

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Timberline Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1023 6th Ave SW Albany, OR 97321	

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

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 5 residents (#1) reviewed for unnecessary medications. This placed residents at risk for adverse side effects of medications. Findings Include:</p> <p>Resident 1 was admitted to the facility in 8/2018 with diagnoses including diabetes.</p> <p>A review of Resident 1's Physician Orders revealed a 7/27/24 order for sumatriptan succinate (a medication used to treat migraines) 25 mg as needed for migraines daily, may repeat dose in two hours if the first dose was ineffective.</p> <p>A review of Resident 1's 9/1/24 through 9/25/24 MAR revealed on 9/20/24 Resident 1 was given sumatriptan succinate 25 mg at 2:46 PM with effective results and a second dose of sumatriptan succinate 25 mg was given on 9/20/24 at 11:04 PM with effective results.</p> <p>On 9/25/24 at 2:59 PM Staff 7 (RNCM) stated on 9/20/24 Resident 1 was given sumatriptan succinate 25 mg at 2:46 PM and 11:04 PM. Staff 7 stated the second dose of sumatriptan succinate 25 mg given at 11:04 PM was not given per Physician Orders, and Staff 7 stated the nurse should have called the provider for new orders prior to giving the sumatriptan succinate 25 mg at 11:04 PM.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47001</p> <p>Based on observation, interview, and record review it was determined the facility failed to obtain oxygen orders for 1 of 2 sampled residents (#211) reviewed for respiratory care. This placed residents at risk for adverse side effects of oxygen use without orders. Findings include:</p> <p>Resident 211 was admitted to the facility in 9/2024 with diagnoses including acute respiratory failure.</p> <p>On 9/23/24 at 12:06 PM Resident 211 was observed using oxygen via nasal cannula at two liters per minute.</p> <p>On 9/25/24 at 8:46 AM Resident 211 was observed using oxygen via nasal cannula at two liters per minute.</p> <p>A 9/26/24 review of Resident 211's Physician Orders revealed no evidence of oxygen orders.</p> <p>On 9/26/24 at 12:32 PM Staff 7 (RNCM) acknowledged Resident 211 was using oxygen but did not have orders for oxygen.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>36494</p> <p>Based on interview and record review it was determined the facility failed to ensure pharmacy recommendations were addressed by the physician for 1 of 5 sampled residents (#33) reviewed for unnecessary medications. This placed residents at risk for adverse side effects of medications. Findings include:</p> <p>Resident 33 was admitted to the facility in 1/2024 with diagnoses including chronic obstructive pulmonary disease and sleep apnea.</p> <p>The 8/2024 pharmacy recommendation indicated Resident 33 had an order for fluticasone (a nasal spray to treat allergies or asthma), to be sprayed in both nostrils two times daily for congestion. The recommendation suggested changing the fluticasone spray to once daily for congestion. The physician assistant agreed to the change and signed the recommendation on 8/15/24.</p> <p>A review of Resident 33's 8/2024 and 9/2024 MARs revealed Resident 33 was administered fluticasone two times daily for congestion.</p> <p>On 9/27/24 at 12:39 PM Staff 7 (RNCM) reviewed the current order and pharmacy review and confirmed the facility did not act upon the pharmacist's recommendation. Staff 7 acknowledged Resident 33 was being administered the fluticasone two times daily and stated the recommendation was overlooked.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>48830</p> <p>Based on observation, interview and record review it was determined the facility failed to protect resident identifiable information for 3 of 3 sampled residents (#s 17, 22 and 32) reviewed for record management. This placed residents at risk for unauthorized use of their personal information. Findings include:</p> <p>1. On 9/23/24 at 9:37 AM resident identifiable information including Resident 17 and 32's names and diet types was observed on a meal ticket inside a clear plastic garbage bag with no lid located on the side of a cart where dirty dishes were placed after a meal service. The cart was located next to the dining room.</p> <p>On 9/23/24 at 9:38 AM Staff 6 (CNA) was discarding food scraps into the clear plastic garbage bag where resident identifiable information was observed. Staff 6 confirmed Residents 17 and 32 were current residents at the facility. Staff 6 stated all resident meal tickets that included the resident's name were to be placed in the confidential shred bin.</p> <p>On 9/23/24 at 9:52 AM Staff 2 (DNS) confirmed Resident 17 and 32's meal tickets with resident identifiable information were in the garbage. She stated her expectation was for all resident identifiable information to be placed in the confidential shred bin.</p> <p>2. On 9/23/24 at 1:00 PM resident identifiable information including Resident 22's name and diet type was observed on a meal ticket inside a clear plastic garbage bag with no lid located on the side of a cart where dirty dishes were placed after a meal service. The cart was located next to the dining room.</p> <p>On 9/23/24 at 1:03 PM Staff 5 (CNA) was discarding food scraps into the clear plastic garbage bag where resident identifiable information was observed. Staff 5 confirmed Resident 22 was a current resident at the facility. Staff 5 stated all resident meal tickets that included the resident's name were to be placed in the confidential shred bin.</p> <p>On 9/23/24 at 1:14 PM Staff 2 (DNS) confirmed Resident 22's meal ticket with resident identifiable information was in the garbage. She stated her expectation was for all resident identifiable information to be placed in the confidential shred bin.