

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER French Prairie Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 601 Evergreen Road Woodburn, OR 97071	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>50928</p> <p>Based on interview and record review it was determined the facility failed to obtain informed consent prior to administration of a psychotropic medication for 1 of 5 sampled residents (#34) reviewed for unnecessary medications. This placed residents at risk for being uninformed of the risks and benefits of their medications. Findings include:</p> <p>Resident 34 was admitted to the facility in 4/2025 with diagnoses including major depressive disorder.</p> <p>A 4/3/25 physician order included bupropion 300mg (used to treat depression) and desvenlafaxine 100mg (used to treat depression) one time daily.</p> <p>Resident 34's 4/2025 MARs revealed the resident received bupropion and desvenlafaxine daily since 4/3/25.</p> <p>Resident 34's medical record revealed the signed consent related to the risks and benefits of bupropion was obtained on 4/23/25 and the signed consent related to the risks and benefits of desvenlafaxine was obtained on 4/24/25.</p> <p>On 4/28/25 at 10:10 AM Staff 2 (DNS) acknowledged the consents were obtained after the medications were administered.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed for self-administration of medications for 1 of 1 sampled resident (#104) reviewed for medication self-administration. This placed residents at risk for adverse outcomes related to unsafe self-administration of medication. Findings include:</p> <p>The facility's 3/2023 Right to Self-Administer Medication outlined the following criteria for a resident to self-administer medications:</p> <ol style="list-style-type: none"> 1. If a resident has requested to self-administer medications, it is the responsibility of the interdisciplinary team to determine it is safe before the resident exercises the right. A resident may self-administer medications after the interdisciplinary team has determined which medication may be self-administered. 2. Considerations in determining of the resident is clinically appropriate to self-administer include: <ol style="list-style-type: none"> a. Which medications are appropriate and safe for self-administration. b. The resident's physical capacity to swallow without difficulty and to open medication packaging. c. The resident's cognitive status, including ability to correctly identify medications and know for which conditions s/he is taking the medication. 3. Appropriate documentation of the determinations will be documented in the resident's medical record and care plan. <p>Resident 104 was admitted to the facility on [DATE] with diagnoses including left arm fracture and left lower leg fracture following a motor vehicle accident.</p> <p>A review of Resident 104's 4/16/25 Admission MDS revealed she/he was cognitively intact.</p> <p>On 4/21/25 at 11:39 AM two bottles of Balance of Nature Veggies and Fruit, one bottle of Ashwaganda supplements and one bottle of Systane eye drops were observed on the resident's bedside table. Resident 104 stated her family brought in her vitamins and eye drops from home several weeks ago. Resident 104 stated she/he took three veggie gummy and three fruit gummy vitamins daily, an Ashwaganda supplement at night to help her/him sleep, and one to two eye drops in each eye multiple times a day for dry eyes.</p> <p>On 4/22/25 at 9:23 AM two bottles of Balance of Nature Veggies and Fruit, one bottle of Ashwaganda supplements and one bottle of Systane eye drops were again observed on the resident's bedside table. Resident 104 stated she/he had these vitamins on the bedside table for several weeks without any issues from the staff.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's clinical record revealed no evidence of a self-administration of medication assessment.</p> <p>On 4/23/25 at 2:41 PM Resident 104 stated the nurse took her vitamins and said she/he needed a doctor's order to continue to receive the vitamins in the facility. The Systane eye drops were observed to still be on the bedside table.</p> <p>On 4/24/25 at 4:53 PM Staff 5 (LPN Unit Manager) stated once the facility was aware that Resident 104 had vitamins from home, Resident 104 was offered the ability to self-administer medications. Staff 5 acknowledged Resident 104 previously had vitamins and still had the Systane drops on her/his bedside table, and the self-administration evaluation was not completed.</p> <p>On 4/25/25 at 2:36 PM Staff 2 (DNS) stated she expected residents to have a physician order and to have an assessment to self-administer medication completed prior to self-administering medication.</p>

