

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Robison Jewish Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 SW Boundary Street Portland, OR 97221	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>43691</p> <p>Based on observations, interviews and record review it was determined the facility failed to develop and implement person centered care plans for 2 of 8 residents (#s 3 and 8) reviewed for falls and medications. This placed residents at risk for falls and adverse medication effects. Findings include:</p> <p>1. Resident 3 was admitted to the facility in 5/2021 with diagnoses including congestive heart failure.</p> <p>A 5/26/24 Fall Risk Evaluation determined Resident 3 to be at a moderate risk for falls.</p> <p>A 6/14/24 Care Plan identified Resident 3 at a moderate risk for falls with interventions including placing her/his bed in a low position to decrease the risk of injuries from falls.</p> <p>On 7/31/24 at 10:03 AM Resident 3 was observed asleep in bed with the bed at a normal height.</p> <p>On 7/31/24 at 10:09 AM Staff 30 (CNA) stated Resident 3 was not at risk for falls and was not aware of interventions in place regarding bed positioning to reduce the risk for falls.</p> <p>On 7/31/24 at 11:30 AM Staff 4 (RNCM) stated Resident 3's care plan including having her/his bed in a low position. Staff 4 observed Resident 3's bed position and stated her/his bed was not in a low position. Staff 4 confirmed Resident 3's fall prevention techniques included in her/his care plan were not being implemented which placed Resident 3 at an increased risk for falls.</p> <p>50926</p> <p>2. Resident 8 was admitted to the facility in 7/2023 with diagnoses including other pulmonary embolism with acute cor pulmonale (a blood clot in the lung that causes the heart to work hard to pump blood in and out of the lungs).</p> <p>Review of Resident 8's Order Summary Report included Apixaban 5 mg (an anticoagulant and high-risk medication used for the treatment of blood clots in the lungs) started 7/12/23.</p> <p>Resident 8's care plan did not include monitoring of high-risk medication.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff 2 (DNS) on 8/2/24 at 11:13 AM confirmed the expectation for high-risk medications, such as an anticoagulant, to be on the care plan. She confirmed Resident 8's care plan did not include high-risk medication.		

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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>43691</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for medication administration for 1 of 5 residents (#26) reviewed for unnecessary medications. This placed residents at risk for medical complications. Findings include:</p> <p>Resident 26 admitted to the facility in 10/2021 with diagnoses including paroxysmal atrial fibrillation (irregular heart beat), hemiplegia as result of a stroke (loss of function of one side of the body) and high blood pressure.</p> <p>A 7/22/22 Physician Order included 5 mg of apixaban (a medication used to prevent blood clotting) to be administered two times a day for paroxysmal atrial fibrillation.</p> <p>Review of 6/2024 and 7/2024's MARs revealed apixaban was documented as refused on the following dates and times:</p> <ul style="list-style-type: none"> - 6/1/24 in the morning, - 6/14/24 in the evening, - 6/16/24 in the evening, - 6/17/24 in the evening, - 6/18/24 in the evening, - 6/28/24 in the evening, - 6/29/24 in the evening, - 6/30/24 in the evening, - 7/2/24 in the evening, - 7/5/24 in the evening, - 7/10/24 in the evening, - 7/12/24 in the evening, - 7/16/24 in the evening, - 7/17/24 in the evening and - 7/23/24 in the morning. <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>A 7/9/24 Encounter Note from Staff 31 (NP) included a statement of Resident 26 refusing medications especially in the evenings.</p> <p>On 8/2/24 at 9:46 AM Staff 32 (LPN) stated Resident 26 often refused medications in evenings when she/he was in bed, but accepted them when out of bed. Staff 32 stated Resident 26 usually received assistance with getting out of bed between 7:00 AM and 8:00 AM and was usually out of bed at 7:00 PM when Staff 32's shift ends.</p> <p>On 8/2/24 at 10:02 AM Staff 4 (RNCM) stated Resident 26 had a pattern of medication refusals which had existed for at least a year especially in the evenings after she/he was in bed. Staff 4 stated an intervention implemented to address refusals of apixaban was an increased administration window which changed from a two hour window to a four hour window, between 7:00 PM and 11:00 PM. Staff 4 confirmed a pattern of refusals had continued with Resident 26 after this change and had no additional information of other interventions implemented.