STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	2201 NW Highland Avenue Grants Pass, OR 97526

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26991 Based on interview and record review it was determined the facility failed to ensure residents were treated with dignity and respect for 4 of 15 sampled residents (Witness 2 and Resident #s 51, 65, and 95) reviewed for dignity and abuse. This placed residents at risk for depression. Findings include: 1. Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. A 3/20/24 Quarterly MDS revealed Resident 51 was cognitively intact. On 6/10/24 at 12:27 PM Resident 51 stated staff did not treat her/him with respect. During this interview Staff 4 (CNA) entered Resident 51's room. Resident 51 informed Staff 4 she/he was having a conversation. Staff 4 stated she could pick up the resident's lunch try even if Resident 51 was talking. After Staff 4 left the room, Resident 51 stated she/he did not feel the staff treated her/him with respect. On 6/10/24 at 1:30 PM Staff 4 stated she entered Resident 51's room because the resident's call light was activated. Staff 4 acknowledged Resident 51 stated she/he was in a conversation but Staff 4 stated she could provide resident care even if the resident was talking. On 6/12/24 at 3:36 PM Staff 1 (Administrator) acknowledged Staff 4 interrupted Resident 51's conversation to pick up a lunch tray. 2. Resident 65 was admitted to the facility in 2024 with a diagnosis of pain. A 5/26/24 Quarterly MDS revealed Resident 65 was cognitively intact. A 6/6/24 Investigation Summary revealed on 5/30/24 Resident 65 reported to social services, Staff 32 (CNA)made rude comments about her/him. The investigation indicated Staff 32 told Resident 65 she/he stinks down there. Resident 65 reported the concern occurred prior to 5/30/24 and did not report the concern sooner due to fear of retaliation. On 6/11/24 at 4:42 PM Staff 41 (RN) stated Staff 32 was condescending to residents and recently was moved from resident care due to her behavior. Staff 41 stated management would communicate with Staff 32 and her attitude would improve for a short period of time and then return. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 10:19 AM Staff 32 (CNA) stated Resident 65 had a skin condition and in order to make it better Staff 32 informed Resident 65 it would be best to take a shower. Staff 32 stated she felt the resident was upset of the comment because Staff 15 (CNA) was in the room at the time of the interaction and Staff 15 was the opposite gender as Resident 65. On 6/12/24 at 11:43 AM Resident 65 stated Staff 32 did not treat her/him with respect. Resident 65 stated Staff 32 made comments about her/his body odor and stated she/he stunk. Resident 65 stated she/he was offered grievance forms by multiple staff. Resident 65 stated previously when she/he was informed Staff 32 was assigned to be her/his CNA it caused her/him anxiety. Resident 65 also stated even when she/he heard Staff 32's voice in the hall it upset her/him. Resident 65 stated Staff 32 no longer worked with her/him because Staff 32 was moved to a different unit. On 6/12/24 at 12:17 PM Staff 15 stated she/he was in the room when Staff 32 made a comment related to Resident 65 and bathing. Staff 15 stated Staff 32 told Resident 65 she/he had a smell about her/him. Staff 15 stated Staff 32 should have communicated with the resident in a less offensive manner. Staff 15 stated she/he communicated with Staff 32 on how her/his approach could be altered to be less offensive. On 6/12/24 at 9:45 AM Staff 2 (DNS) stated there have been reported concerns related to Staff 32 and her interactions with residents including Resident 65. Staff 2 stated it was usually a personality mismatch and not abuse or mistreatment. Staff 2 stated Staff 32 no longer worked in the unit where Resident 65 resided. 35855 3. Witness 2 (Resident) was admitted to the facility in 2024 with diagnoses including depression. A 4/2024 MDS indicated Witness 2 was cognitively intact with no concerns with behaviors. On 6/10/24 at 6:56 PM, Staff 43 (Former RN) reported Staff 32 (CNA) was not respectful to the residents. The concern was reported to the facility management and Staff 32 continued to be disrespectful. On 6/11/24 at 7:32 AM and 6/12/24 at 10:03 AM Witness 2 stated some staff members were sarcastic and lacked compassion. Witness 2 expressed concern about potential retaliation and requested anonymity. Witness 2 confirmed Staff 32 (CNA) treated her/him rudely, using sarcasm and rushing during interaction. Although there were a couple of other staff members involved, Witness 2 considered Staff 32 to be the worst. Witness 2 stated she/he did not turn in a grievance because she/he did not want to experience the day to day awkwardness with staff. On 6/12/24 at 9:35 AM Staff 30 (LPN Resident Care Manager) and Staff 27 (LPN Resident Care Manager) stated they heard about issues with Staff 32's interactions with residents. Staff 27 was uncertain which residents expressed concerns. Management was supposed to address these issues if a complaint was filed. Staff 27 mentioned that Staff 32 had been between different units due to staff-to-staff interactions rather than staff to resident