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	03/13/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on Interview and record review it was determined the facility failed to ensure residents using psychotropic medications received gradual dose reductions for 4 of 5 sampled residents (#s 4, 8, 9, and 71) reviewed for medications. This placed residents at risk for unnecessary uses of psychotropic medications. Findings include:1. Resident 8 was admitted to the facility in 6/2024 with diagnoses including paranoid schizophrenia (mental health condition) and anxiety disorder (mental health condition). Resident 8's 12/13/25 Quarterly MDS indicated the resident received antipsychotic and antianxiety medications with no Gradual Dose Reduction (GDR) attempted and no documentation existed from the physician indicating a GDR was clinically contraindicated. Resident 8's 3/2026 Physician Orders included the following: - buspirone HCl Oral Tablet (antianxiety medication) 10 mg by mouth two times a day and 15 mg by mouth at bedtime for anxiety, active since 11/19/24. - perphenazine Oral Tablet 4 MG (antipsychotic medication) 4 mg by mouth two times a day, active since 6/4/24 Resident 8's 2/2026 and 3/2026 MARs revealed the resident received buspirone 10 mg twice per day, buspirone 15 mg at night, and perphenazine 4 mg twice per day as ordered. Resident 8's health record did not include documented evidence GDRs were attempted for buspirone or perphenazine, nor was there documented rationale for both medications why a GDR was clinically contraindicated. On 3/12/26 at 12:29 PM and 3/13/26 at 11:32 AM Staff 3 (RNCM) stated the resident was on a specialized unit and believed the residents on the Enhanced Care Unit (ECU) would not warrant a GDR due to their diagnoses. Staff 3 stated the residents on the ECU had their psychotropic medications and potential changes in condition reviewed monthly by the IDT (Intradisciplinary Team). Staff 3 was unable to provide the required GDR documentation for Resident 8. 2. Resident 9 was admitted to the facility in 2020 with diagnoses including bipolar disorder (mental health condition). Resident 9's 2/2025 Physician Orders included the following:- olanzapine (antipsychotic) 5 mg by mouth in the morning and 10 mg by mouth in the evening. (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

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 9's 1/26/26 Quarterly MDS indicated the resident received an antipsychotic, no Gradual Dose Reduction (GDR) was attempted, and the physician did not document a GDR was clinically contraindicated. Resident 9's 2/2025 MARs through 2/2026 MARs revealed the resident received olanzapine BID as ordered. Resident 9's health record did not include documented evidence a GDR for olanzapine was attempted between 2/2025 and 2/2026 or a documented rationale why a GDR was clinically contraindicated. On 3/12/26 12:47 PM and on 3/13/26 at 9:52 AM Staff 3 (RNCM) stated the resident was on a specialized unit and believed the residents on the Enhanced Care Unit (ECU) would not warrant a GDR due to their diagnoses. Staff 3 stated the residents on the ECU had their psychotropic medications and potential changes in condition reviewed monthly by the IDT (Intradisciplinary Team). Staff 3 was unable to provide the required GDR documentation for Resident 9. 3. Resident 4 was admitted to the facility in 2007 with diagnoses including antisocial personality disorder (mental health condition) and dementia with behavioral disturbance. Resident 4's 8/1/25 Annual MDS indicated the resident received no Gradual Dose Reduction (GDR) was attempted and the physician did not document a GDR was clinically contraindicated. Resident 4's 2/2026 Physician Orders directed the facility staff to administer quetiapine fumarate (antipsychotic medication) 600 mg by mouth at bedtime. Resident 4's 2/2025 through 3/2026 MARs revealed the resident received quetiapine fumarate as ordered. Resident 4's health record did not include documented evidence a GDR was attempted or a documented rationale why a GDR was clinically contraindicated. On 3/12/26 12:40 PM and 3/13/26 at 9:52 AM Staff 3 (RNCM) stated the resident was on a specialized unit and believed the residents on the Enhanced Care Unit (ECU) would not warrant a GDR due to their diagnoses. Staff 3 stated the residents on the ECU had their psychotropic medications and potential changes in condition reviewed monthly by the IDT (Intradisciplinary Team). Staff 3 was unable to provide the required GDR documentation for Resident 4. 4. Resident 71 was admitted to the facility in 2024 with diagnoses including bipolar disorder (mental health condition). Resident 71's 7/2/25 Annual MDS indicated the resident received an antipsychotic, no Gradual Dose Reduction (GDR) was attempted, and the physician did not document a GDR was clinically contraindicated. Resident 71's 2/2025 Physician Orders for medications included the following: - olanzapine (antipsychotic) give 10 mg by mouth in the evening.- Depakote sprinkles oral capsule delayed release (mood stabilizer) to give 1750 mg by mouth in the morning and 2000 mg by mouth at bedtime. Resident 71's 2/2025 through 3/2026 MARs revealed the resident received olanzapine and Depakote (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications as ordered. Resident 71's health record did not include documented evidence a GDR was attempted or a documented rationale why a GDR was clinically contraindicated. On 3/12/26 12:40 PM and 3/13/26 at 9:52 AM Staff 3 (RNCM) stated the resident was on a specialized unit and believed the residents on the Enhanced Care Unit (ECU) would not warrant a GDR due to their diagnoses. Staff 3 stated the residents on the ECU had their psychotropic medications and potential changes in condition reviewed monthly by the IDT (Intradisciplinary Team). Staff 3 was unable to provide the required GDR documentation for Resident 71.