STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385136	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glisan Post Acute	9750 NE Glisan Street Portland, OR 97220

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41458 Based on observation and interview it was determined the facility failed to ensure shower rooms were clean and in good repair for 1 of 3 shower rooms and to accommodate residents with wheelchair arm rests in proper cleanable order for 2 of 7 sampled residents (#28 and 40) reviewed for environment. This placed residents at risk for lack of a clean and homelike environment and with personal equipment in disrepair. Findings include: 1. Multiple random observations from 11/18/24 through 11/20/24 between the hours of 8:00 AM and 4:00 PM revealed the shower on the TCU (Transitional Care Unit) had a black colored substance along the entire metal floor board edging, the left front corner of the shower's flooring had several deep cracks with black substance in the cracks, the overhead fan had a layer of dirt/dust in all vents and made a loud grinding noise. On 11/20/24 at 9:03 AM Staff 14 (Housekeeping Supervisor) confirmed the TCU shower floor board edging was rusted and could not be cleaned, the left corner flooring was cracked and not cleanable and the fan was dirty. Staff 14 acknowledged the TCU shower was not clean or home like. 38140 2. On 11/18/24 at 10:46 AM Resident 28's left wheelchair arm rest was observed with the black covering torn and about three inches of foam exposed. The surface was in disrepair and uncleanable. Resident 40's left wheelchair arm rest was observed with black tape peeled back from the arm rest. The surface was not cleanable under the peel back tape. On 11/20/24 at 10:27 AM Staff 12 (Maintenance Assistant) acknowledged the residents' wheelchairs which need to be fixed were reported the maintenance department to fix. Staff 12 confirmed Resident 28's and Resident 40's wheelchair arm rests were in poor condition. On 11/20/24 at 11:01 AM Staff 2 (DNS) confirmed Resident 28's and Resident 40's wheelchair arm rests were in poor condition and not cleanable.