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43690</p> <p>Based on interview and record review it was determined the facility failed to implement interventions to prevent a fall for 1 of 3 sampled residents (# 20) reviewed for accidents. This failure resulted in Resident 20 having a fall with serious injury including a head hematoma (a pool of blood under the skin), a gluteal hematoma, multiple rib fractures and skin avulsions (skin tears) which required emergency medical services and treatment at the hospital. Findings include:</p> <p>Resident 20 was admitted to the facility 12/2020 with diagnoses including dementia and anxiety.</p> <p>Resident 20's 12/10/23 Annual MDS indicated Resident 20 was noted to have wandering behavior and was exit seeking.</p> <p>A 4/17/24 Behavior and Psychotropic Meeting Note indicated Resident 20 exhibited wandering behaviors.</p> <p>Resident 20's 6/11/24 Quarterly MDS revealed she/he had severe cognitive impairment.</p> <p>A 6/18/24 Care Plan indicated Resident 20 had a pattern of wandering.</p> <p>A 7/9/24 Facility Incident Report revealed Resident 20 had an unwitnessed exit from her/his unit and was found at the bottom of the stairs where she/he had fallen with her/his walker. Facility door alarms were found not to be armed when Resident 20 exited the side door from her/his unit resulting in a fall with injuries.</p> <p>A 7/9/24 Incident Note reported Resident 20 experienced an abrasion to her/his right arm, lump on the forehead, lump on top of the head, and a lump on the right side of her/his head as a result of the fall. The resident also had a small bruise to the left side of her/his eye and was holding her/his side.</p> <p>A 7/12/24 Hospital Record revealed Resident 20 was admitted to the hospital from 7/9/24 through 7/12/24 due to injuries sustained from her/his fall at the facility on 7/9/24. Resident 20 was treated for displaced left rib fractures, hematomas to the frontal scalp and gluteal posterior and an avulsion to her/his right forearm.</p> <p>On 7/31/24 at 8:27 AM Staff 19 (CNA) stated Resident 20 would push on doors in an attempt to open them and would try to follow people out of doors. Staff 19 also stated if the door alarms had been armed, they would have sounded for the resident's protection.</p> <p>On 7/31/24 at 8:38 AM Staff 9 (CNA) stated Resident 20 was exit seeking and would try to follow people out of doors. Staff 9 also stated there were no exit seeking/wandering interventions in place prior to the resident's fall and she/he had started wandering more often a few weeks before she/he fell .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 11:55 AM Staff 4 (RNCM) stated the door alarm was not armed at the time of Resident 20's unwitnessed fall on 7/9/24. Staff 4 stated an unknown staff member exited the door and did not reset the alarm which resulted in an unwitnessed fall with multiple injuries. Staff 4 acknowledged Resident 20 had increased wandering prior to the fall but no new interventions or care plan updates had been implemented.</p> <p>On 8/1/24 at 12:12 PM Staff 2 (DNS) confirmed Resident 20 experienced a fall with injuries as a result of fall interventions not being implemented.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>50926</p> <p>Based on interview and record review, it was determined the facility failed to ensure the residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 1 of 5 sampled residents (#8) reviewed for medications. This placed residents at risk for unassessed needs.</p> <p>Findings include:</p> <p>Resident 8 was admitted to the facility in 7/2023 with diagnoses including atrial fibrillation (a type of irregular heartbeat that causes the heart to beat too fast).</p> <p>A review of Resident 8's health record indicated there were no physician visits documented since his/her admission.</p> <p>Staff 4 (RNCM) on 8/1/24 at 2:54 PM he/she stated Resident 8 had not been seen by their primary care physician since the time of admission.</p> <p>Staff 2 (DNS) on 8/2/24 at 11:13 AM stated the facility policy was for residents to have been seen by the physician every 30 days for 90 days, and every 60 days thereafter. She verified Resident 8 had not been seen by her physician since his/her admission 7/2023.