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to assist residents to formulate an advanced directive for 2 of 2 sample residents (#s 10 and 14) reviewed for advance directives. This placed residents at risk for healthcare decisions to be in conflict with resident wishes. Findings include:1. Resident 10 was admitted to the facility in 2/2026 with diagnoses including hypertension (high blood pressure).A care plan dated 2/5/226 indicated Resident 10 was a full code, her/his advanced directive would be honored, and her/his advanced directive would be in the medical record at all times.A review of Resident 10's medical record revealed no evidence of an advanced directive.On 3/10/26 at 1:13 PM, Staff 2 (DNS) stated Resident 14 did not have an advanced directive and education was initiated regarding the difference between an advanced directive and a POLST (Physician Order for Life Sustaining treatment). Staff 2 stated the expectation was for the RCM or the Social Service Director to ensure if a resident has an advanced directive, it was obtained and scanned into the resident's chart. 2. Resident 14 was admitted to the facility in 2/2026 with diagnoses including asthma.A 2/10/26 Baseline Care Plan Person-Centered Care Planning Evaluation revealed Resident 14's advanced directive had been reviewed with Resident 14.A review of Resident 14's medical record revealed no evidence of an advanced directive.On 3/10/26 at 1:13 PM, Staff 2 (DNS) stated Resident 14 did not have an advanced directive and education was initiated regarding the difference between an advanced directive and a POLST (Physician Order for Life Sustaining treatment). Staff 2 stated the expectation was for the RCM or the Social Service Director to ensure if a resident has an advanced directive, it was obtained and scanned into the resident's chart.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review it was determined the facility failed to ensure privacy was maintained when care was provided for 1 of 3 sampled resident (#11) reviewed for dignity. This placed residents at risk for a lack of privacy during care. Findings involved:The facility's Resident Rights Policy from 8/2019 revealed:-Employees shall treat all residents with kindness, respect, and dignity. Federal and states laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality.Resident 11 was admitted to the facility in 2/2026 with diagnoses including cerebral infarction (blood flow blockage of a section of the brain which often results in death of brain cells), tracheostomy (surgical airway opening to facilitate breathing), and locked-in state (full consciousness but an inability to move or speak).A 2/18/26 admission MDS indicated Resident 11 to be in a comatose state with an inability to communicate.A 3/2/26 physician order included Resident 11's tracheostomy to be suctioned every six hours and as needed to prevent airway blockage.On 3/10/26 at 8:31 AM Staff 10 (Respiratory Therapist) was observed performing suctioning for Resident 11's tracheostomy with Resident 11's door fully open. Resident 11 was visible from the main hallway of the facility. During the suctioning, Resident 11 was observed lifting both of her/his legs one foot off her/his bed and tremoring strongly for approximately three seconds multiple times. Residents were observed looking into Resident 11's room from the hallway while the suctioning care was provided to Resident 11.On 3/11/26 at 1:00 PM Staff 10 was observed performing suctioning for Resident 11's tracheostomy with Resident 11's door fully open. Resident 11 was visible from the main hallway of the facility. During the suctioning, Resident 11's legs were observed lifting one foot off her/his bed while tremoring strongly for approximately three seconds a total of six times. During the reactions to suctioning, three staff members and two residents passed by Resident 11's room and looked into her/his room at Resident 11.On 3/11/26 at 1:17 PM Staff 10 stated Resident 11's legs lifted off the bed and shook when the suctioning tube was required to go more than two inches deep. Staff 10 stated Resident 11 grimaced during the suctioning process. Staff 10 stated she had never been instructed to have Resident 11's door closed when performing suctioning but understood maintaining privacy was important for all residents, but especially when a resident was unable to communicate or advocate for themselves.On 3/11/26 at 3:52 PM Witness 1 (Resident Representative) stated Resident 11 would not want her/his care to be provided visible to others and stated Resident 11's door should be closed when suctioning care was provided. Witness 1 stated she/he was uncomfortable knowing suctioning care was provided to Resident 11 with the door wide open. On 3/11/26 at 4:06 PM Staff 9 (LPN/Resident Care Manager) stated when suctioning care was provided, having the door closed was important for Resident 11's privacy.On 3/11/26 at 4:26 PM Staff 2 (DNS) confirmed Resident 11's door should remain closed to maintain privacy when tracheostomy care was provided.