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: 385136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50927 Based on interview and record review it was determined the facility failed to initiate a grievance process for 1 of 2 sampled residents (#169) reviewed for personal property. This placed residents at risk for unaddressed concerns. Findings include: Resident 169 admitted to the facility in 10/2024 with diagnoses of displaced intertrochanteric fracture of left femur and schizophrenia. On 11/18/24 at 12:27 PM Resident 169 stated after he/she arrived staff took her/his clothes to the laundry and did not return them. Resident 169 stated to several staff members that her/his clothing items were missing. Resident 169's 10/31/24 inventory sheet revealed Resident 169 admitted with a shirt, underpants and jeans. On 11/21/24 at 9:54 AM Staff 14 (Housekeeping Supervisor) stated if a resident reported a missing item staff looked for the item. If the item was not found, staff would assist the resident to fill out a grievance form. Staff 14 indicated she/he was not aware Resident 169 was missing clothing. On 11/21/24 at 12:34 PM Staff 22 (CNA) stated resident 169 mentioned her/his clothing was missing, but she did not report it to anyone. On 11/21/24 at 12:58 PM Staff 2 (Director of Nursing) stated if a resident voiced concern regarding missing clothing, staff were to check the inventory sheet and look for the missing items. If items were not found CNAs were to start a grievance and the resident would be reimbursed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services in the area of communication for 1 of 2 sampled residents (#9) reviewed for communication. This placed residents at risk for diminished quality of life and potential decline in their ability to carry out activities of daily living. Findings include: Resident 9 was admitted to the facility in 10/2019 with diagnoses including hemiparesis (partial weakness on one side of the body) and hemiplegia (complete paralysis on one side of the body) following a stroke affecting the left non-dominant side. Resident 9's 9/11/24 Annual MDS Assessment indicated the resident was moderately cognitively impaired, experienced moderate difficulty hearing, the resident's preferred language was Vietnamese and she/he wanted an interpreter to communicate with health care staff. The Communication CAA indicated staff who communicated with the resident needed to elevate their voice, face the resident and minimize background noise due to her/his hearing impairment. Resident 9's 10/2/24 Communication Care Plan revealed the following: -Language: Vietnamese. -The resident was mostly non-English speaking. She/he could say certain simple words. -Telephone interpreter: (503) [PHONE NUMBER]. -The resident could communicate her/his needs. Use interpreter as needed for medical needs. -The resident was to have access to cue cards for communication assistance. On 11/18/24 at 11:32 AM Resident 9 was observed to sit in her/his wheelchair in her/his room. No communication cue cards were observed in the resident's room. The state surveyor communicated with the resident in English, and the resident was able to nod her/his head in response to some basic yes or no questions but was unable to answer specific questions about how long she/he had lived at the facility, the care she/he received at the facility or her/his daily routine. On 11/18/24 at 11:43 AM, 11/18/24 at 2:42 PM and 11/19/24 at 8:55 AM the state surveyor called the phone number listed in Resident 9's Care Plan for an interpreter. On each occasion, the phone did not ring and the screen on the phone read user busy. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:49 PM Resident 9 was observed in her/his room in bed. No communication cue cards were observed in the resident's room. With the use of the state's translation service, an interview was conducted with the resident in Vietnamese. Resident 9 stated she/he could only speak and understand a little English and the folks here spoke English. Resident 9 stated there was only one staff person she/he was able to communicate with as this staff person spoke Vietnamese. Resident 9 stated she/he was hard of hearing and needed staff to speak slowly and elevate their voice. Resident 9 stated she/he sometimes could not hear or understand the people who take care of me but I pretend to. Resident 9 did not know what a communication cue card was or if she/he had one. On 11/20/24 at 9:41 AM Staff 23 (CNA) stated Resident 9 primarily spoke Vietnamese, she did not necessarily use a translation service when communicating with the resident and she had never seen cue cards for the resident. On 11/20/24 at 9:52 AM Staff 28 stated Resident 9 did not really speak English. Staff 28 stated she never used a translator when communicating with the resident and did not know if the facility had a translation service available. Staff 28 stated she had never seen a cue board used with Resident 9. Staff 28 further stated she thought the resident's hearing was good and she just spoke loud when [the resident] couldn't understand. On 11/20/24 at 11:09 AM Staff 21 (CNA) stated Resident 9 had trouble hearing people with a quieter voice. Staff 21 stated she found information about a resident's hearing impairment and related interventions in the resident's care plan. On 11/20/24 at 2:38 PM and 3:19 PM Staff 6 (RNCM) stated she put a picture board in Resident 9's room about a month ago to help with communication but thought the resident's roommate took it shortly after it was provided and it was never replaced. Staff 6 stated the resident experienced difficulty hearing and interventions including repeating questions, face to face, eliminating loud noises and elevate voice should be in her/his care plan but were not. On 11/20/24 at 2:53 PM Staff 2 (DNS) confirmed the phone number for the translation service listed in Resident 9's care plan did not work, the resident's care plan was missing necessary interventions related to her/his hearing impairment and communication cue cards were not available to the resident and should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47000 Based on observation, interview and record review it was determined the facility failed to provide adequate bathing for 1 of 3 sampled residents (#37) reviewed for ADLs. This placed residents at risk for unmet hygiene needs. Findings include: Resident 37 was admitted to the facility in 11/2023 with diagnoses including neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Resident 37's 8/25/24 Quarterly MDS Assessment indicated the resident was cognitively intact and dependent upon staff assistance for showers/bathing. Resident 37's 9/23/24 ADL Care Plan revealed the resident was to receive showers on Monday and Friday evenings. Resident 37's 10/25/24 through 11/18/24 Bathing Task sheet revealed the following: -10/25/24, Friday: not applicable. -11/4/24, Monday: resident refused. No documentation was found to indicate the resident was reoffered a shower during the shift, the resident's refusal was reported to the nurse or the resident was reoffered a shower on an alternative shift. -11/8/24, Friday: not applicable. -11/11/24, Monday: resident refused. No documentation was found to indicate the resident was reoffered a shower during the shift, the resident's refusal was reported to the nurse or the resident was reoffered a shower on an alternative shift. -11/18/24, Monday: not applicable. On 11/18/24 at 12:33 PM Resident 37 was observed in her/his room and sat in her/his wheelchair. Resident 37 stated she/he was lucky if [she/he] got a shower once every two weeks. Resident 37 stated staff were always too busy to assist her/him with a shower on her/his scheduled days and they don't have time on my off days. Resident 37 stated she/he preferred showers in the afternoons, and on shower days, staff would frequently enter her/his room and say you can have one right now, right now, without any warning. Resident 37 stated she/he needed time to prepare, and if she/he refused, she/he would not be offered a shower at a different time during the shift. Resident 37 further stated she/he was occasionally told she/he could not shower because the shower was broken. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 4:07 PM Resident 37 stated she/hetold two people today [she/he] wanted a shower and they said they hope I get one. The resident's room was observed to smell of urine and a plastic bag was observed on the floor in the corner of the room. Resident 37 stated the bag was filled with a draw sheet and wash cloths from last night. Resident 37 stated she/he used the wash cloths to wipe her/his groin area as she/he often felt moist and sticky and the wash cloths would be covered in urine and blood. On 11/21/24 at 8:15 AM Resident 37 was observed in her/his room and sat in her/his wheelchair. Resident 37 stated she/he did not receive a shower yesterday despite her/his request and stated she/he asked this morning for a shower and was told we will have to see. On 11/21/24 at 8:21 AM Staff 23 (CNA) stated CNAs were supposed to offer a resident a shower more than once if the resident refused, and if the resident continued to refuse, CNAs were to report the refusals to the nurse, document the refusals and let the next shift know so they could reoffer a shower. Staff 23 stated Resident 37 would wait to the last hour of her shift before agreeing to take a shower and then I have to tell [her/him] I don't have time. On 11/21/24 at 9:03 AM Staff 26 (CNA) stated residents were supposed to be reoffered showers two to three times, and if they still refused, CNAs were to inform the nurse. CNAs were responsible for documenting refusals, and if a CNA documented not applicable, that would indicate the shower was not offered. Staff 26 stated Resident 37 never refused showers when she worked with her/him. Staff 26 further stated other CNAs did not offer Resident 37 a shower until 8:30 PM or 9:00 PM at night because they knew the resident would refuse at those times. Staff 26 stated other CNAs did not offer showers on alternative days so residents had to wait until their next scheduled day to receive a shower. On 11/21/24 at 9:30 AM Staff 27 (RN) stated Resident 37 preferred to take her/his showers around 4:00 PM to 4:30 PM and showers were very important for the resident because she/he had a lot of folds and could be incontinent in the bed at night. On 11/21/24 at 12:44 PM Staff 2 (DNS) stated CNAs were expected to reoffer a resident a shower three times during their shift, the nurse was expected to document any continued refusals and the next shift was to do a PRN shower. Staff 2 reviewed Resident 37's clinical record, stated she did not know if the resident was offered a shower on 10/25/24, 11/8/24 or 11/18/24 and confirmed there was no documentation to indicate the resident was reoffered a shower on 11/4/24 or 11/11/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41458 Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activity program for 2 of 4 sampled dependent residents (#s 9 and 36) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's Activity Evaluation policy, dated 2/2023 and Activities Attendance policy, dated 6/2018 indicated the following: -The activity evaluation was used to develop an individualized activity care plan that allowed the resident to participate in activities of her/his choice and interest. -Each resident's activities care plan related to her/his comprehensive assessment and was reflective of the resident's individual needs. -Attendance and participation was recorded for every resident in group and individual activities on a daily basis. 