</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>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure there was sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet care needs. Findings include:</p> <p>The facility's revised 4/2007 Staffing Policy indicated the facility provided adequate staffing to meet the needed care and services of the residents.</p> <p>On 7/29/24 the facility had a census of 39 residents in four houses (each house was a self-contained unit). On 8/2/24, Staff 2 (DNS) provided a list of residents who:</p> <ul style="list-style-type: none"> -Required two-person mechanical lift transfers: 13; -Required one or two-person extensive or total assistance for bathing: 24; -Required one or two-person extensive or total assistance for toileting: 29; -Required one or two-person extensive or total assistance for dressing: 30; -Required two person assistance at all times for all care: 2; -Had behavioral healthcare needs which required monitoring: 7; -Were at risk for elopement: 2; -Were considered high fall risks: 2 and -Were bariatric residents (having a body mass index greater than 40): 4. <p>On 7/29/24 at 10:33 AM Resident 8 reported the facility did not have enough staff and she/he had to wait a while in her/his bathroom for assistance, at times.</p> <p>On 7/31/24 at 8:55 AM Staff 23 (CNA) stated each of the four houses typically had two CNAs assigned on day and evening shift. Staff 23 stated staffing was an issue because there were times on day shift when both CNAs were in a room providing care and no other staff were in the house so residents were left unattended. Staff 23 stated approximately 50% of the time there were enough staff to manage the residents.</p> <p>On 7/31/24 at 9:44 AM Staff 24 (CNA) stated the facility was at least one CNA short, at times, which made it hard for staff to provide two person assistance with transfers and to provide all of the care the residents required. Staff 24 stated the residents ended up waiting longer for call lights to be answered.</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 7/31/24 at 2:10 PM Staff 18 (Staffing Coordinator) stated she used the State mandatory minimum staffing ratio to determine CNA staffing. Staff 18 stated the facility had three residents who were approved to receive the State bariatric rate but was unaware the facility was required to staff an additional CNA per shift. Staff 18 stated staffing was challenging since COVID-19 and especially since the facility stopped utilizing agency staff. Staff 18 stated any staffing over the State mandatory minimum staffing requirements were determined by Staff 1 (Administrator) and Staff 2 (DNS).</p> <p>On 8/1/24 at 8:46 AM Staff 22 (CNA) stated the facility had many residents who required two person assistance with transfers and care, and the 400 house had residents with the highest acuity needs. Staff 22 reported there were three residents in the facility that required close monitoring and frequent checks. Staff 22 stated on night shift, there were not enough CNAs and nursing staff to provide the level of care and supervision necessary to monitor the residents and keep them safe so residents wandered into other resident's rooms and there were increased falls, especially in the 400 house. Staff 22 stated many times there were no other staff available to assist with two person transfers or care so she had to provide care by herself. Staff 22 stated she reported her concerns to Staff 2 (DNS) and Staff 18 (Staffing Coordinator) but nothing changed.</p> <p>On 8/1/24 at 9:57 AM Staff 28 (LPN) stated the facility needed more CNA and nursing staff, especially on the night shift. Staff 28 stated there were not enough staff available to supervise all of the residents who were at high risk for falling and elopement or to take care of the residents' needs. Staff 28 stated there were many heavy care residents, especially in the 400 house, and many residents who required two person assistance with transfers and care. In addition, there were two residents who required frequent checks and constant monitoring for safety. Staff 28 stated she assisted CNAs when she could but often was too busy so CNAs had to provide two person assistance with transfers and care with only one staff. Staff 28 stated there were nights when it was impossible to provide the level of care and supervision that was needed.</p> <p>On 8/1/24 at 10:52 AM Staff 20 (CNA) stated the facility was in the process of being sold so many staff in housekeeping and activities were let go which resulted in the CNA staff having to pick up extra tasks such as spot cleaning carpets and transporting residents to and from activities. Staff 20 stated CNAs were responsible for several other non-resident care tasks which included doing residents' laundry, taking out the garbage, getting groceries and stocking the individual house kitchens. Staff 20 stated in order to get all of the required tasks completed and provide care for the residents, she had to skip breaks.