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36494</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure resident equipment was kept sanitary and proper hand hygiene was completed during a dressing change for 2 of 2 sampled residents (#s 6 and 19) and, ensure proper hand hygiene was completed during meals for 1 of 3 halls reviewed for dining, pressure ulcers and tube feeding. This placed residents at risk for unsanitary equipment and cross contamination. Findings include:</p> <p>1. Resident 19 was admitted to the facility in 7/2024 with diagnoses including muscular dystrophy and dysphagia (difficulty swallowing).</p> <p>On 9/23/24 at 12:23 PM and 9/25/24 at 2:48 PM, Resident 19 stated she/he received her/his nutrition via tube feed because of being unable to swallow or eat food. Resident 19 stated she/he utilized a suctioning device to remove saliva and phlegm due to her/his inability to swallow safely. Resident 19 stated staff did not empty her/his suctioning device consistently and was unsure who was responsible to empty and or clean the device, which was upsetting to her/him.</p> <p>A review of Resident 19's clinical record revealed no evidence of how often her/his suctioning device was cleaned or who was responsible for emptying the canister, which collected excessive saliva and phlegm.</p> <p>Random observations from 9/23/24 through 9/26/24 revealed Resident 19 received her/his nutritional intake via tube feeding and had a suctioning device on her/his bedside table to the right of the bed. The resident was able to suction excessive saliva or phlegm out of her/his own mouth. The suctioning device had saliva and secretions in the canister section, which held approximately 1000 milliliters. The canister was always over half way or three quarters full with saliva and phlegm.</p> <p>On 9/25/24 at 9:24 AM, Staff 21 (LPN) stated Resident 19 was able to use the suctioning device on her/his own, had a lot of secretions, and used the suctioning device continuously. Staff 21 stated the CNAs were responsible for emptying and cleaning the device. Staff 21 stated she expected CNAs to empty and clean it at least once daily. Staff 21 was unsure when the device or tubing was last changed.</p> <p>On 9/25/24 at 1:51 PM, Staff 18 (CNA) stated she could empty the canister if it was full but had never seen Resident 19's canister full of saliva. Staff 18 stated the nurses were responsible for cleaning the suctioning device and replacing the tubing.</p> <p>On 9/26/24 at 10:40 AM, Staff 17 (CNA) stated Resident 19 always had the suctioning device on her/his bedside table. Staff 17 stated he was trained to never clean or empty the device because nurses were responsible for emptying and cleaning the device.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 1:15 PM Staff 15 (LPN), Staff 16 (LPN) and Staff 14 (LPN) were observed in Resident 19's room. Staff 15 was hooking up Resident 19's TF (tube feeding). Staff 16 was on the right side of Resident 19's bed and moved the bedside table to the side so she could instruct and guide Staff 15 with hooking up the resident's TF. The suctioning device was on the bedside table that Staff 16 moved, and the canister was three quarters full with saliva. Staff 15, Staff 16 and Staff 14 exited the room once the resident's tube feeding was hooked up but did not empty the suctioning device.</p> <p>On 9/26/24 at 1:39 PM Staff 14 stated she thought since the the suctioning device was a medical device, the nurses should be cleaning it because the device would need to be taken apart. Staff 14 acknowledged Residents 19's canister was full when she was in the room with Staff 15 and Staff 16. Staff 14 stated at 4:23 PM, per CDC guidelines, there were no recommendations on how often to clean the device and indicated it was being cleaned regularly by a nurse. Staff 14 acknowledged there was no information in the clinical record regarding when the suctioning device was cleaned or how often it should be emptied.</p> <p>On 9/27/24 at 12:39 PM, Staff 7 (RNCM) stated she was informed of the concern regarding Resident 19's suctioning device and who was responsible for emptying the canister and when the device should be cleaned.</p> <p>47001</p> <p>2. Resident 6 was admitted to the facility in 8/2024 with diagnoses including paraplegia (paralysis of the lower half of the body).</p> <p>On 9/25/24 at 9:53 AM Staff 9 (LPN) was observed changing the dressing around Resident 6's left nephrostomy (kidney) tube. Staff 9 performed hand hygiene and applied clean gloves. Staff 9 removed Resident 6's dirty dressing around her/his left nephrostomy tube, with the same gloves Staff 9 cleaned the site with normal saline and with the same gloves Staff 9 applied a clean dressing around Resident 6's left nephrostomy tube. Staff 9 removed the dirty gloves and performed hand hygiene.</p> <p>On 9/25/24 at 9:58 AM Staff 9 stated she normally performed hand hygiene before starting a dressing change and after she completed a dressing change. Staff 9 stated she normally does not perform hand hygiene during a dressing change.</p> <p>On 9/25/24 at 3:17 PM Staff 8 (RNCM) stated she expected staff to perform hand hygiene at the beginning of dressing changes, after taking off old, dirty dressings, after removing dirty gloves and after the dressing change. Staff 8 acknowledged Staff 9 did not follow appropriate infection control practices when changing Resident 6's dressing around her/his left nephrostomy tube.</p> <p>42270</p> <p>3. On 9/23/24 at 12:19 PM Staff 11 (CNA) was observed to deliver a lunch tray to a resident in room [ROOM NUMBER], exited room [ROOM NUMBER], went to the tray cart and immediately delivered a lunch tray to a resident in room [ROOM NUMBER]. Staff 11 then exited room [ROOM NUMBER] and immediately went to the tray cart. Hand hygiene was not completed between each meal tray delivered.</p> <p>On 9/23/24 at 12:23 PM Staff 11 stated she completed hand hygiene when she remembered and did not complete hand hygiene between each tray delivered.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/24/23 at 1:50 PM Staff 2 (DNS) stated the staff were to complete hand hygiene between each tray delivered during meal pass.</p>