1. Resident 36 was admitted to the facility in 5/2024 with diagnoses including cardiomyopathy (a disease of the heart muscle), dementia, restlessness and anxiety disorder. Resident 36's 6/11/24 Activities Initial Evaluation revealed the following: -Resident 36 wished to participate in activities while in the facility including group and independent activities such as reading and doing puzzles. -Resident 36 wished to go on outings. Resident 36's 9/5/24 Significant Change MDS revealed the resident had moderate cognitive impairments and Resident 36 considered it somewhat to very important to do the following activities: listen to music, be around animals, keep up with the news, have books, newspapers or magazines to read, do things with groups of people, do favorite activities and go outside when the weather permitted. Resident 36's 9/19/24 Activities Care Plan revealed the following: -Resident 36 had a need for activities that were consistent with her/his abilities and interests. Enjoyable and meaningful activities for Resident 36 included but were not limited to: -Bingo; -Board games; -Using her/his cell phone; -Group activities; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hair appointments; -Movies; -Nail care; -Smoke breaks; -Special events; -Television (Resident 36 liked watching the History Channel, news, science fiction, space shows and anything related to airplanes) and -Visiting with friends and family. The facility's Activity Calendar revealed the following scheduled activities: -11/18/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss 2:30 PM: Crafts -11/19/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Resident Council Meeting 2:30 PM: Resident shopping -11/20/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss 2:30 PM: Bingo -11/21/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss 2:30 PM: Crafts (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/22/24 11:00 AM: Ball Toss 2:30 PM: Bingo 3:30 PM: Movie and popcorn A review of Resident 36's 10/20/24 through 11/20/24 Independent, One to One and Group Activity Logs indicated the resident participated in no activities of any kind in the past 30 days. Random observations of Resident 36 conducted from 11/18/24 through 11/20/24 between the hours of 8:00 AM and 4:00 PM revealed the resident was typically in her/his bed with the blinds drawn. The resident was either asleep or fidgeting in her/his bed. The resident had no TV on, no music playing, and no books, newspapers or magazines in the room. The resident was seen one time up in her/his wheelchair but not engaged in any group activities and no one to one activities occurred in Resident 36's room. On 11/20/24 at 8:08 AM Staff 21 (CNA) reported she had never seen Resident 36 out of her/his bed until, yesterday, 11/19/24. Staff 21 stated she had not seen Resident 36 in any group or one to one activities and she did not notice music playing in the resident's room nor her/his TV turned on. Staff 21 reported the only activity she observed occurring with Resident 36 was sometimes her/his family visited. On 11/20/23 at 8:23 AM Staff 23 (CNA) reported she had not seen Resident 36 engaged in any group or one to one activities. She stated the resident typically was in her/his bed and occasionally the TV was on or the resident's daughter visited. Staff 23 stated Resident 36 had no other real activities. On 11/20/24 at 2:20 PM and 11/21/24 at 11:44 AM Staff 9 (Activities Director) and Staff 10 (Activities Assistant) both acknowledged they did not know Resident 36, were unaware of her/his activity preferences and the resident had not been involved in any group or one to one activities. Staff 9 and Staff 10 stated the last activity director left around the third week in 9/2024 and Staff 9 started as the Activity Director on 11/4/24, thus minimal activities occurred since 9/2024. Staff 10 stated she assisted with activities on a very part-time basis up until the last few weeks. Staff 10 stated when she assisted with activities, her primary focus was on the residents she was familiar with. 47000 2. Resident 9 was admitted to the facility in 10/2019 with diagnoses including hemiparesis (partial weakness on one side of the body) and hemiplegia (complete paralysis on one side of the body) following a stroke affecting the left non-dominant side. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 9's 9/11/24 Annual MDS Assessment indicated the resident was moderately cognitively impaired, the resident's preferred language was Vietnamese and she/he wanted an interpreter to communicate with health care staff. The MDS also indicated listening to music she/he enjoyed, having books, newspapers and magazines to read, being around pets, doing things with groups of people, going outside when the weather was good and participating in religious practices were important activities to the resident. Resident 9's 10/2/24 Activity Care Plan revealed the following: -Activity preferences included to self-propel around the facility, interact with staff and residents, traditional Vietnamese music and food and exercise class. -The resident enjoyed to get her/his nails done, play games and meet with her/his spouse and friends for worship. -The resident wanted to garden when the weather was nicer. -The resident liked to do ball toss for exercise class. Ball toss was one of her/his favorite activities. A review of Resident 9's 10/21/24 through 11/19/24 Activity Tasks which documented activity participation revealed the resident did not participate in a group, one to one or self-directed/independent activity. The facility's 11/2024 Activity Calendar revealed the following scheduled activities: -11/18/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss 2:30 PM: Crafts -11/19/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Resident Council Meeting 2:30 PM: Resident shopping -11/20/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:30 PM: Bingo -11/21/24 9:00 AM to 10:00 AM: One to one activities 11:00 AM: Ball Toss 2:30 PM: Crafts -11/22/24 11:00 AM: Ball Toss 2:30 PM: Bingo 3:30 PM: Movie and popcorn On 11/19/24 at 3:49 PM Resident 9 was observed in her/his room in bed. With the use of the state's translation service, an interview was conducted with the resident in Vietnamese. Resident 9 stated she/he could only speak and understand a little English, the folks here spoke English and the activities were all in English. Resident 9 stated she/he enjoyed listening to Vietnamese music on a music box she/he had a long time ago, but it was broken so they threw it away. Resident 9 stated she/he really liked exercise but had only been invited to the exercise group once. Resident 9 stated she/he did not get invited to the group ball toss today, but if she/he had been invited, she/he would have participated. Resident 9 stated she/he enjoyed reading the newspaper but all of the newspapers at the facility were in English. Resident 9 further stated she/he could only read large print and the newspapers were all written in small print. On 11/20/24 at 9:41 AM Staff 23 (CNA) stated Resident 9 hung out and did [her/his] own thing. Staff 23 stated she had never seen the resident read, listen to music, receive a pet visit or garden. On 11/20/24 at 9:52 AM Staff 28 (CNA) stated Resident 9 just hung out. Staff 28 stated she did not know if the resident liked pets or to read and was unsure of what type of music the resident enjoyed. Staff 28 stated the resident loved to garden but she had never seen indoor gardening offered at the facility. On 11/20/24 at 10:32 AM Staff 21 (CNA) stated Resident 9 liked group activities and wanted to be in there and participate. On 11/20/24 at 2:20 PM Staff 9 (Activities Director) stated she started to work at the facility on 11/4/24 and she had seen Resident 9 in the hallway briefly but had not had a chance to speak with [the resident] yet. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:29 PM and 11/21/24 at 11:43 AM Staff 10 (Activities Assistant) stated activity preference information from a resident's MDS assessment should go in the care plan. Staff 10 stated her interactions with Resident 9 over the past few weeks consisted of just saying hi. Staff 10 stated the resident enjoyed to get her/his nails done but she/he had not been getting them done because she did not have a key to the nail supplies. Staff 10 stated the resident enjoyed to garden but she had never tried indoor gardening, all of her interactions with Resident 9 were in English and all of the reading material she provided the resident was in English. On 11/20/24 at 3:27 PM Staff 1 (Administrator) acknowledged the findings and did not provide any additional information.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41458 Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 1 of 3 sampled residents (#16) reviewed for pain. This placed residents at risk for ongoing pain or over sedation. Findings include: Resident 16 was admitted to the facility in 10/2024 with diagnoses including chronic pain and opioid dependency (a chronic brain disease that causes a person to compulsively seek out opioid pain medications). a. An 11/2/24 Physician Order indicated Resident 16 was prescribed oxycodone (an opioid medication used for pain management) 10 mg every 4 hours as needed for severe pain of 7 to 10 out of a pain scale of 10. A review of Resident 16's 11/2024 MAR revealed the resident was administered 10 mg of oxycodone outside of the physician's parameters on the following days: -11/10/24: pain was documented as 5; -11/13/24: pain was documented as 6; -11/16/24: pain was documented as 5 and -11/20/24: pain was documented as 6. On 11/22/24 at 8:19 AM Staff 2 (DNS) reviewed Resident 16's 11/2024 MAR and acknowledged on 11/10/24, 11/13/24, 11/16/24 and 11/20/24, the resident received 10 mg of oxycodone when she/he should have received 5 mg, and confirmed Resident 16's oxycodone was administered outside of the physician ordered parameters. b. An 11/2/24 Physician Order indicated Resident 16 was prescribed oxycodone (an opioid medication used for pain management) 5 mg every 4 hours as needed for moderate pain of 4 to 6 out of a pain scale of 10. A review of Resident 16's 11/2024 MAR revealed the resident was administered 5 mg of oxycodone outside of the physician's parameters on the following days: -11/11/24: pain was documented as 7 and -11/12/14: pain was documented as 7. On 11/22/24 at 8:19 AM Staff 2 (DNS) reviewed Resident 16's 11/2024 MAR and acknowledged on 11/11/24 and 11/12/24, the resident received 5 mg of oxycodone when she/he should have received 10 mg, and confirmed Resident 16 was administered oxycodone outside of the physician ordered parameters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glisan Post Acute	9750 NE Glisan Street Portland, OR 97220