</p> <p>On 8/1/24 at 11:04 AM Staff 19 (CNA) stated sometimes the facility was short staffed. Staff 19 stated evening shift was especially challenging because there were many residents who required two person assistance with transfers or care and residents had to wait a long time to get back to bed or to get their showers because another staff member was not always available.</p> <p>On 8/1/24 at 11:10 AM Staff 13 (CNA) stated night shift was very challenging because there was only one CNA assigned to each house and the facility had many residents who required frequent checks and had to be closely monitored. Staff 13 stated it was challenging to ensure another staff member was available to cover the house while she was in a room providing care.</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 8/1/24 at 11:24 AM Staff 21 (CNA) stated on evening and night shift, there were often no other staff to cover the houses when CNAs were providing two person assistance with care, and that left the houses unattended. Staff 21 stated, at times, a nurse was available to assist but not always, so CNA staff had no other choice except to leave the residents unattended. Staff 21 stated staff were concerned because there was a resident in the 400 house who required close supervision because she/he was fast and did a lot of wandering and staff were not always able to provide the level of supervision the resident needed. Staff 21 stated she would try to reach a nurse to help cover the house but the nurse can't be every where at once. Staff 21 stated staff were often unable to get all of the required tasks and care done because they were too busy chasing around the resident that required frequent checks and close monitoring. Staff 21 stated staffing issues were ongoing since the last survey.</p> <p>On 8/1/24 at 11:37 AM Resident 7 stated the facility did not have enough staff in the 400 house, especially on night shift. Resident 7 stated she/he often waited between 30 and 90 minutes for her/his brief to be changed. Resident 7 stated the lack of staff resulted in residents not being properly supervised and on 8/1/24 in the early morning, a resident, who required 15 minute checks, wandered into her/his room naked. Resident 7 stated people are falling because it took too long for staff to respond to call lights so residents got up and fell . Resident 7 stated, because of the staffing issues, she/he did not feel the 400 house was safe during the night shift.</p> <p>On 8/1/24 at 11:09 PM Staff 26 (CNA) stated staffing on evening shift was challenging because it was difficult to get help when residents required two person assistance with transfers or care. In addition, Staff 26 stated when she worked the night shift, at times, she was the only person available to provide care to the residents who needed two person assistance because there were no other staff available. Staff 26 reported the biggest issue with staffing on night shift was having no help.</p> <p>On 8/1/24 at 11:25 PM Staff 27 (CNA) stated there was a resident in the 400 house who is up all night and has trouble sleeping and required 15 minutes checks. Staff 27 stated when both CNAs were with a resident, the resident who wandered had to be left unattended which was unsafe.</p> <p>On 8/2/24 at 10:41 AM Staff 2 (DNS) stated she assisted with staffing and staffing was determined based on the State mandatory minimum CNA ratios. Staff 2 reported the facility had three State approved bariatric residents but she was unaware of the bariatric staffing requirements. Staff 2 reported she had been informed that staff were not always readily available in a house when two person assistance with transfers or care was required, so staff had to attempt to locate a staff member from a different house. Also, staff reported that sometimes they had to wait a long time for help to arrive and sometimes a staff member said they would come to help, but then never showed up. Staff 2 stated she expected the facility to be staffed so the residents got the care they needed in a timely manner.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690</p> <p>Based on interview and record review it was determined the facility failed to ensure expired COVID-19 immunizations were not administered to 2 of 11 residents (#s 19 and 36) reviewed for immunizations. This placed residents at risk for adverse immunization consequences. Findings include:</p> <p>1. Resident 19 admitted to the facility in ,d+[DATE] with diagnoses including congestive heart failure.