interactions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 9:47 AM and 06/14/24 at 10:34 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated Staff 32 was removed from various units within the facility due to resident complaints about interactions related to Staff 32's attitude. Staff 1 stated it was an expectation for staff to treat residents with dignity and respect. On 6/12/24 at 10:57 AM, Staff 45 (Former Staffing) stated she relocated Staff 32 from multiple halls due to residents' complaints of mistreatment. Although management was aware of the issue, they did not address it. 38140 4. Resident 95 admitted to the facility in 5/2023 with diagnoses including a femur (thigh) fracture. Resident 95's 5/25/23 Admission MDS assessed her/him as cognitively intact. Review of an investigation dated 6/1/23, revealed Resident 95 made a verbal complaint to Staff 10 (former Social Services Assistant). Resident 95 reported Staff 39 (former Physical Therapy Assistant) called her/him trash. Staff 1's (Administrator) completed investigation dated 6/1/23 which concluded Staff 39 used the word trash that was not the best choice of words. On 6/13/24 at 12:34 PM Resident 95 stated she/he was called a piece of trash by Staff 39 and it hurt her/his feelings. On 6/13/24 at 2:51 PM Staff 1 acknowledged the incident and expected residents to be treated with dignity and respect.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on interview and record review it was determined the facility failed to inform residents and/or resident's responsible party of the risk and benefits for the use of an antipsychotic medication and the risk and benefits of not following a prescribed diet for 3 of 6 sampled residents (#s 16, 33, and 335) reviewed for medications and diet. This placed residents' and resident responsible parties at risk for lack of informed consent and decision making. Findings include: 1. Resident 16 was admitted to the facility in 2023 with diagnoses including anxiety and depression. A 3/2023 MAR instructed staff to administer aripiprazole (an antipsychotic medication treat depression and schizophrenia) one time a day related to schizophrenia with a start date of 3/3/23. There was no documentation found in Resident 16's clinical record to show she/he had a diagnosis of schizophrenia. Resident 16's 5/17/23 Antispychotic Medication Informed Consent indicated she/he had a physician order for aripiprazole for depression and anxiety, and the resident experienced inconsolable fear and crying. An informed consent was provided to Resident 16. Resident 16's 11/7/23 Mood Stablizer Medication Informed Consent indicated she/he had a physician order for aripiprazole (an antipsychotic medication) for schizophrenia and mood lability (rapid, exaggerated changes in mood). A 12/2023 MAR instructed staff to administer aripiprazole 10 milligrams one time a day which discontinued on 12/22/23 and aripiprazole 7.5 milligrams was started on 12/23/23. There was no documentation in Resident 16's clinical record she/he was notified of her/his diagnosis change or the change in her/his dosage amount. On 6/14/24 at 9:35 AM Resident 16 stated she/he could not remember when she/he was diagnosed with schizophrenia, but she was no longer taking the medication for it and whoever diagnosed her/him stated it would not be for long. In an interview on 6/14/24 at 10:52 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated if a resident was out of the facility for 30 or more days, they would have them sign a consent again. If there was a dosage change or if change of diagnosis, they would notify the resident of the change but would not complete a new consent. Staff 2 indicated it should be documented when residents were notified. 36494 2. Resident 33 was admitted to the facility on ,d+[DATE] with diagnoses including diabetes. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's care plan dated 9/30/21, indicated Resident 33 was a diabetic and on a controlled carboydrate diet with regular texture and regular thin liquids. Staff were to discuss and encourage appropriate portion sizes, dietary restrictions, snacks and compliance with nutritional regimen. There was no documented evidence the physician or interdisciplinary team informed the resident of the risk to the resident's health status when not following a diabetic diet. On 6/11/24 at 1:43 PM Resident 33 was observed in bed with three small empty ice cream containers and one liter of soda, which was empty on her/his bedside table next to the bed. The resident was asleep in bed. 6/12/24 at 8:23 AM Staff 17 (CNA) and at 10:48 AM Staff 6 (CNA) stated Resident 33 was non-compliant with her/his diabetic diet. Staff 17 and Staff 6 stated the resident often ate 100% of her/his meals at the facility and ordered fast food in addition. Staff 17 stated the resident drank one in a half liters of soda almost daily and freqently requested snacks. On 6/12/24 at 11:16 AM Resident 33 stated she/he was a diabetic and liked to eat whatever she/he wanted. Resident 33 stated she/he had fast food delivered often. On 6/12/24 at 7:28 PM, Staff 18 (LPN) and on 6/13/24 at 9:35 AM, Staff 21 (LPN) stated Resident 33 was non-compliant with her/his diabetic diet. The resident blood sugars consistently ranged in upper 200s to 300s. Staff 18 and Staff 21 stated the resident ordered pizza three to four times weekly, consumed excessive soda pop and indulged in multiple unhealthy snacks. Staff 18 and Staff 21 stated education was provided, and when residents were non-compliant, a risk and benefts form should be completed. Staff 18 and Staff 21 acknowledged a risk and benefits was not completed for Resident 33. On 6/13/24 at 10:16 AM and 11:10 AM, Staff 2 (DNS), Staff 27 (LPN and Unit Manager) and Staff 30 (LPN Unit Manager) stated Resident 33 was non-compliant with her/his diabetic diet and expected staff to educate, inform the physician and complete a risk and benefits form with Resident 33. Staff 2, Staff 27 and Staff 30 acknowledged the form was not completed. 