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review it was determined the facility failed to ensure a safe discharge for 1 of 4 sampled residents (#82) reviewed for discharge. This placed residents at risk for lack of medical services. Findings include: Resident 82 was admitted to the facility in 9/2025 with diagnoses including seizures and anxiety.A physician order from 9/1/25 included 200 mg of lacosamide (antiseizure medication) to be administered twice a day for seizures.A physician order from 9/1/25 included 1 mg of clonazepam (antianxiety medication) to be administer twice a day for anxiety.Review of progress notes revealed Resident 82 transitioned home to an assisted living facility on 9/15/25. This note reports Resident 82 was provided his/her medications upon discharge.Review of Controlled Substance Log records from 9/2025 revealed Resident 82 had 33 tablets of lacosamide and 24 tablets of clonazepam which remained in the facility until they were disposed of on 11/9/25. Records showed the medications were not provided to Resident 82 upon discharge.On 3/10/26 at 2:31 PM Staff 9 (LPN/Resident Care Manager) stated residents discharge with their scheduled and PRN medications, but not general over the counter medications. Staff 9 stated antiseizure and antianxiety medications were types of medications a resident should be discharged home with.On 3/10/26 at 2:59 PM Staff 6 (RN) stated Resident 82 was to be provided her/his antiseizure and antianxiety medications upon discharge.On 3/10/26 at 3:04 PM Witness 2 (RN, External Facility Staff) reviewed Resident 82's records regarding her/his transfer home. Witness 2 stated Resident 82 was not provided with the remaining doses of lacosamide and clonazepam upon discharge which required these medication to be reordered. Witness 2 stated Resident 82 experienced increased anxiety as result of not having her/his anxiety and seizure medications available.On 3/11/26 at 9:05 AM Resident 82 stated she/he was afraid after learning she/he did not arrive to the new facility with all of her/his medications but did not experience any seizures or anxiety attacks as a result of missed medications.On 3/11/26 at 10:36 AM Staff 2 (DNS) confirmed Resident 82 should have been provided the remaining doses lacosamide and clonazepam upon her/his discharge from the facility.

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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. Based on interview and record review it was determined the facility failed to thoroughly investigate falls for 1 of 2 sampled residents (#83) reviewed for accidents. This placed residents at risk for further falls. Findings include:Resident 83 was admitted to the facility in 3/2025 with diagnoses includine Alzhimer's Disease and insomnia.A public complaint was made on 12/10/25 which alleged the facility failed to have intervention in place to mitigate Resident 83's falls.A 4/3/25 facility investigation indicated on 3/21/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/3/25 facility investigation indicated on 3/23/25 Resident 83 was observed self ambulating in the hall near the nurse's station and Resident 83 was observed to fall.A 4/3/25 facility investigation indicated on 3/26/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/3/25 facility investigation indicated on 3/27/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/3/25 facility investigation indicated on 3/30/25 Resident 83 was observed falling in the hallway. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/6/25 facility investigation indicated on 3/24/25 Resident 83 was observed to fall in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/14/25 facility investigation indicated on 4/8/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 4/14/25 facility investigation indicated on 4/11/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 5/1/25 facility investigation indicated on 4/27/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 5/1/25 facility investigation indicated on 5/1/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 5/19/25 facility investigation indicated on 5/16/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 6/25/25 facility investigation indicated on 6/10/25 Resident 83 was observed standing up for her/his wheelchair and falling to the floor. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 6/25/25 facility investigation indicated on 6/18/25 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 7/11/25 facility investigation indicated on 7/2/25 Resident 83 was found on the floor of the hallway. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 7/11/25 facility investigation indicated on 7/9/25 Resident 83 was found on the floor of her/his room. The investigation did not include an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 9/19/25 facility investigation indicated on 8/30/25 Resident 83 was found on the floor in the hallway. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 10/2/25 facility investigation indicated on 9/13/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 11/3/25 facility investigation indicated on 10/5/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 11/3/25 facility investigation indicated on 10/19/25 Resident 83 had a witnessed fall onto the floor. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 12/7/25 facility investigation indicated on 11/9/25 Resident 83 was found on the floor in the hallway. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 12/7/25 facility investigation indicated on 11/12/25 Resident 83 was found on the floor in the hallway. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 1/4/26 facility investigation indicated on 12/6/25 Resident 83 was found on the floor in her/his room. The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A 3/1/26 facility investigation indicated on 2/8/26 Resident 83 was found on floor in the hallway, The investigation did not include an analysis of the root cause or the fall, or whether care planned interventions were effective, or if any additional interventions were put in place.A review of Resident 83's medical record revealed she/he passed away on 2/24/26.On 3/11/26 at 11:40 AM, Staff 2 (DNS) stated investigation were expected to be completed within five business days. Staff 2 stated the fall investigations for the falls on 3/21/25, 3/23/25, 3/24/25, 3/26/25, 6/10/25, 6/18/25, 7/2/25, 8/30/25, 9/13/25, 10/5/25, 10/19/25, 11/9/25, 11/12/25, 12/6/25, and 2/8/26 were completed late. Staff 2 stated the fall investigations were not through, were missing the root cause analysis for the falls, and were missing interventions put in place to help prevent further falls or help prevent injuries from falls.