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47000 Based on observation, interview and record review it was determined the facility failed to implement interventions to prevent pressure ulcers and skin breakdown for 1 of 1 sampled resident (#37) reviewed for skin conditions. This placed residents at risk for the development of pressure ulcers and skin breakdown. Findings include: Resident 37 was admitted to the facility in 11/2023 with diagnoses including neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Resident 37's 8/25/24 Quarterly MDS Assessment revealed the resident was cognitively intact, at risk to develop pressure ulcers/injuries and to have a pressure reducing device for her/his chair. Resident 37's 11/2024 Physician Orders directed the resident to receive wound care to her/his right and left thigh rear skin tears twice daily. On 11/18/24 at 12:33 PM Resident 37 was observed in her/his room and sat on a folded towel in her/his wheelchair. Resident 37 stated she/he experienced skin irritation and breakdown on her/his bottom area and she/he did not have a cushion for her/his wheelchair so she/he had to sit on a folded towel instead. Resident 37 stated the wheelchair was uncomfortable and she/he had asked for a cushion many times and but still did not have one. Random observations of Resident 37 from 11/19/24 to 11/21/24 between 8:15 AM through 4:07 PM revealed the resident to be in bed or in her/his wheelchair. When the resident was observed in her/his wheelchair, she/he sat on a folded towel. On 11/21/24 at 8:15 AM Resident 37 stated the facility offered her/him a cushion for her/his wheelchair about four months ago but it was too thick, caused her/him to sit up too high in her/his wheelchair and was uncomfortable. Resident 37 stated she/he asked again about receiving a cushion for her/his wheelchair a few weeks ago and staff brought back the same one with a stain. Resident 37 further stated she/he asked about trying a different cushion and was told they did not know. On 11/21/24 at 8:21 AM Staff 23 (CNA) stated Resident 37 was supposed to have a cushion when up in her/his wheelchair, and the resident had regular complaints about [her/his] bottom hurting. Staff 23 further stated there were days when the resident was up in the wheelchair a majority of the day. On 11/21/24 at 9:03 AM Staff 26 (CNA) stated Resident 37 usually spent one to three hours up in her/his wheelchair during each day shift. Staff 26 stated she had never seen a cushion in the resident's wheelchair but had seen the resident sit on bath blankets instead. On 11/21/24 at 9:30 AM Staff 27 (RN) stated Resident 37 should sit on a cushion every time [she/he] was in the wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 12:44 PM Staff 2 (DNS) reviewed Resident 37's clinical record, confirmed she/he was at risk for the development of pressure ulcers/injuries and stated the resident should have a cushion for her/his wheelchair.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

