeated previous information about the refrigerator having had problems for a few weeks and added Staff 19 (Maintenance Director) was maybe notified about it. Records of this notification were requested, but no records were provided. On 9/26/24 at 10:54 AM Staff 8 was requested to check the temperature of the uncooked beef which was observed to be 41.3 degrees F. No action was taken by Staff 8 after the temperature check. On 9/26/24 at 11:05 AM Staff 19 stated he had not been informed of the refrigerator temperatures being outside of the acceptable range until 9/26/24. On 9/26/24 at 1:20 PM Staff 8 was requested to check the temperature of the uncooked beef which was found to be at 42.9 degrees F with one thermometer. To ensure temperature accuracy, a second thermometer was used which read 42.6 degrees F. Staff 8 stated the uncooked beef had been in the fridge to thaw since 9/24/24. Staff 8 said she had planned on cooking the beef on 9/27/24 but then said, I guess I'll do it tonight. On 9/26/24 at 2:44 PM the facility was notified of the Immediate Jeopardy (IJ) situation beginning 9/1/24 and an immediacy removal plan was requested. On 9/26/24 at 4:44 PM the facility submitted an acceptable immediacy removal plan which would abate the IJ situation. The immediacy removal plan included the following: - No foodborne illness had been identified. - All food was removed from the refrigerator and disposed. - The refrigerator was taken out of service. - New foods would be purchased to serve to residents. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- All kitchen refrigerators would be checked for correct temperatures - The Administrator would educate the Dietary Manager and all dietary staff on 9/26/24 on the importance of refrigerator temperatures and action that should occur immediately with any food temperature concerns. Education would include storage, thawing, cooking and danger zone temperatures as well as when to dispose of any food that is in question. If dietary staff does not answer, they will be educated prior to their shift. - The Administrator would educate maintenance on the importance of placing a malfunctioning refrigerator out of service and action that should occur immediately with any food temperature concerns. - The Administrator of designee would audit refrigerator temperature logs daily for one week, then weekly for three weeks and then monthly for two months. - The findings would be brought to QAPI (Quality Assurance and Performance Improvement) for two months to ensure substantial compliance is met. - The Administrator would be responsible to ensure compliance. On 9/27/24 at 10:03 AM it was determined through observations, staff interviews and review of the facility documentation all aspects of the plan of correction were implemented and completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50927 Based on observation and interview it was determined the facility failed to ensure sanitary laundry services were provided for 2 of 6 halls reviewed for infection control. This placed residents at risk for cross contamination. Findings include: On 9/24/24 at 12:57 PM and at 1:10 PM Staff 20 (Laundry Services) was observed to deliver clean resident clothing throughout the 400 and 500 Halls and used a small uncovered laundry cart. The laundry cart was left unattended while Staff 20 delivered resident clothing from room to room. On 9/27/24 at 10:02 AM Staff 1 (Administrator) acknowledged that clean resident clothing should be covered while being delivered.