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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. Based on observation, interview and record review it was determined the facility failed to ensure residents received care and services related to the use of an indwelling catheter for 1 of 2 sampled residents (#56) reviewed for catheter care. This placed residents at risk for catheter care complications. Findings include: The facility's 9/1/24 policy and procedure related to indwelling catheters indicates care of residents' catheters includes monitoring for signs of complications.Resident 56 was admitted to the facility in 9/2025 with a diagnosis of acute and chronic respiratory failure with hypoxia (a potentially life-threatening condition where the lungs cannot adequately oxygenate the blood).Resident 56's health record revealed she/he was her/his own representative and was cognitively intact.A review of Resident 56's 9/24/25 admission and 12/25/25 Quarterly MDS assessments revealed she/he had an indwelling suprapubic catheter.Resident 56's 10/1/25 Care Plan indicated the facility was to follow up with urology consults as ordered.A progress note written by Staff 5 (Attending Physician) on 11/20/25 at 8:31 AM revealed Resident 56 complained her/his suprapubic catheter leaked at the stoma which left her/his bed wet. The note indicated if Resident 56's suprapubic catheter was leaking, staff were to refer to urology for an exchange or different size.A handwritten note from Staff 5 requested staff to refer Resident 56 to Urology to care for her/his leaking suprapubic catheter was uploaded to her/his health record on 11/20/25.A nursing progress note written by Staff 6 (RN) on 1/24/26 at 5:57 PM revealed a large amount of urine leaking around suprapubic catheter. On 3/9/26 at 11:29 AM Resident 56 stated, I wish they could fix my catheter. It leaks and I end up being wet on my belly and it is uncomfortable. Resident 56 pointed to a wet area low on her/his garment and stated, I don't like to feel wet.On 3/12/26 at 12:04 PM Staff 7 (CNA) stated she performed peri care around Resident 56's suprapubic catheter stoma because it leaked. Staff 7 stated she used a warm wet washcloth to keep Resident 56 as clean and dry as possible whenever she provided incontinence care and whenever urine leaked from the stoma. Staff 7 stated Resident 56 let staff know when she/he leaked urine from her/his stoma.On 3/12/2026 at 3:20 PM Staff 4 (CNA) stated he was aware Resident 56's suprapubic catheter leaked and she/he complained about her/his belly feeling wet. Staff 4 stated this was pretty much the norm and CNAs perform peri care around the stoma, cleaned the area and regularly placed an absorbent pad below the stoma to help absorb the leaking urine. On 3/12/26 at 3:23 PM Staff 8 (LPN) stated the stoma for Resident 56's suprapubic catheter was too big which caused it to leak urine. Staff 8 stated she observed Resident 56's stoma regularly and CNAs had to provide peri care to the stoma to ensure the site was clean and dry because it leaked urine daily. Staff 8 stated she did not know if a urology referral and appointment were made.On 3/12/26 at 3:39 PM Staff 9 (LPN/RCM) stated she was aware Resident 56's suprapubic catheter stoma leaked continuously and it was bothersome. Staff 9 stated she was aware of Staff 5's order to refer Resident 56 to Urology but confirmed the referral was not made. Staff 9 stated she expected a referral to be made to urology when a suprapubic catheter stoma leaked.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review it was determined the facility failed to maintain healthy parameters of nutritional status for 1 of 2 sample residents (#10) reviewed for nutrition. This placed residents at risk for impaired nutrition. Findings include:Resident 10 was admitted to the facility in 2/2026 with diagnoses including a Stage 3 Pressure Ulcer (a deep, full-thickness skin wound, often appearing as a crater, where the skin has broken down completely, exposing the fatty subcutaneous tissue) to her/his sacral region and left heel and moderate protein-calorie malnutrition.A 2/5/26 care plan indicated Resident 10 was at risk for nutritional imbalance