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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>48830</p> <p>Based on interview and record review it was determined the facility failed to administer bowel care medication and ensure physician orders related to bowel care were followed for 1 of 5 sampled residents (#4) reviewed for unnecessary medications. This placed residents at risk for adverse outcomes related to constipation. Findings include:</p> <p>A review of the facility's undated constipation protocol revealed to administer the following orders:</p> <ul style="list-style-type: none"> -milk of magnesia 30mL PO PRN daily. -MiraLAX 17 grams mix with four-eight oz of fluid PO PRN daily OR Senna-Colace 8.6mg/50mg two tablets PRN daily. -Bisacodyl five-10 mg extended-release tablets PRN daily. -Bisacodyl 10mg PRN daily. -Then add Fleet Enema PRN daily. -Notify physician if >4 days since last BM. <p>Resident 4 was admitted to the facility in 5/2022 with diagnoses including dementia and multiple sclerosis.</p> <p>The 2/22/25 Quarterly MDS indicated Resident 4's cognition was severely impaired.</p> <p>The 12/12/24 care plan indicated Resident 4 was to be monitored for side effects of constipation and to keep the physician informed of any problems.</p> <p>A 3/20/25 physician order indicated the use of Dulcolax Suppository as needed every 24 hours for constipation and to notify the physician after four days of no bowel movement.</p> <p>A review of Resident 4's bowel record indicated no bowel movement from 3/24/25 to 3/30/25 (seven days) and from 4/6/25 to 4/10/25 (five days).</p> <p>A review of the 3/2025 MAR revealed a Dulcolax Suppository was administered on 3/30/25 (seven days after last bowel movement).</p> <p>A review of the 4/2025 MAR revealed no indication Resident 4 received as needed bowel care medication.</p> <p>A review of Resident 4's medical record revealed no documentation of monitoring bowel movements or implementing the facility bowel protocol and no indication the physician was notified after four or more days of no bowel movement for both occurrences.</p> <p>(continued on next page)</p>		

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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>On 4/28/25 at 10:52 AM Staff 20 (Agency RN) stated all residents were monitored for constipation after three days of no bowel movement and the facility bowel protocol was implemented.</p> <p>On 4/28/25 at 11:58 AM Staff 6 (RNCM) stated staff were to follow the facility bowel care protocol. Staff 6 was asked to provide evidence that the bowel care protocol was followed. No additional information was provided.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>49377</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received vision treatment and services for 1 of 2 sampled residents (#27) reviewed for vision. This placed residents at risk for vision loss. Findings include:</p> <p>Resident 27 was admitted to facility on 4/2021 with diagnoses including diabetes.</p> <p>A 12/17/24 Eye Exam Summary indicated a diagnosis of combined forms of age-related cataract - bilateral. Planning on cataract surgery. The summary instructed to hold off on glasses until after cataract surgery.</p> <p>No additional documentation was found to indicate the facility followed up on the recommendation for cataract surgery.</p> <p>A 3/21/25 Significant Change MDS documented a BIMS score of 14, indicating Resident 27 was cognitively intact.