47000

Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to prevent further decreases in range of motion for 2 of 3 sampled residents (#s 9 and 10) reviewed for position and mobility. This placed residents at risk for worsening contractures (a permanent tightening of the muscle, tendons and skin causing the joint to shorten and stiffen) and conditions. Findings include:

The facility's 8/2024 Restorative Nursing Policy and Procedure revealed the following:

-On-going assessment of each resident's functional status occurred no less often than quarterly with completion of the MDS.

-If the Resident Care Manager or licensed staff determined the resident had the ability to improve in one or more area of communication, mobility, range of motion, ADL performance, eating or toileting, a therapy referral or restorative nursing referral was initiated.

-If the resident expressed a desire to improve in one or more area of communication, mobility, range of motion, ADL performance, eating or toileting, a restorative nursing referral was initiated.

-If the Resident Care Manager or licensed staff determined the resident needed to maintain current function in communication, mobility, range of motion, ADL performance, eating or toileting, a restorative nursing referral was initiated.

-The restorative nursing referral documented the resident's current functional status, need to improve or maintain functional status, recommended goals, approaches and plan for periodic re-evaluation of the program. Restorative nursing programs were added to the appropriate nursing care plan and in-room care plan.

-Residents with the need to improve functional status were re-evaluated monthly to determine effectiveness of the current interventions and need to revise goals or interventions.

-Residents with the need to maintain current function status were re-evaluated at least quarterly to determine effectiveness of the current interventions and need to revise goals or interventions.

1. Resident 9 was admitted to the facility in 10/2019 with diagnoses including hemiparesis (partial weakness on one side of the body) and hemiplegia (complete paralysis on one side of the body) following a stroke and affecting the left non-dominant side.