47001 3. Resident 335 admitted to the facility on ,d+[DATE] with diagnoses including dementia. A 6/11/24 review of Resident 335's orders revealed a 6/7/24 order for quetiapine fumarate (an antipsychotic medication) and a 6/7/24 order for sertraline (an antidepressant medication). A 6/11/24 review of Resident 335's medical record revealed no evidence of a consent for quetiapine fumarate and sertraline. A 6/11/24 review of Resident 335's June 2024 MAR revealed she/he had taken quetiapine fumarate and sertraline on 6/8/24, 6/9/24 and 6/10/24. On 6/13/24 at 3:25 PM Staff 27 (LPN Unit Manager) stated Resident 335's son had not signed the consent for quetiapine fumarate and sertraline yet.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on interview and record review the facility failed to notify a resident's representative of a fall for 1 of 2 sampled residents (#89) reviewed for falls. This placed resident representatives at risk for being uninformed of resident accidents. Findings include: Resident 89 was admitted to the facility in 12/2022 with diagnoses including a fractured leg and pelvis. The MDS dated [DATE] revealed Resident 89 had a BIMS score of nine, which indicated the resident had moderate cognitive impairment. Resident 89's undated Admission Record revealed Witness 1 (Family Member) was Resident 89's emergency contact. On 6/5/24 at 12:48 PM Witness 1 stated Resident 89 fell out of bed at the facility two days after her/his admission. Witness 1 stated Resident 89 informed Witness 1 of the fall, but was unsure how the resident had fallen out of bed. Witness 1 was upset because facility staff did not notify her of the incident or potential injuries. On 6/12/24 at 4:00 PM Staff 21 (LPN) stated Resident 89 had an unwitnessed fall out of bed on 12/23/22 and acknowledged Witness 1 was not notified of the incident. On 6/13/24 at 11:01 AM Staff 2 (DNS) stated Witness 1 was the emergency contact and should have been notified about Resident 89's unwitnessed fall on 12/23/22.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38140 Based on observation and interview it was determined the facility failed to maintain privacy and confidentiality of resident records in 1 of 1 Social Services office. This placed residents at risk for lack of privacy and confidentiality. Findings include: On 6/14/24 at 10:18 AM Staff 36's (Social Services Director) office door was observed open with no staff present. The left computer monitor screen was visible with a resident's electronic health record and the right computer monitor screen was open and accessible email. The office was observed to contain with many papers with residents names and information which included transportation forms, State of Oregon letters to residents, completed discharge checklists, completed requests to transfer and individual resident care conference information. On 6/14/24 from 10:18 AM to 10:38 AM multiple staff and residents were observed in the area of Staff 36's office and were able to access the resident records. On 6/14/24 at 10:38 AM Staff 36 stated she left her office door open while she was in the facility to let people know she was in the facility working. Staff 36 confirmed unauthorized people had access to the resident records in her office when she was not in the office. On 6/14/24 at 12:37 PM Staff 1 (Administrator) confirmed he expected resident records to be secured with no access to unauthorized individuals.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26991 Based on observation and interview it was determined the facility failed to ensure a resident's wheelchair, residents' walls and floors were in good repair and failed to provide comfortable sound levels for 5 of 13 sampled residents (#s 20, 29, 51, 90, and 137) reviewed for environment. This placed residents at risk for skin tears and unhomelike conditions. Findings include: 1. Resident 20 was admitted to the facility in 2021 with a diagnosis including heart disease. On 6/10/24 at 2:30 PM a bathroom tile was observed to be missing on Resident 23's bathroom floor in front of the toilet. There was also a patched area on the bathroom wall with no paint to cover the caulking. The patch was approximately two feet wide and two feet long. On 6/12/24 at 2:13 PM Staff 2 (Administrator) observed the missing tile and the patched wall. On 6/12/24 at 2:48 PM Staff 46 (Maintenance) stated rooms were patched and then were painted when the residents were not in the room. Patching was a priority and not painting. 