</p> <p>On 4/21/25 at 11:14 AM and on 4/21/25 at 12:40 PM Resident 27 stated her/his vision was not good. and was supposed to have her/his cataracts removed. Resident 27 said it was a while ago and no one talked to her/him about the surgery since then.</p> <p>On 4/23/25 at 2:14 PM Staff 13 (Social Services Director) stated she talked with Resident 27 about her/his vision concerns and was aware Resident 27 was anticipating cataract surgery. Staff 13 stated the unit manager would typically schedule follow-up visits, but the facility did not have a unit manager for some time. Staff 13 stated there was a lot of staff turnover and it fell through the cracks.</p> <p>On 4/24/25 at 2:06 PM Staff 6 (RNCM) reviewed Resident 27's 12/17/24 Eye Exam Summary and acknowledged the facility did not follow up with scheduling Resident 27's cataract surgery.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received required dialysis care including post-dialysis assessments for 1 of 1 sampled resident (#28) reviewed for dialysis. This placed residents at risk for dialysis complications. Findings include:</p> <p>Resident 28 was admitted to the facility in 10/2023 with diagnoses including end-stage renal disease and dependence on dialysis (a medical treatment that removes waste products from the blood when the kidneys are not working properly).</p> <p>Resident 28's 11/1/24 Annual MDS indicated the resident was cognitively intact and received dialysis.</p> <p>A review of the 3/20/25 physician order indicated the resident received dialysis on Mondays, Wednesdays, and Friday's. The physician order also indicated a post-dialysis assessment was to be completed when the resident returned to the facility from dialysis.</p> <p>A review of Resident 28's medical record revealed the last completed post-dialysis assessment evaluation was on 3/24/25. There was no indication the resident was assessed post-dialysis on the following dates: -3/26/25, 3/28/25, 3/31/25, 4/2/25, 4/4/25, 4/7/25, 4/9/25, 4/11/25, 4/14/25, 4/16/25, 4/18/25, 4/21/25, and 4/23/25 (13 days).</p> <p>On 4/22/25 at 9:10 AM Resident 28 stated she/he had dialysis on Mondays, Wednesdays, and Fridays. Resident 28 stated the facility nurse did not assess her/him upon return to the facility.</p> <p>On 4/28/25 at 10:52 AM Staff 20 (Agency RN) stated when Resident 28 returned from dialysis she looked at the paperwork that returned with the resident and entered any new orders, then the resident goes about her/his business. Staff 20 stated she did not always document if she assessed the resident post-dialysis.</p> <p>On 4/28/25 at 11:48 AM Staff 5 (LPN Unit Manager) acknowledged the identified dates with no documentation of a post-dialysis assessment of Resident 28. He stated he expected nursing staff to assess the resident, including the dialysis access site, and to document in the resident's medical record after each dialysis treatment.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure sufficient staffing to meet resident care needs for 3 of 3 halls reviewed for staffing. This placed residents at risk for delayed and unmet care needs. Findings include:</p> <p>On 4/23/25 the facility provided a list of residents who:</p> <ul style="list-style-type: none"> -Required assistance with mechanical lifts: 18 -Required two person assistance with ADLs: 4 -Required assistance with eating: 5 -Had behaviors: 10 <p>The 3/24/25 Facility Assessment indicated to continue to analyze and review specific times and circumstances where additional or directed staffing needed. Admin and/or DNS assure appropriate staffing levels for compliance.</p> <p>a. A review of the Direct Care Staff Daily Reports from 8/1/24 through 8/31/24 revealed the facility had insufficient CNA staff, per state minimum requirements, for one or more shifts on the following dates:</p> <ul style="list-style-type: none"> -8/3/24 -8/9/24 -8/14/24 <p>A review of the Direct Care Staff Daily Reports from 3/20/25 through 4/20/25 revealed the facility had insufficient CNA staff, per state minimum requirements, for one or more shifts on the following dates:</p> <ul style="list-style-type: none"> -3/24/25 -4/6/25 -4/7/25 -4/9/25 -4/10/25 -4/12/25 <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-4/13/25</p> <p>-4/15/25</p> <p>-4/16/25</p> <p>b. A public complaint received on 4/11/25 alleged the call-light displayed outside of Resident 252's room was obstructed from view and resulted in long call-light wait times.