Resident 9's 9/10/24 Restorative Nursing Re-Evaluation indicated the resident had a left hand splint/brace, the splint/brace was too big and OT was going to fit her/him for a new one.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 9's 9/11/24 Annual MDS Assessment indicated the resident was moderately cognitively impaired, experienced upper and lower extremity impairment on one side, was dependent on assistance from staff for lower body dressing and required substantial/maximal assistance from staff with upper body dressing and personal hygiene. The Functional Abilities CAA indicated the resident experienced contractures on her/his left side and she/he had ROM exercises and a splint to assist with preventing further contractures. Resident 9's 10/2/24 ADL and Left Sided Weakness/Impairment Care Plans revealed the following: -The resident had contractures to the right arm/hand and right leg. -Adaptive devices as recommended by therapy or physician. Monitor for safe use. Monitor/document to ensure appropriate use of adaptive device. -Assist the resident to wear the left hand palm guard daily as tolerated. -The resident was to use a left hand therapy carrot (a device that helps position hands with severe contractures) as tolerated to facilitate contracture management. -Range of motion exercises to be completed several times a day. -Passive ROM program for right and left upper extremities was to be completed daily. -Monitor/document mobility status. If the resident presents with problems or paralysis, obtain an order for PT and OT to evaluate and treat. Resident 9's 10/22/24 Therapy to Nursing Communication indicated the resident was to wear a left hand palm guard and therapy carrot as tolerated daily to facilitate contracture management. Resident 9's 11/2024 Physician Orders directed the resident's left hand palm protector to be in place continuously. The orders directed the licensed nurse to remove the palm protector at least twice per shift in order to inspect and clean the resident's left hand. A review of Resident 9's 10/21/24 through 11/16/24 Daily Exercise Program for Right and Left Upper Extremities Task revealed the following: -10/21/24: no. -10/22/24: not applicable. -10/23/24: not applicable. -10/24/24: not applicable. -10/25/24: not applicable. -10/26/24: not applicable. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/27/24: not applicable. -10/28/24: no. -10/29/24: no. -11/2/24: no. -11/4/24: not applicable. -11/5/24: not applicable. -11/6/24: not applicable. -11/7/24: no. -11/9/24: not applicable. -11/10/24: no. -11/12/24: no. -11/13/24: not applicable. -11/16/24: no. Instructions listed on Resident 9's Splint/Brace Assistance Task directed staff to assist the resident to wear left hand palm guard daily as tolerated and the resident was to use the left hand therapy carrot as tolerated. A review of Resident 9's Splint/Brace Assistance Task from 10/24/24 through 11/17/24 revealed the following: -10/24/24: not applicable. -10/25/24: not applicable. -10/26/24: not applicable. -10/27/24: not applicable. -10/28/24: no. -10/28/24: no. -11/1/24: no. -11/2/24: no. -11/4/24: not applicable. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/5/24: not applicable. -11/6/24: no. -11/7/24: no. -11/8/24: no. -11/9/24: not applicable. -11/12/24: no. -11/13/24: not applicable. -11/16/24: no. -11/17/24: no. On 11/18/24 at 11:32 AM Resident 9 was observed in her/his room and sat in her/his wheelchair. The resident's left thumb was tucked in tightly to the palm of her/his hand and the remaining four fingers on her/his left hand pressed in on top of the left thumb. The tip of a therapy carrot was observed in between the resident's thumb and index finger but a majority of the therapy carrot hung out of the resident's hand. The resident was unable to extend any of her/his fingers or thumb on her/his left hand with verbal prompting and indicated she/he used the therapy carrot sometimes. No splint or brace was observed in the resident's room. On 11/18/24 at 3:09 PM Resident 9 was observed in her/his room in bed. The resident's left thumb was tucked in tightly to the palm of her/his hand and the remaining four fingers on her/his left hand pressed in on top of the left thumb. The tip of a therapy carrot was observed in between the resident's thumb and index finger with a majority of the carrot hanging out of the resident's hand. No splint or brace was observed in the resident's room. On 11/19/24 at 3:49 Resident 9 was observed in her/his room in bed. No splint, brace or therapy carrot was observed in the resident's contracted left hand. With the assistance of a translator, Resident 9 stated her/his left hand hurt all of the time and she/he was very sad about this situation. Resident 9 was unable to answer specific questions about her/his splint, brace or therapy carrot but did state she/he did not participate in any exercise or ROM program at the facility. On 11/20/24 at 9:41 AM Staff 23 (CNA) stated Resident 9 had a brace and a therapy carrot for her/his left hand and the resident put them on and took them off independently. Staff 23 stated she did not know how long each day the resident was supposed to wear the brace or therapy carrot, did not know if the resident had an RA program and stated the resident never refused anything, including to put on her/his therapy carrot or splint when offered. On 11/20/24 at 9:52 AM Staff 28 (CNA) stated she helped to place the therapy carrot in Resident 9's left hand when the resident asked for assistance and the resident was always cooperative. Staff 28 stated PT was responsible for Resident 9's splint and stated she had not done any RA tasks with the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:08 AM Staff 29 (LPN) stated therapy was still working on getting a new splint so [the resident] did not have one right now. Staff 29 stated he thought Staff 21 (CNA) was responsible for Resident 9's RA program but thought other CNAs could also help. On 11/20/24 at 10:16 AM Staff 30 (Director of Rehab) stated Resident 9 was seen by OT from 9/17/24 and 10/24/24 for left hand contracture management. Staff 30 stated therapy discharge recommendations included the resident to wear the left hand therapy carrot and palm guard daily as tolerated. Staff 30 stated the resident knew she/he needed to wear the therapy carrot and she/he wanted to use it. Staff 30 further stated the resident wheeled her/himself into the therapy room a few times after [she/he] was discharged from therapy for help getting the carrot in. On 11/20/24 at 2:38 PM Staff 6 (RNCM) stated the resident was to wear her/his therapy carrot daily as tolerated and staff were to offer her/him the therapy carrot in the morning and reoffer it again should the resident remove it. Staff 6 reviewed the resident's order for the continuous use of the left palm protector and stated she was not sure when [the resident] should have the palm protector on. Staff 6 reviewed Resident 6's RA tasks and stated she did not know if the RA was offered to the resident when no or not applicable was documented. On 11/20/24 at 2:53 PM Staff 2 (DNS) stated Resident 9's order for the continuous use of the left palm protector needed clarification and staff were to assist the resident to place her/his therapy carrot daily and reoffer to place it if it was observed hanging out of her/his hand. Staff 2 further stated it was unclear from the documentation if the resident was offered RA as indicated. 2. Resident 10 was readmitted to the facility in 11/2023 with diagnoses including dementia. Resident 10's 1/7/24 Annual MDS Assessment indicated the resident was moderately cognitively impaired and experienced upper extremity impairment on one side. The Pressure Ulcer/Injury CAA indicated the resident experienced left-sided weakness since she/he admitted to the facility. An 11/19/24 Physician Assistant Note revealed the resident experienced chronic left-sided deficits and had left upper extremity contractures and edema. No evidence was found in Resident 10's clinical record to indicate the resident's left upper extremity contractures were comprehensively assessed, ongoing monitoring of her/his contractures was being provided or any support or exercises were being provided to maintain or improve the resident's range of motion/mobility or to prevent further declines. No rationale was found as to why range of motion services were not being provided. On 11/18/24 at 12:08 PM Resident 10 was observed in her/his room in her/his geri chair (a large, padded and wheeled chair designed to help people with limited mobility). Resident 10's fingers and thumb on her/his left hand were observed to curl in towards the palm of her/his hand. Resident 10 stated the facility did not do anything for her/his left hand and did not think they even knew about her/his contractures. Resident 10 stated she did not participate in any range of motion exercises for her/his left hand, she/he did not have a therapy carrot (a device that helps position hands with severe contractures), splint or brace for her/his left hand and she/he was willing to try anything that could help. (continued on next page)

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Glisan Post Acute	9750 NE Glisan Street Portland, OR 97220