</p> <p>The [DATE] Quarterly MDS indicated Resident 19 had moderately impaired cognition.</p> <p>A [DATE] Event Progress Note indicated Resident 19 received an expired COVID-19 vaccine on [DATE]. Resident 19 was placed on alert charting and monitored for adverse side effects.</p> <p>On [DATE] at 2:08 PM Staff 8 (RN) stated she was distracted when she administered the COVID-19 vaccine to Resident 19 and did not check the expiration date prior to administering the vaccine.</p> <p>On [DATE] at 3:23 PM Staff 2 (DNS) stated it was her expectation the expired vaccines were disposed of in a timely manner.</p> <p>2. Resident 36 admitted to the facility in ,d+[DATE] with diagnoses including fracture of left femur.</p> <p>The [DATE] Quarterly MDS indicated Resident 36 had moderately impaired cognition.</p> <p>A [DATE] Event Progress note indicated Resident 36 received an expired COVID-19 vaccine on [DATE]. Resident 36 was placed on alert charting and monitored for adverse side effects.</p> <p>On [DATE] at 2:08 PM Staff 8 (RN) stated she was distracted when she administered the COVID-19 vaccine to Resident 36 and did not check the expiration date prior to administering the vaccine.</p> <p>On [DATE] at 3:23 PM Staff 2 (DNS) stated it was her expectation the expired vaccines were disposed of in a timely manner.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690</p> <p>Based on observation and interview it was determined the facility failed to ensure drugs and biologicals were secured and not expired for 3 of 4 medication carts and 1 of 1 medication room reviewed for medication storage. This placed residents at risk for adverse medication effects. Findings include:</p> <p>The facility Storage of Medication policy statement dated April 2007, stated The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p> <p>1. On 8/1/24 at 11:06 PM the treatment cart on the [NAME] Hall was observed to be unlocked and unattended by staff.</p> <p>On 8/1/24 at 11:31 PM Staff 16 (RN) confirmed she left the treatment cart unlocked and unattended.</p> <p>50926</p> <p>2. On 7/31/24 at 8:13 AM Staff 10 (LPN) discovered expired Lantus (an injectable insulin for treatment of Diabetes) in a medication cart.</p> <p>On 7/31/24 at 8:13 AM with Staff 10 confirmed the Lantus insulin had expired on 7/24/24 and should not be in the medication cart.</p> <p>In the medication storage room on 07/31/24 at 08:20 AM with Staff 10 (LPN) noted the emergency refrigerator was unlocked.</p> <p>Staff 10 (LPN) on 07/31/24 at 08:20 AM confirmed the emergency medication refrigerator should have been locked.</p> <p>On 7/31/24 at 11:29 AM Staff 17 (CMA) reviewed a medication cart on the 400 hall. Staff 17 observed a bottle of fish oil (a supplement) with an expiration date of 6/2024 and confirmed the supplement was expired and did not belong on the cart.</p> <p>On 7/31/24 at 12:13 PM an observation in the medication storage room with Staff 4 (RNCM) the medication refrigerator contained four boxes Fluzone High Dose Quadrivalent prefilled syringes and one box Seqirus Influenza vaccine an Adjuvanted Fluad Quadrivalent prefilled syringes (two types of influenza vaccines) that expired in 6/2024 .</p> <p>On 7/31/24 at 12:13 PM Staff 4 confirmed the prefilled syringes had expired 6/2024 and should not be in the refrigerator.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Robison Jewish Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 SW Boundary Street Portland, OR 97221	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On the 200 hall on 8/1/24 at 10:56 PM revealed two medication carts were left unlocked and unattended.</p> <p>Staff 16 (RN) on 8/1/24 at 11:17 PM, confirmed the two medication carts on the 200 hall were left unlocked and unattended.</p> <p>Staff 2 (DNS) on 8/2/24 at 11:25 AM stated her expectation was the carts and refrigerators would not contain expired medications and would be locked when unattended.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46053</p> <p>Based on observation, interview and record review it was determined the facility failed ensure the ice machine was cleaned adequately to maintain sanitary conditions in 1 of 1 kitchen reviewed for sanitary kitchen services. This placed residents at risk of foodborne illness. Findings include:</p> <p>On 7/29/24 at 9:49 AM the facility's ice machine located adjacent to the dry storage area and non-meat side of the kitchen was observed to have a powdery gray/green substance accumulated in the grooves of the panel directly above supply of ice. Condensation dripped across the panel's grooves and onto the supply of ice. Staff 29 (Executive Chef/Director of Dining Services) acknowledged the presence of the powdery substance and stated, It should not be like that and should be cleaned.