</p> <p>Observations from 4/21/25 through 4/28/25 revealed the call-light outside of Resident 252's room was obstructed by a deodorizer attached to the ceiling.</p> <p>An interview on 4/23/25 at 11:08 AM with Staff 26 (LPN) revealed the call-light for Resident 252 was not visible for staff and resulted in long call-light wait times.</p> <p>c. Observations and interviews with residents and family revealed the following concerns:</p> <p>-On 4/21/25 at 3:14 PM Witness 5 (Family) stated she visited often on Sundays and observed staff to be running back and forth to resident rooms.</p> <p>-On 4/22/25 at 2:27 PM room [ROOM NUMBER]'s call light was activated and answered at 2:50 PM (23 minutes).</p> <p>-On 4/23/25 at 7:31 PM room [ROOM NUMBER]'s call light was activated and answered at 8:00 PM (29 minutes).</p> <p>-On 4/23/25 at 7:31 PM room [ROOM NUMBER]'s call light was activated and answered at 8:00 PM (29 minutes).</p> <p>-On 4/23/25 at 7:32 PM room [ROOM NUMBER]'s call light was activated and answered at 7:53 PM (21 minutes) by two CNAs. Both CNAs did not exit room [ROOM NUMBER] until 8:55 PM (58 minutes of care were provided to the resident).</p> <p>-On 4/23/25 at 7:35 PM room [ROOM NUMBER]'s call light was activated and answered at 9:13 PM (1 hour 38 minutes).</p> <p>-On 4/23/25 at 7:52 PM room [ROOM NUMBER]'s call light was activated and answered at 8:20 PM (28 minutes).</p> <p>-On 4/23/25 at 8:03 PM room [ROOM NUMBER]'s call light was activated and answered at 9:07 PM (1 hour 4 minutes).</p> <p>-On 4/23/25 at 8:16 PM room [ROOM NUMBER]'s call light was activated and answered at 9:42 PM (1 hour 26 minutes). An interview on 4/22/25 at 9:24 AM with Witness 4 (family) stated the resident experienced long wait times to be transferred from his/her wheelchair to bed after dinner.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-On 4/23/25 at 8:17 PM room [ROOM NUMBER]'s call light was activated and answered at 8:40 PM (23 minutes). On 4/23/25 at 8:48 PM Resident 108 said she/he needed help putting on pants and regularly experienced long wait times in the evening.</p> <p>-On 4/23/25 at 8:18 PM room [ROOM NUMBER]'s call light was activated and answered at 8:59 PM (41 minutes).</p> <p>-On 4/23/25 at 8:26 PM room [ROOM NUMBER]'s call light was activated and flashed continuously. At 8:36 PM the resident was heard through the closed door screaming, Hey! At 8:48 PM the call light was answered (22 minutes).</p> <p>-On 4/23/25 at 8:33 PM room [ROOM NUMBER]'s call light was activated and answered at 9:01 PM (28 minutes).</p> <p>-On 4/23/25 at 9:07 PM room [ROOM NUMBER]'s call light was activated and answered at 9:34 PM (27 minutes).</p> <p>-On 4/23/25 at 9:09 PM room [ROOM NUMBER]'s call light was activated and answered at 9:38 PM (29 minutes).</p> <p>-On 4/23/25 at 9:22 PM room [ROOM NUMBER]'s call light was activated and answered at 9:43 PM (21 minutes).</p> <p>d. Interviews with staff revealed the following concerns:</p> <p>-On 4/21/25 at 12:19 PM Staff 32 (CNA) stated the acuity was high on the floor and typically cannot complete all tasks when works day and evening shifts.</p> <p>-On 4/23/25 at 7:48 PM Staff 11 (CNA) and Staff 12 (CNA) stated it was just the two of them assigned to the entire 300 hall. Staff 11 and Staff 12 stated they were running back and forth and tried to prioritize helping the residents who yelled for help. Staff 11 and Staff 12 were observed to be out of breath, sweaty and walked briskly from room to room.</p> <p>-On 4/23/25 at 8:10 PM Staff 31 (Agency CNA) stated she worked evening shifts, and it was common for the facility run short-staffed.</p> <p>On 4/28/25 at 10:07 AM Staff 33 (Scheduling Coordinator) stated she staffed the floor based off the daily census. She stated if a staff called off shift she sent a mass message to the floor staff and offered bonuses. Staff 33 stated she also utilized staffing agency companies and a PRN staff pool.