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 8:12 AM Resident 10 stated her/his left hand hurt sometimes and she/he was not able to straighten out her/his fingers or thumb on her/his left hand. On 11/21/24 at 8:31 AM Staff 23 (CNA) stated Resident 10 did not have movement in the left side of [her/his] body. Staff 23 stated the resident did not have an RA program, she had never seen the resident use a carrot, splint or brace for her/his left hand and the only assignment she had related to the resident's left hand was to scrub it. On 11/21/24 at 9:15 AM Staff 26 (CNA) stated Resident 10's left hand contractures had gotten worse over the years and nothing recent was being done for [her/his] hand. On 11/21/24 at 9:39 AM Staff 27 (RN) stated she was not aware of any RA program for [Resident 10's] upper extremities, and she had seen the resident use a carrot once or twice. On 11/21/24 at 9:44 AM Staff 30 (Director of Rehab) stated she had not received a referral for Resident 10 to be seen for her/his left-sided weakness. On 11/21/24 at 11:06 AM Staff 4 (LPN-Care Manager) stated a resident's physician and therapy was to be notified if a resident's contracture was observed to worsen, and residents with contractures should have a care plan related to their contractures. Staff 4 stated there was no documentation to indicate Resident 10's contractures were assessed or being monitored and the resident did not have a care plan related to the management of her/his upper extremity contractures. On 11/21/24 at 11:18 Staff 2 (DNS) reviewed Resident 10's clinical record and confirmed the resident's contractures lacked assessment and care planning and stated the resident's contractures should have been evaluated already by therapy.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 2 sampled residents (#62) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include: The facility's ,d+[DATE] Trauma-Informed Care Policy and Procedure revealed the following: -The facility screened newly admitted residents for indications of trauma as part of the comprehensive care plan process. -The facility developed an appropriate plan of care and interventions based upon the screening responses and observations of the resident. -The facility avoided re-traumatization that may be experienced due to repeated interviews regarding trauma history. The facility observed the resident for changes in behavior or mood that may indicate a need to modify the plan of care, quarterly. Resident 62 was admitted to the facility in ,d+[DATE] with diagnoses including Post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions) and stimulant abuse (the continued use of amphetamine-type substances, cocaine or other stimulants that lead to clinically significant impairment or distress). Resident 62's [DATE] Hospital History and Physical records revealed the following: -The resident was involved in a motor vehicle accident in 2021 which resulted in paraplegia (the inability to voluntarily move the lower parts of the body). -The resident reported being awake during the entirety of this event during which she/he tried to keep a child alive who died on the scene before emergency medical services arrived. -The resident experienced PTSD/panic symptoms related to this event. -The resident reported night terrors every night since this event in which she/he re-enacted the traumatic event in her/his dreams. -The resident reported regular panic attacks which were triggered by being alone. -The resident had a methamphetamine use disorder, and pain and her/his family's home were triggers for substance abuse. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident did not want to discharge to a long-term care facility because these types of facilities reminded the resident of being in a correctional facility and she/he would rather discharge to the streets. Resident 62's [DATE] Baseline Care Plan indicated the resident had a known or reported trauma history, received an antidepressant related to her/his diagnosis of PTSD, the medication worked okay and she/he had not had any symptoms of PTSD. Resident 62's [DATE] Social History Assessment indicated the resident had a diagnosis of PTSD and did not exhibit any behaviors related to this diagnosis. Resident 62's [DATE] Admission MDS Assessment indicated the resident was cognitively intact. Resident 62's [DATE] Psychosocial-Emotional/Trauma Care Plan revealed the following: -Encourage the resident to express emotions. -Assist to normalize feelings. -Attempt non-pharmacological approaches as indicated such as music therapy, breathing exercises, talking to the resident about her/his feelings, meditation, aroma therapy, reading materials and offering preferred activities. -Evaluate non-verbal cues to assess the degree and severity of pain for pain management. -PTSD triggers include nightmares. Intervention included to wake the resident and reorient to help her/him to get out of the nightmare. Resident 62's ,d+[DATE] MARs revealed the resident received hydroxyzine (an antihistamine used to help control anxiety and tension caused by nervous and emotional conditions) PRN for anxiety on [DATE]. No evidence was found in Resident 62's clinical record to indicate a care plan for her/his PTSD was developed until [DATE], 38 days after the resident admitted to the facility, the resident was asked specific questions related to triggers of her/his traumas, the resident's hospital records were reviewed to help to develop a person-centered trauma care plan, additional staff or relevant family members were offered the opportunity to provide information about the resident's traumas and potential triggers, possible triggers related to the resident's history of incarceration or substance use disorder were considered or why the resident received a PRN medication for anxiety on [DATE]. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:50 AM Resident 62 was observed to sit in her/his bed with the privacy curtain pulled and the blinds closed. Resident 62 stated she/he experienced anxiety related to her/his PTSD and a lot of little things triggered her/his anxiety, including hearing a car crash or sirens, doors slamming, people yelling, a loud environment, other residents falling or needing help, being stressed and homeless people asking for a hit of [her/his] vape pen (a battery-operated vaping device) when outside smoking. Resident 62 stated she/he barely watched television because her/his PTSD was triggered by various television shows. Resident 62 stated the guys across the hallway were hard of hearing so their televisions were up loud, and when this happened, the resident put her/his head under a pillow or blanket because there was nothing else she/he could do. Resident 62 stated she/he wanted to discharge to a normal environment where it was not so loud. Resident 62 stated Staff 2 (DNS) spoke with her/him briefly about her/his PTSD but she/he had not spoken with anyone at the facility in-depth about potential triggers for re-traumatization. Resident 62 stated she/he had nightmares about her/his car wreck every night and she/he fell out of bed once in ,d+[DATE] trying to run from [her/his] dream. Resident 62 stated she/he was provided with a larger bed after this incident but the facility had otherwise done nothing to help her/him with her/his nightmares. Resident 62 stated she/he had never been woken up by staff from a dream which was her/his preference if she/he was observed to talk in her/his sleep or was hunched over because this meant she/he was either trying to run from something or hold [her/his] body, and staff had never offered to talk with her/him about her/his nightmares or to assist with any breathing exercises to help her/his anxiety. Resident 62 further stated she/he had an anxiety attack on [DATE] when she/he woke up and there were a lot of people in her/his room assisting her/his roommate and it was really loud. Resident 62 stated she/he felt like she/he had to get out of the room because there were people everywhere. On [DATE] at 10:30 AM Staff 23 (CNA) stated a lot of people in the room, vehicles and erratic drivers hitting the breaks a lot triggered Resident 62's anxiety. Staff 23 stated Resident 62's care plan did not list any triggers related to her/his PTSD or anxiety but she had learned some of the resident's triggers by talking with her/him. On [DATE] at 10:48 AM Staff 18 (LVN/LPN) stated cars and car accidents triggered Resident 62's anxiety and the resident experienced nightmares about the car accident she/he was involved in. Staff 18 stated she gave the resident a PRN medication for anxiety on [DATE] because the resident stated she/he felt really anxious but did not have any additional details about cause of the resident's anxiety. On [DATE] at 11:24 AM Staff 7 (Social Services Director) stated she interviewed Resident 62 on her/his day of admission to the facility about her/his PTSD and possible triggers, and the resident told her confrontation was an issue. Staff 7 stated she had not interviewed the resident about her/his PTSD since admission, did not add confrontation as a trigger for anxiety to the resident's care plan, did not review the resident's clinical record in order to understand other additional triggers of her/his PTSD or ask the resident about other specific potential triggers given her/his history of traumas, including about the environment at the nursing facility. Staff 7 further stated she was not aware the resident experienced nightly night terrors and was not aware she/he experienced an anxiety attack on [DATE]. On [DATE] at 11:51 AM Staff 2 (DNS) confirmed Resident 62's care plan to address her/his PTSD was not developed until [DATE] and after the resident experienced a fall out of bed, and the resident's care plan was not comprehensive. Staff 2 further stated she was not aware the resident experienced an anxiety attack on [DATE].

