| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385144 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clatsop Care Center | 646 16th Street<br>Astoria, OR 97103 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>Based on interview and record review it was determined the facility failed to have a system in place to deliver mail on Saturdays for 1 of 1 Resident Council reviewed. This placed residents at risk for lack of timely written communications. Findings include:The Facility'sˆResident Right to Privacy in Communicationˆ Policy, dated 1/1/26, stated the facility would ensure each resident received any mail addressed to that resident promptly, defined as delivery within 24 hours of delivery by the postal service. On 1/28/26 at 1:45 PM during the Resident Council group interview, residents stated their mail was not delivered on Saturdays. Resident 9 stated she/he complained to facility staff three times about not receiving mail on Saturdays and was told no staff worked on the weekends who delivered mail. Resident 9 stated this was very frustrating. Resident 27 agreed with Resident 9's statement, and Resident 4 nodded her/his head in agreement. Resident 25 stated she/he made sure not to have any deliveries for Saturdays due to the lack of mail delivery. On 1/28/26 at 4:10 PM, Staff 9 (CNA) stated she was responsible for delivering resident mail. Staff 9 stated she worked Monday through Friday, and any resident mail received over the weekend was placed in a locked office. Staff 9 stated when she arrived at work on Mondays, the mail was delivered to residents. On 1/29/26 at 9:30 AM, Staff 1 (Administrator) was informed of residents' concerns regarding not receiving mail on Saturdays. Staff 1 acknowledged the facility did not have a system in place to ensure residents received timely written communication. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure a resident with a history of trauma received trauma informed care for 1 of 1 sampled resident (#6) reviewed for mood and behavior. This placed residents at risk for re-traumatization. Findings include:The facility's Trauma Informed Care Policy dated 1/1/26 indicated:-The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social/history assessment, and others.-The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plans. Resident 6 was admitted to the facility in 8/2024 with diagnoses including PTSD (Post-Traumatic Stress Disorder) and depression.Resident 6's 11/6/25 Quarterly MDS indicated the resident was cognitively intact.Resident 6's 8/5/24 Social Services & Initial Assessment indicated Resident 6 had a diagnosis of depression; however, there was no mention of the resident's documented PTSD or related triggers.No evidence was found in Resident 6's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. Record review revealed Resident 6 had an open PTSD claim with the Veterans Administration (disability compensation application in review process), which was discussed during the care conference on 8/7/25.On 1/28/26 at 8:57 AM Resident 6 was observed in her/his room. Resident 6 stated the facility had not asked her/him about any triggers she/he had. Resident 6 stated she/he had experienced nightmares in the past and seeing news coverage related to the U.S. Coast Guard triggered distressing memories. Resident 6 further stated the facility had not discussed or assessed these triggers with her/him.On 1/29/26 at 9:47 AM Staff 7 (CNA) stated she did not know if Resident 6 had a diagnosis of PTSD. Staff 7 reviewed the resident's Kardex (quick-reference bedside care plan), PTSD or trauma-related triggers were not listed. Staff 7 further stated Resident 6 would become upset when her/his requests were not met, would refuse cares and would yell at staff. Staff 7 was unable to identify any trauma-related triggers or interventions in place to address these behaviors.On 1/29/26 at 9:55 AM Staff 8 (CNA) stated she did not know Resident 6 had a diagnosis of PTSD. Staff 8 reviewed the resident's Kardex, PTSD or trauma-related triggers were not addressed. Staff 8 stated when Resident 6 became upset she/he would yell at staff. Staff 8 was unable to identify any trauma-related triggers or interventions in place.On 1/29/26 at 10:04 AM Staff 5 (LPN Resident Care Manager) stated she was unaware Resident 6 had a diagnosis of PTSD and could not identify any triggers. Staff 5 confirmed the resident's care plan did not include interventions or approaches related to PTSD or known triggers.On 1/29/26 at 10:26 AM Staff 6 (Social Services) stated resident trauma screenings were to be completed at the time of admission. Staff 6 stated a care plan had not been developed related to Resident 6's history of trauma or potential triggers. Staff 6 stated she was unaware if Resident 6 had any triggers.On 1/29/26 at 10:53 AM Staff 2 (DNS) and Staff 3 (Nurse Consultant) acknowledged Resident 6 had a diagnosis of PTSD and no interventions were implemented to address the resident's trauma or trauma triggers. Staff 2 stated she expected a care plan to be developed to address Resident 6's potential PTSD triggers and staff were responsible to implement the care plan. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>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 25 medication administration opportunities resulting in an 8% error rate. This placed residents at risk of receiving a sub-therapeutic medication dose and reduced medication efficacy. Findings include:The facility's Insulin Pen Policy dated 1/1/26 specified insulin pens were to be primed with two units of insulin prior to each use to avoid the collection of air in the reservoir. Resident 18 was admitted to the facility in 10/2020 with diagnoses including type 2 diabetes mellitus (a chronic condition affecting the body's ability to control blood sugar levels).Resident 18's Physician Orders included the following:-insulin glargine (a long-acting mediation for diabetes) 100 units/ml inject 25 units two times daily-insulin lispro (a rapid-acting medication for diabetes) 100 units/ml inject 10 units before mealsOn 1/28/26 at 7:19 AM Staff 10 (LPN) administered insulin glargine and insulin lispro to Resident 18 and did not prime the insulin pens prior to administration. On 1/28/26 at 7:19 AM Staff 10 acknowledged they did not prime the insulin pens prior to administration and expressed they were not aware priming was required.On 1/28/26 at 10:39 AM Staff 2 (DNS) stated she expected all nursing staff to prime the insulin pens prior to administering insulin. Staff 2 acknowledged Resident 18's insulin pens had not been primed before insulin administration. |