</p> <p>On 4/28/25 at 2:35 PM Staff 1 (Administrator) acknowledged the staffing shortages and long call lights.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to ensure a registered nurse was available for at least eight consecutive hours, seven days a week for 13 of 91 days reviewed for RN coverage. This placed residents at risk for lack of RN oversight including nursing assessments. Findings include:</p> <p>A review of the Direct Care Staff Daily Reports from 8/1/24 through 8/31/24, 9/1/24 through 9/30/24, and 3/20/25 through 4/20/2025 revealed the following dates with no RN coverage:</p> <p>-8/4/24</p> <p>-8/9/24</p> <p>-8/10/24</p> <p>-8/13/24</p> <p>-8/16/24</p> <p>-8/17/24</p> <p>-8/20/24</p> <p>-8/22/24</p> <p>-8/25/24</p> <p>-8/28/24</p> <p>-9/4/24</p> <p>-9/6/24</p> <p>-9/8/24</p> <p>On 4/28/25 at 2:35 PM Staff 1 (Administrator) acknowledged the identified dates without the required RN coverage.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005</p> <p>Based on interview and record review it was determined the facility failed to provide timely pharmaceutical services for 1 of 2 sampled residents (#102) reviewed for pain. This placed residents at risk for untreated medical needs. Findings include:</p> <p>Resident 102 admitted to the facility on [DATE] with diagnoses including right ankle fracture and candidal stomatitis (oral thrush).</p> <p>A review of Resident 102's 4/10/25 Admission orders revealed an order for Magic Mouthwash - lidocaine/Maalox/Diphenhydramine Liquid to be given four times a day for throat pain.</p> <p>A review of Resident 102's April MAR indicated the Magic Mouthwash was marked not available from 4/10/25 to 4/23/25.</p> <p>On 4/23/25 at 1:35 PM Resident 102 stated she/he did not recall receiving the Magic Mouthwash.</p> <p>On 4/23/25 at 8:19 PM Staff 21 (Agency LPN) stated she contacted the pharmacy and notified the provider the medication was not available on 4/14/25 and again on 4/15/25, the days she worked.</p> <p>On 4/25/25 at 11:34 AM Staff 8 (Pharmacist) stated the pharmacy contacted the facility on 4/14/25 regarding the Magic Mouthwash medication ratios in order to compound and dispense the medication. Staff 8 stated the pharmacy did not receive a response from the facility and the Magic Mouthwash was not delivered to the facility until 4/25/25.</p> <p>On 4/25/25 at 2:19 PM Staff 2 (DNS) acknowledged Resident 102 did not receive the medicated mouthwash as ordered. Staff 2 stated she expected staff to call the pharmacy if a resident's medication was not available and to follow-up with the provider.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>52547</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure a medication error rate of less than five percent. There were 2 errors out of 26 medication administration opportunities resulting in a 7.69% error rate. This placed residents at risk for reduced medication efficacy and feeding tube complications. Findings include:</p> <p>The facility's Pharmacy Services Medication Administration dated 3/2023 specified crushed medications will not be combined to give multiple medications at once, whether administered orally or via a feeding tube.</p> <p>Resident 47 was admitted to the facility in 3/2025 with diagnoses including an inability to swallow following a stroke.</p> <p>Resident 47's 4/2025 Physician Orders included the following:</p> <ul style="list-style-type: none"> -metoprolol tartrate (medication for high blood pressure) 25 mg, give one tablet via PEG-Tube two times a day -atorvastatin calcium (medication for high cholesterol) 40 mg, give one tablet via PEG-Tube one time a day <p>On 4/24/25 at 9:52 AM Staff 10 (LPN) administered medications to Resident 47 via feeding tube. Staff 10 crushed one tablet of atorvastatin and one tablet of metoprolol together and administered the combination through the feeding tube.</p> <p>On 4/24/25 at 9:52 AM Staff 10 acknowledged that she crushed, combined, and administered the two medications to Resident 47 via feeding tube. Staff 10 expressed she was not aware that multiple medications were not to be crushed and administered at the same time.