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NAME OF PROVIDER OR SUPPLIER Glisan Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9750 NE Glisan Street Portland, OR 97220	

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 47000 Based on observation, interview and record review it was determined the facility failed to provide necessary behavioral health care and services for 1 of 2 sampled residents (#62) reviewed for behavioral-emotional needs. This placed residents at risk for unmet behavioral and emotional needs and a decrease in their quality of life. Findings include: The facility's 2/2019 Behavioral Health Services and 3/2019 Behavioral Assessment, Intervention and Monitoring Policies revealed: -Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. -As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations, the resident's typical or past responses to stress, fatigue, fear, anxiety frustration and other triggers and the resident's previous patterns of coping with stress, anxiety and depression. -Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. Resident 62 was admitted to the facility in 9/2024 with diagnoses including Post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions) and stimulant abuse (the continued use of amphetamine-type substances, cocaine or other stimulants that lead to clinically significant impairment or distress). Resident 62's 9/29/24 Hospital History and Physical records revealed the following: -The resident was involved in a motor vehicle accident in 2021 which resulted in paraplegia (the inability to voluntarily move the lower parts of the body). -The resident experienced PTSD/panic symptoms related to this event. -The resident reported night terrors every night since this event in which she/he re-enacted the traumatic event in her/his dreams. -The resident reported regular panic attacks which were triggered by being alone. -The resident had a methamphetamine use disorder. -The resident benefited from the support of the hospital's IMPACT (Improving Addiction Care Team) peer team, having a peer recovery mentor and participating in virtual Narcotics Anonymous (NA) meetings. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident could be a candidate for the Affect App (a smartphone application designed to provide a digital addiction recovery program) after discharge. Resident 62's 10/8/24 Social History Assessment indicated the resident had a diagnosis of PTSD and did not exhibit any behaviors related to this diagnosis. Resident 62's 10/18/24 Admission MDS Assessment indicated the resident was cognitively intact. Resident 62's 11/6/24 Psychosocial-Emotional/Trauma Care Plan revealed the following: -Encourage the resident to express emotions. -Assist to normalize feelings. -Attempt non-pharmacological approaches as indicated such as music therapy, breathing exercises, talking to the resident about her/his feelings, meditation, aroma therapy, reading materials and offering preferred activities. -Evaluate non-verbal cues to assess the degree and severity of pain for pain management. -PTSD triggers included nightmares and the resident was to be woken up and reoriented to help her/him to get out of the nightmare. Resident 62's 11/18/24 Behavior Care Plan revealed the following: -Focused behaviors included yelling, crying, verbal outbursts, constant fidgeting and refusing care. -Interventions included redirection, reminding the resident yelling was not okay, one-to-one conversations, re-approach and music of own choosing. Resident 62's 11/2024 MARs revealed the resident received hydroxyzine (an antihistamine used to help control anxiety and tension caused by nervous and emotional conditions) PRN for anxiety on 11/19/24. No evidence was found in Resident 62's clinical record to indicate the resident was offered the opportunity to receive mental health services or to participate in NA meetings, assistance with obtaining the Affect App, a person-centered care plan was developed to address Resident 62's potential mood symptoms or why the resident received a PRN medication for anxiety on 11/19/24. On 11/22/24 at 9:50 AM Resident 62 was observed to sit in her/his bed with the privacy curtain pulled and the blinds closed. Resident 62 stated she/he had not been offered any counseling, group, peer or therapy services since she/he admitted to the facility and was interested in all of these services as she/he thought they would help to relieve stress and talk it out. Resident 62 stated the facility's social worker won't talk to or help [her/him] and the facility does nothing for her/his PTSD and anxiety outside of giving her/him medications. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 10:48 AM Staff 18 (LVN/LPN) stated she gave Resident 62 a PRN medication for anxiety on 11/19/24 because the resident stated she/he felt really anxious but did not have any additional details about the cause of the resident's anxiety. On 11/22/24 at 11:24 AM Staff 7 (Social Services Director) stated Resident 62's behavior care plan was not person-centered as the resident did not yell, cry, have outbursts, fidget or refuse care and reminding the resident not to yell was an inappropriate intervention for this resident. Staff 7 stated she did not know if music therapy, breathing exercises, meditation or aroma therapy were effective interventions to relieve anxiety for Resident 62. Staff 7 stated she had not asked Resident 62 if she/he was interested in receiving peer support, attending support groups or having any additional mental health support outside of asking the resident if she/he wanted to see a therapist at the time of her/his admission to the facility in 9/2024. Staff 7 further stated she was not aware the resident experienced an anxiety attack on 11/19/24. On 11/22/24 at 11:51 AM Staff 2 (DNS) stated she did not know if any mental health services were offered to Resident 62, she was not aware the resident experienced an anxiety attack on 11/19/24 and the resident's care plan was not person-centered.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47000 Based on observation, interview and record review it was determined the facility failed to accommodate resident food choices for 1 of 7 sampled residents (#37) reviewed for food. This placed residents at risk for food choices not being honored. Findings include: Resident 37 was admitted to the facility in 11/2023 with diagnoses including neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Resident 37's 11/22/23 Food and Nutrition Admission Interview revealed the resident normally ate oatmeal for breakfast and requested a salad with meals. The Interview also indicated the resident did not like peas, green beans, pepper, raisin bread or raisins. Resident 37's 8/25/24 Quarterly MDS Assessment revealed the resident was cognitively intact and on a therapeutic diet. Resident 37's 11/11/24 Nutrition At Risk Evaluation revealed the resident received a regular texture diet with small starch portions and sodium limited to two grams. The resident was to receive a salad with lunch and dinner. On 11/18/24 at 1:31 PM Resident 37 was observed in her/his room and sat in her/his wheelchair. The resident's lunch tray sat on top of her/his bed. Resident 37 removed the lid that covered the plate and revealed her/his lunch of garlic bread, pasta with meat sauce and green beans. Resident 37 stated she/he would not touch her/his lunch because she/he did not like green beans and the green beans touched the other food items on her/his plate. Resident 37 stated she/he was served items she/he disliked again and again. No salad was observed on the resident's meal tray. Resident 37 handed the state surveyor her/his meal ticket from the lunch tray which indicated the following: -The resident disliked gravies, gravy on meat, sugar free juice, scrambled eggs, green beans, peas and raisin bread. -No salt packs were to be placed on the resident's tray. On 11/19/24 at 12:43 PM Resident 37 was observed in her/his room and sat in her/his wheelchair. The resident's lunch tray with a salt packet sat on top of the resident's bed. Resident 37 removed the lid that covered the plate and revealed meat and potatoes covered in gravy. Resident 37 stated she/he was not going to eat her/his lunch because it was covered in gravy and she/he did not like gravy. No salad was observed on the resident's meal tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 12:24 PM Staff 25 (Cook) was observed to plate Resident 37's lunch. Staff 25 used a spoon with holes to drain the mushroom gravy from the beef and placed the strained beef on top of a plate of rice and carrots. Staff 25 stated he intended to serve Resident 37 the beef even though it was coated in gravy because he did not want to give Resident 37 dry meat and wanted her/him to have flavor. Staff 25 further stated the resident could come back to the kitchen and get something else if she/he did not like the beef. On 11/20/24 at 12:36 PM Staff 15 (Dietary Director) reviewed Resident 37's meal ticket, stated the resident did not like gravy and she/he should have not been served the beef coated in gravy. Staff 15 further stated he expected the cooks to follow resident preferences. On 11/20/24 at 12:58 PM Resident 37 stated she/he did not want to eat lunch because it looked like gravy. On 11/20/24 at 1:13 PM Staff 1 (Administrator) acknowledged the findings and did not offer any additional information.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on observation, interview and record review it was determined the facility failed to maintain sanitary equipment to prevent the unintended presence of potentially harmful substances, label and store food appropriately or handle and prepare food in a sanitary manner for 1 of 1 ice machine, 1 of 1 mobile ice carts and 1 of 1 kitchen reviewed for dining services. This placed residents at risk of illness and contaminated food. Finding include: In the dining room on [DATE] at 12:25 PM Staff 21 (CNA) was observed to scoop ice from the large ice machine into the mobile ice cart chest. Staff 21 used the ice scoop located to the left of the ice machine, mounted on the wall and contained in a black container. Staff 21 was then observed to use an ice scoop, stored in a white mesh bag on the mobile ice cart, to place ice into a cup. The white mesh bag had a black substance on the bottom of the bag about the size of a playing card. On [DATE] at 12:28 PM Staff 21 stated they did not know if the white mesh bag to hold the scoop was clean or not, but it appeared to have mold growth on the bag. On [DATE] at 12:32 PM Staff 2 (DNS) stated they would expect the ice scoop to be contained in a clean environment. Staff 2 and surveyor approached Staff 21 with the mobile ice cart. Staff 21 stated the white mesh bag for the mobile ice cart scoop was thrown away. On [DATE] at 12:36 PM Staff 11 (Maintenance Director) confirmed the white mesh bag for the mobile ice cart scoop was thrown away because it was nasty. On [DATE] at 12:37 PM the surveyor used a white paper towel to wipe the bottom inside of the black ice machine scoop holder mounted on the wall left of the ice machine. The paper towel came out with a black [NAME] debris which felt slimy. On [DATE] at 12:40 PM Staff 14 (Housekeeping Supervisor) stated the housekeeping department was responsible to clean the ice scoop and its container to the left of the ice machine. Staff 14 placed a cloth rag into the container and wiped the bottom. Staff 14 confirmed the container was not clean and they were unsure exactly how often it was cleaned. On [DATE] at 1:45 PM Staff 1 (Administrator) acknowledged this finding and confirmed they expected both ice scoop containers to be clean. 47000 2. The facility's ,d+[DATE] Food Preparation and Service Policy and Procedure directed the following: -Gloves were to be worn when handling food directly and changed between tasks. -Refrigerators and/or freezers were to be maintained in good working condition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Frozen foods were to be maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. -All food was to be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) were to be marked on cases and on individual items removed from cases for storage. Use by dates were to be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food were to be observed and use by dates were to indicate once food was opened. -Supervisors were responsible for ensuring food items in the pantry, refrigerators and freezers were not past the use by or expiration dates. Supervisors were to contact vendors or manufacturers when expiration dates were in question or to decipher codes on packaging. On [DATE] at 9:46 AM during the initial tour of the facility's kitchen, the following was observed in the dry storage area: -an opened bag of French onions, undated; -an opened container of vinegar, undated; -an opened bag of Sloppy [NAME] seasoning, undated; -an opened bag of biscuit gravy mix, undated; -an opened bag of mashed potato mix, undated; -an opened bag of chicken gravy mix, undated; -an unopened container of horseradish, expired on [DATE]; -an unopened container of mayonnaise, expired on [DATE]; -four unopened coleslaw dressings, expiration date unable to be determined; -two unopened containers of ranch dressing, expiration date unable to be determined; and -three unopened containers of mayonnaise, expiration date unable to be determined. On [DATE] at 10:00 AM during the initial tour of the facility's kitchen, the following were observed in the facility's walk-in freezer: -a large chunk of ice attached to a pipe in the back of the freezer hung down and was positioned above an open box of corn. The box contained many chunks of ice that appeared to have broken off from the ice chunk that hung above; -a bag of freezer burned asparagus; and -an open bag of bratwurst. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:52 AM Staff 15 (Dietary Director) stated all of the opened and undated, expired and freezer burned food items should be thrown out. On [DATE] at 11:12 AM Staff 15 stated the items with an expiration date that was unable to be determined needed to be removed from the shelf in the dry storage. On [DATE] between 11:55 AM and 12:30 PM during a return visit to the kitchen the following was observed during the lunch tray line service: -At 11:55 AM Staff 25 (Cook) was observed to plate resident meal trays and wore gloves. At 11:57 AM Staff 25 opened a drawer in the kitchen, removed two utensils and resumed plating resident meal trays. Staff 25 did not change his gloves after he touched the kitchen drawer. -At 12:06 PM Staff 25 wore the same pair of gloves and opened the door to the facility's freezer, retrieved a salad and a sandwich, removed the sandwich from the bag, placed the sandwich on a plate and resumed plating resident meal trays. Staff 25 did not change his gloves after he touched the door handle to the freezer. -At 12:10 PM Staff 25 wore the same pair of gloves and opened the door to the facility's freezer and retrieved another sandwich. The state surveyor asked Staff 25 at this time about when he was expected to change his gloves to which Staff 25 stated he changed his gloves when he touched the doors. Staff 25 did not change his gloves and continued to plate resident meal trays. On [DATE] at 12:36 PM Staff 15 stated staff were expected to change their gloves between tasks.