</p> <p>A review of the Ice Machine Cleaning Log posted adjacent to the ice machine revealed staff cleaned the machine on a monthly basis. The task of cleaning the ice machine was not indicated in the kitchen's weekly Deep Cleaning Schedule or Daily Cleaning Schedule.</p> <p>On 8/2/24 at 11:48 AM Staff 29 stated she expected the ice machine to be cleaned to prevent ice provided to residents from being contaminated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43691</p> <p>Based on observations, interviews and record review it was determined the facility failed to implement infection control practices for 18 of 18 residents (#s 2, 4, 5, 8, 9, 10, 11, 14, 18, 21, 25, 26, 27, 29, 31, 33, 34 and 36) and 1 of 4 staff (# 15) reviewed for infection control. This placed residents at risk for infection. Findings include:</p> <p>1. The Center for Disease Control and Prevention (CDC) website section titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) specified enhanced barrier precautions (EBP) include the use of gowns and gloves during high contact resident care activities when a resident has a wound or an indwelling medical device such as an urinary catheter. Examples of high contact resident care activities requiring gown and glove use for EBPs include:</p> <ul style="list-style-type: none"> - Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing <p>Review of medical records revealed four residents (#s 2, 11, 25 and 29) had a urinary catheter and were to be placed on enhanced barrier precautions.</p> <p>Review of medical records revealed 14 residents (#s 4, 5, 8, 9, 10, 14, 18, 21, 26, 27, 31, 33, 34 and 36) received wound care and were to be placed on enhanced barrier precautions.</p> <p>Observations of all units of the facility on 7/30/24 and 7/31/24 revealed enhanced barrier precautions were not implemented for any of the residents listed above when high contact resident care activities were being provided.</p> <p>On 7/31/24 nursing staff were interviewed in each section of the facility. All staff stated gloves were worn when providing care which involved direct resident contact but gowns were not worn when providing care with any residents in the facility.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 7/31/24 at 3:54 PM Staff 2 (DNS) stated she was the facility's Infection Preventionist. Staff 2 stated infection control techniques were only used with residents with an active infection and enhanced barrier precautions could be used based on their discretion when a resident does not have an active infection.</p> <p>On 8/1/24 10:13 AM Staff 2 (DNS) confirmed enhanced barrier precautions including use of gloves and gowns should have been in place for residents who received wound care or had a catheter.</p> <p>50926</p> <p>2. The facility Administering Medication policy (revised 2019) specified Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.</p> <p>The facility procedure guidelines Administering Oral Medications (revised October 2010) included 26 steps. Three steps in the procedure were related to infection control practices:</p> <ul style="list-style-type: none"> -1. Wash your hands. - 9 e. for tablets or capsules from a bottle. Pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication with your hands. -23. Perform hand antisepsis. <p>During medication administration on 7/31/24 at 8:45 AM. Staff 15 (LPN) used her fingers to retrieve a pill out of the med cup and placed it in a resident's mouth. Staff 15 did not perform hand hygiene. She then returned to cart, prepared another resident's medications, and administered them without performing hand hygiene.</p> <p>Staff 15 on 7/31/24 at 9:15 AM stated she was expected to perform hand hygiene before and after administering medication and should not touch medications with bare hands. Staff 15 confirmed she touched the medication with her bare hand and did not complete hand hygiene before and after medication administration.</p> <p>Staff 2 (DNS) on 8/2/24 at 11:21 AM confirmed her expectation that hand hygiene should be completed before and after each medication administration and the medications should not be touched with bare hands.</p>		