</p> <p>On 04/25/25 1:36 PM Staff 2 (DNS) reported medications should be given separately between flushes.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>47005</p> <p>Based on interview and record review it was determined the facility failed to obtain lab samples for 1 of 5 sampled residents (#21) reviewed for unnecessary medications. This placed residents at risk for lack of treatment. Findings include:</p> <p>Resident 21 was admitted to the facility in 9/2022 with diagnoses including multiple sclerosis and slow transit constipation.</p> <p>A review of Resident 21's 4/2025 Physician Orders revealed an order to collect stool sample and complete IFOBT test - screening for colo-rectal cancer-Optum to provide the kit with an order start date of 11/19/24.</p> <p>On 4/23/25 at 12:43 PM Staff 18 (CNA) stated Resident 21 was incontinent of bowels and needed bowel care routinely during the day and/or evening shift. Staff 18 stated the charge nurse alerted CNAs if the resident was the bowel list or needed a stool sample for collection. Staff 18 stated she did not recall Resident 21 needing her/his stool sample to be collected.</p> <p>On 4/24/25 at 2:48 PM Staff 10 (LPN) stated it was difficult to collect a stool sample from Resident 21 due to the test requiring three stool samples from the resident. Staff 10 stated the CNAs were to collect the sample and the nurse was to send in the sample to the lab for testing. Staff 10 stated she only worked three days a week and was unsure if it was communicated to the CNAs that a stool sample was needed from Resident 21.</p> <p>On 4/24/25 at 4:59 PM Staff 5 (LPN Unit Manager) stated he expected the charge nurse to communicate orders such as the need for stool samples at the beginning of each shift to the CNAs.</p> <p>On 4/25/25 at 2:26 PM Staff 2 (DNS) stated she expected physician orders to be followed in a timely manner, and if they were unable to be completed the physician would be notified.</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005</p> <p>Based on observation, interview, and record review it was determined the facility failed to identify, assess, treat, and implement contact precautions for residents with symptoms of clostridioides difficile (c-diff, a bacterium that can cause severe diarrhea and inflammation of the colon) and failed to utilize appropriate contact precautions to prevent the spread of c-diff for 4 of 4 sampled residents (#s 31, 32, 40 and 109) with diagnoses of c-diff. This failure, determined to be an Immediate Jeopardy situation, placed all residents at risk for exposure to c-diff, which is highly contagious and requires treatment including the use of a toxic anti-infective medication with potential to cause serious side effects. Findings include:</p> <p>According to the Centers for Disease Control and Prevention (CDC) website (https://www.cdc.gov/c-diff/prevention/index.html), washing your hands with soap and water is the best way to prevent hte spread of c-fiff from person to person. Healthcare professionals are to clean their hands before and after caring for residents with c-diff.</p> <p>1. Resident 31 admitted to the facility in 2024 with diagnoses including chronic obstructive pulmonary disease.</p> <p>Bowel records from 4/9/25 through 4/16/25 indicated Resident 31's bowel movements were loose/diarrhea each time the resident had a bowel movement.</p> <p>A 4/11/25 progress note indicated Resident 31 had abdominal discomfort.</p> <p>There were no progress notes from 4/12/25 through 4/14/25.</p> <p>A 4/15/25 progress note indicated Resident 31 had abdominal discomfort.</p> <p>No evidence was found in the resident's clinical record to indicate the resident was assessed or the physician was contacted regarding the resident's consistent loose stools/diarrhea.</p> <p>A 4/16/25 progress note indicated Resident 31 was sent to the hospital for difficulty breathing.</p> <p>A 4/21/25 hospital discharge summary indicated Resident 31 was diagnosed with c-diff on 4/19/25.