due to a diagnosis of malnutrition.A review of Resident 10's weights revealed the following:-2/11/26 200 lbs-2/17/26 190 lbs-3/5/26 179.8 lbsA review of the 2/4/26 Skin Issues Evaluations revealed Resident 10 had a Stage 3 Pressure Ulcer on her/his left ankle and sacrum at admission.A 2/12/26 Nutrition at Risk Evaluation revealed Resident 10 was started on a protein supplement twice a day due to wounds.A 2/13/26 physician order revealed Resident 10 had orders for a nutritional supplement twice a day.A review of a 2/23/26 Skin Issues Evaluations revealed Resident 10's pressure ulcer on her/his sacrum worsened to a Stage 4 Pressure Ulcer (wounds that involve complete tissue loss with exposure of muscle, tendon, or bone).A 2/26/26 Nutrition at Risk Evaluation revealed Resident 10 was refusing her/his nutritional supplement and Resident 10 was consuming the protein supplement.A review of 2/2026 and 3/2026 MARs revealed Resident 10 refused the nutritional supplement which was started on 2/13/26.On 3/11/26 at 8:29 AM, Resident 10 was observed in bed with her/his breakfast tray in front of her/him, Resident 10 appeared to be sleeping and not eating.On 3/12/26 at 9:28 AM Resident 10 was observed sleeping in bed with her/his breakfast tray in from of her/him and food on her/his chest.A 3/12/26 review of Resident 10's meal intake for the last 30 days from date of review, revealed Resident 10 ate 50% or less than of her/his meals or refused the meal 37 times. The documentation revealed Resident 10 was offered a health shake or ensure six times and refused 13 times.On 3/12/26 at 11:05 AM Staff 13 (RNCM) stated the expectation was if a resident consumes 50% or less of their meal, an alternate or meal replacement was offered. Staff 13 stated a protein supplement, and a nutritional supplement was started on 2/5/26, but Resident 10 has refused the nutritional supplement. Staff 13 confirmed Resident 10 had a significant weight loss and there were no interventions put in place since the weight loss occurred.On^3/12/26 at^11:31^AM, Staff^2 (DNS) acknowledged Resident^10 had experienced significant weight loss and no interventions had been implemented in response to the decline. Staff^2 stated discussions regarding hospice care had occurred with the family; however, the family was not yet ready for Resident^10 to transition to hospice services.

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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hood River Post Acute	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to ensure precautions were in place for 1 of 6 sampled hallways (400 hall) reviewed for enhanced barrier precautions. This placed the residents at risk of acquiring an infection. Findings include:CDC's 6/2021 Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities instructed EBP were recommended for residents with indwelling medical devices, regardless of multidrug-resistant organism colonization status. Resident 55 was admitted to the facility in 2/2026 with diagnoses including gastrostomy status (a tube placed directly into the stomach through a small opening in the belly used for administering nutrition, fluids, and medications).Resident 55's 2/10/26 admission orders included an order for enhanced barrier precautions (EBP) (protective measures taken by nursing home staff for residents with specific germs or medical devices).On 3/9/26 and 3/10/26 between the hours of 8:37 AM and 3:38 PM no EBP signage or PPE was observed inside or outside Resident 55's room.On 3/9/26 at 2:32 PM and 3/10/26 at 1:34 PM staff, including Staff 4 (CNA), were observed to complete cares with Resident 55 without wearing PPE beyond gloves.On 3/10/26 at 1:26 PM Staff 4 stated when providing care with residents with tube feeding, staff should wear a gown, mask, and gloves. Staff 4 stated a sign would be posted outside the resident's door if they were on EBP. Staff 4 confirmed Resident 55 did not have EBP in place and PPE was not used beyond wearing gloves. On 3/10/26 at 1:56 PM Staff 2 (DNS) acknowledged Resident 55 did not have EBP in place, confirmed EBP signage was not posted, and confirmed EBP was indicated for Resident 55 due to the resident's gastrostomy tube.