

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER West Hills Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 SW Multnomah Blvd Portland, OR 97219	

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)
<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>46054</p> <p>Based on interview and record review it was determined the facility failed to provide education and training for the self-administration of an anticoagulant subcutaneous medication prior to discharge for 1 of 3 sampled residents (#2) reviewed for discharge. This placed residents at risk for an unsafe discharge. Findings include:</p> <p>The 10/14/24 Facility Discharge Planning Policy stated it is the facility's responsibility to develop and implement an effective discharge planning process that focused on the resident's discharge goals, and the preparation of residents to be active partners so they may be effectively transitioned into post-discharge care to prevent readmissions. This included an evaluation of the resident's discharge needs, the development of a final discharge plan, and continuous education to be provided to the resident and the resident's family to ensure any unnecessary delays in the resident's care post discharge.</p> <p>Resident 2 was admitted to the facility in 2024, with diagnosis including left femur fracture and stroke.</p> <p>Resident 2's Care Plan revealed the resident received subcutaneous injectable anticoagulant therapy with interventions that included resident, family and caregiver training and education on medication administration.</p> <p>A review of Resident 2's July MAR revealed the resident was prescribed a subcutaneous injectable medication upon admission that was used to treat blood clots. The medication prescribed was noted with an end date of use by 7/10/24. Resident 2 was noted to have discharged from the facility on 7/1/24 with the prescription still in active use.</p> <p>Additional review of Resident 2's progress notes and assessments revealed no documentation Resident 2 or her/his representative were trained and educated on self-administration of the injectable medication.</p> <p>On 12/10/24 at 10:21 AM, Staff 4 (LPN) stated she was the nurse responsible for discharge planning. Staff 4 stated it was the facility's procedure for the nurse to review all medications including how to administer medications upon discharge. Staff 4 stated she could not confirm if Resident 2 received training and education on how to administer injectable anticoagulant therapies.</p> <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/24 at 11:48 AM, Staff 3 (RNCM) stated the facility had no documentation to show the resident safely discharged from the facility with the training on how to self-administer the injectable anticoagulant medication. Staff 3 stated it was the expectation of care staff to document, train and educate residents on self-administration of medication prior to discharge.</p> <p>On 12/11/24 at 11:09 AM, Staff 2 (DNS) confirmed findings and stated the facility was responsible in ensuring residents and resident representatives were to be trained on how to administer medications prior to discharge.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46054</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (#5) reviewed for medication administration. This placed residents at risk for adverse medication consequences. Findings include:</p> <p>The Facility's 10/14/24 Medication Administration Procedure revealed the following:</p> <p>Medication Incidents are to be reported to the Director of Nurses so that an investigation can be initiated. Medication incidents are incidents where medication is omitted from the order, administered to the incorrect resident, provided with the wrong dosage, form, route or time of administration, and/or provided with unprescribed medications.</p> <p>When the incident is made, the person committing the incident shall:</p> <ul style="list-style-type: none"> - Notify the nurse of the resident (if this incident is made by the nurse, then the supervisor or DON is to be notified immediately). - Complete a medication incident form when appropriate which will go directly to the DNS and the ED. - Notify the MD, family, and relay physician response. - Record the facts in the resident chart, indicate physician notified regarding medications and family and clinical outcomes as appropriate. <p>When the incident is discovered on a subsequent shift, the person discovering the incident will be responsible for notifying the charge nurse and the physician and initiating the medication incident form. The DON will follow facility protocol including follow up with any person or persons involved in medication error and ensure the completion of the incident report.</p> <p>Resident 5 was admitted to the facility in 2024, with diagnosis including hypothyroidism and hypertension.</p> <p>A review of Resident 5's December MAR revealed the resident was ordered levothyroxine 25 mcg (a thyroid hormone medication) and spironolactone 25 mg (a blood pressure medication) that was to be administered at 6 AM before meals. The MAR indicated the resident was not administered any of the medications.</p> <p>On 12/10/24 at 3:09 PM, Staff 6 (LPN) confirmed Resident 5 was not administered his/her thyroid medication or blood pressure medication. Staff 6 stated she wasn't aware of when or what time Resident 5's morning medications should be administered. Staff 6 stated it was not her responsibility to review any previous medication passes to confirm if they had been completed by the last shift. Staff 6 stated she did not report this missed medication administration to the RCM, DNS or the Physician.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 at 11:03 AM, Staff 2 (DNS) confirmed findings and indicated the oncoming nurse failed to review the previous med pass to ensure they were completed. Staff 2 stated it was the responsibility of the oncoming facility nurse to ensure all medications had been passed when beginning their shift. Staff 2 indicated it is the expectation of the facility that any nurse who discovered a medication error should report it to the DNS, RCM, and Physician and file an incident report.</p>		