</p> <p>A 4/21/25 progress note indicated Resident 31 returned to the facility.</p> <p>The 4/22/25 care plan for c-diff indicated Resident 31 was on isolation precautions for c-diff.</p> <p>On 4/23/25 at 7:53 PM Staff 17 (Agency CNA) was observed to don a gown and gloves to assist another CNA to provide pericare for Resident 31. On 4/23/25 at 8:08 PM Staff 17 was observed to doff gloves and gown while exiting Resident 31's room. Staff 17 then walked to the 100 hallway, donned gloves, and retrieved a shower chair. Staff 17 acknowledged she did not wash her hands after leaving Resident 31's room. Staff 17 stated she was aware that Resident 31 was on precautions because of the sign on the door.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 4/23/25 at 8:48 PM Staff 24 (LPN) was observed to doff a gown and gloves while exiting Resident 31's room. Staff 24 used an alcohol-based hand rub (ABHR), then picked up a water pitcher and headed toward another resident's room. Staff 24 stated he was not aware he needed to wash his hands with soap and water after exiting Resident 31's room, and thought ABHR was enough.</p> <p>On 4/24/25 at 11:48 AM Staff 25 (LPN) stated after residents had three reported loose stools, it was charted in the medical record, and the resident was to be assessed for bowel tones and symptoms, and reported to the provider.</p> <p>On 4/24/25 at 1:50 PM these findings were shared with Staff 2 (DNS). Staff 2 indicated residents with repeated loose stools were to be assessed for the need to contact a physician and to determine if contact precautions were needed. Staff 2 acknowledged there were concerns with staff not following appropriate infection control practices for residents with c-diff.</p> <p>2. Resident 32 admitted to the facility in 4/2024 with diagnoses including Parkinson's Disease and stroke.</p> <p>Bowel records from 4/4/25 through 4/17/25 indicated Resident 32's bowel movements were loose/diarrhea most of the time the resident had a bowel movement.</p> <p>No evidence was found in the resident's clinical record to indicate the resident was assessed or the physician was contacted regarding the resident's consistent loose stools/diarrhea.</p> <p>A 4/17/25 progress note indicated Resident 32 was sent to the hospital for weakness and confusion.</p> <p>A 4/17/25 hospital visit note indicated Resident 32 was diagnosed with c-diff on 4/17/25.</p> <p>A 4/21/25 progress note indicated Resident 32 returned to the facility and was placed on alert.</p> <p>The 4/22/25 care plan for c-diff indicated Resident 32 was on isolation precautions for c-diff.</p> <p>On 4/24/25 at 3:42 PM Staff 31 (Agency CNA) was observed to don gloves and a gown and then enter Resident 32's room. At 3:48 PM Staff 31 exited Resident 32's room with PPE doffed and Staff 31 used an alcohol-based hand rub (ABHR). Staff 31 was then observed to enter the visitor's bathroom and exit.</p> <p>On 4/24/25 at 3:49 PM Staff 31 stated she was aware Resident 32 was on contact precautions and she needed to wash her hands with soap and water after care was provided. Staff 31 stated she did not wash her hands with soap and water before exiting the resident's room because she was told to not use the resident's bathroom, but to wash her hands in the closest bathroom after exiting the resident's room, which was the visitor's bathroom.</p> <p>During multiple interviews with Staff 2 (DNS) on 4/24/25, Staff 2 acknowledged the staff were unclear regarding how to properly sanitize their hands after leaving the rooms of residents with c-diff.</p> <p>3. Resident 40 admitted to the facility in 2/2025 with diagnoses including stroke and cellulitis of left leg (a bacterial infection beneath the skin).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Bowel records from 4/14/25 through 4/20/25 indicated Resident 40's bowel movements were loose/diarrhea each time the resident had a bowel movement.</p> <p>A 4/17/25 provider progress note indicated Resident 40 was assessed by the physician assistant for a follow-up visit for lower extremity cellulitis. There was no indication the provider was aware or informed Resident 40 had loose/diarrhea for several days.</p> <p>A 4/20/25 progress note indicated Resident 40 had a fall while rushing to the bathroom due to diarrhea. Resident 40 was sent to the hospital for an elevated temperature and three loose bowel movements earlier in the day.</p> <p>On 4/24/25 at 10:50 AM Staff 27 (Admission Director) stated Resident 40 was admitted to the hospital with a new diagnosis of c-diff, and stated the the infection was acquired in the facility prior to the resident's hospital admission.</p> <p>4. Resident 109 admitted to the facility on [DATE] with diagnoses including multiple falls, and a chronic upper abdominal wound.</p> <p>A 4/15/25 progress note indicated Resident 109 reported severe and abrupt abdominal pain.</p> <p>A 4/23/25 hospital discharge summary indicated Resident 109 was diagnosed with c-diff on 4/22/25.</p> <p>A 4/23/25 progress note indicated Resident 109 returned to the facility.</p> <p>The 4/24/25 care plan for c-diff indicated Resident 109 was on isolation precautions for c-diff.</p> <p>On 4/23/25 at 7:45 PM Staff 11 (CNA) was observed to exit Resident 109's room, which was identified as a contact precautions room. Staff 11 used an alcohol-based hand rub (ABHR) and then entered another resident's room, which was not identified with any transmission-based precautions.</p> <p>On 4/23/25 at 7:46 PM Staff 12 (CNA) exited Resident 109's room, used ABHR, and entered the clean linen closet to retrieve clean linens.</p> <p>On 4/23/25 at 7:48 PM Staff 11 stated the contact precautions signage on Resident 109's room indicated staff needed to do hand cleaning. When asked what type of hand cleaning, Staff 11 pointed to the ABHR dispenser. Staff 11 stated she was too busy answering call lights and assisting residents, and did not have time to do any other type of hand cleaning, specifically with soap and water. Staff 12 acknowledged contact precautions indicated staff were to wash their hands in a sink with soap and water. Staff 12 acknowledged she used ABHR and did not wash her hands with soap and water prior to handling clean linens and providing care to other residents. Staff 12 stated she was too busy providing resident care and answering call lights to walk down the hall and around the corner to the soiled utility room to wash her hands with soap and water.</p> <p>On 4/24/25 at 11:48 AM Staff 25 (LPN) stated after residents had three reported loose stools, it was charted in the medical record, the resident was assessed for bowel tones and symptoms, and it was reported to the physician.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 4/24/25 at 1:50 PM Staff 2 (DNS) indicated residents with repeated loose stools were to be assessed for the need to contact a physician and to determine if contact precautions were needed. Staff 2 acknowledged there were concerns with staff not following appropriate infection control practices for residents with c-diff.</p> <p>On 4/24/25 at 1:50 PM Staff 2 and Staff 1 (Administrator) were informed the facility's failure to implement appropriate precautions to prevent the spread of c-diff constituted an Immediate Jeopardy situation. An IJ removal plan was requested.</p> <p>On 4/24/25 at 4:08 PM an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> - Identification and assessment of any residents with suspected c-diff. Any affected residents were placed on contact precautions with appropriate signage posted, and reviewed by a physician. - Shared equipment was sanitized or removed from use by affected residents. - Affected residents would be monitored daily. - Staff currently working were inserviced on c-diff precautions and infection control practices. - Oncoming staff would be inserviced prior to their shift. - Nurses were inserviced on assessing residents with signs and symptoms of c-diff. - Daily PPE competency testing would be conducted. - Daily and weekly infection control audits and monitoring. - Weekly reporting to QAPI. - Monthly governing body review. - Immediate retraining and disciplinary action for non-compliant staff members. <p>The immediacy was removed on 4/26/25 after onsite verification of the IJ removal plan.</p>		