2. Resident 29 was admitted to the facility in 2017 with diagnosis of stroke. On 6/10/24 at 3:18 PM a patch on the wall to the left of the bathroom door was observed. The patch was not painted to cover the caulking. The patched area was approximately 5 inches by 12 inches. On 6/12/24 at 2:13 PM Staff 2 (Administrator) acknowledged the caulking was not painted. On 6/12/24 at 2:48 PM Staff 46 (Maintenance) stated rooms were patched and then were painted when the residents were not in the room. Patching walls was a priority but not painting. 3. Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. A 3/20/24 quarterly MDS revealed Resident 51 was cognitively intact. On 6/10/24 at 12:30 PM a patched area on the wall was observed above the resident's head of the bed but the caulking was not painted. Resident 51 stated the wall was patched and not painted since she/he was admitted to the room. On 6/12/24 at 2:13 PM Staff 2 (Administrator) acknowledged the caulking was not painted. On 6/12/24 at 2:48 PM Staff 46 (Maintenance) stated rooms were patched and then were painted when residents were not in the room. Patching was a priority not painting. 4. Resident 137 was admitted to the facility in 2024 with a diagnosis of a stroke. On 6/10/24 at 2:54 PM Resident 137's wheelchair armrests were observed covered with green tape. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 2:46 PM Staff 30 (LPN Resident Care Manager) observed the tape on the resident's wheelchair and acknowledged the surface could be rough on the skin and difficulty to clean. 35855 5. Resident 90 was admitted to the facility in 2023 with diagnosis of neck fracture. A 7/5/23 at 1:27 AM Alert Note indicated Resident 90 was agitated and was kept up by the fireworks and one sounded like it had come through her/his window. On 7/6/23 the State Survey Agency received a public complaint which indicated nights were noisy with people in the hallway and carts going up and down the hallway by the resident. At 6/10/24 at 2:20 PM Resident 90 confirmed the 7/6/23 complaint with concerns of loud noises at night while she/he stayed in the facility. On 6/11/24 at 5:51 AM a cart with full plastic bags was wheeled down the 300 hall with a squeaky wheel. Another staff member rolling two yellow garbage pails down the 300 hall could be observed and heard while standing in the 200 hallway. At 6:09 AM staff was heard talking loudly at the nurses' station. On 6/13/24 at 5:56 AM, a cart was heard rolling loudly by the nurse's station. At 6:02 AM Staff 16 (CNA) was observed wheeling to large garbage cans loudly down the 200 hall and entered the soiled linens room the sound of the cans was loud. Staff 16 stated residents did complain of the loud noise of the garbage cans. As well as other noises during the night such as residents yelling, coughing, or having their TV up too loud. Staff 16 stated she had brought up the noisy garbage cans wheels up to management, but she had not heard anything back for a possible change. In an interview on 6/14/24 at 10:30 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated they would expect noise levels to be quiet during sleeping hours and for staff to be quiet during shift change from night shift to day shift.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47001 Based on interview and record review it was determined the facility failed to provide a written grievance resolution or communicate with a resident or resident's representative regarding the resolution of a resident grievance for 6 of 14 sampled residents (#s 8, 83, 84, 86, 87, and 90) reviewed for abuse and dignity. This placed residents at risk for unaddressed concerns and grievances. Findings include: 1. Resident 8 was admitted to the facility in 4/2024 with diagnoses including a fracture of the right leg. A 6/6/24 Grievance Form revealed Resident 8 had a concern related to a male CNA providing persona care after she/he had requested a female CNA and the male CNA made Resident 8 feel uncomfortable after he requested to change her gown. A 6/7/24 grievance resolution reveled an investigation related to a male CNA requesting to change Resident 8's gown, no evidence of addressing Resident 8's concern related to a male CNA providing personal care. On 6/10/24 at 12:11 PM Resident 8 stated a male CNA came in during the night to provide personal care. Resident 8 stated she/he told the male CNA she/he preferred a female CNA. Resident 8 stated the male CNA walked out of the room and came back a few minutes later, proceeded to provide Resident 8's personal care needs and then requested to change Resident 8's gown. Resident 8 stated she/he said no to the gown change, and the male CNA left. Resident 9 stated this incident was reported to Staff 2 (DNS) , and she/he had not seen the male CNA since. 6/10/24 review of Resident 8's care plan revealed no evidence of Resident 8's request for female CNAs only for personal care. On 6/11/24 at 2:19 PM Staff 57 (CNA) stated Resident 8 had expressed wanting female CNAs on multiple occasions. Staff 42 stated Resident 8 would allow care from a few male CNAs and Staff 2 was aware of Resident 8's preference for female CNAs to provide personal care. On 6/13/24 at 3:03 PM Staff 29 (CNA) stated Resident 8 had expressed wanting female CNAs for personal care, and he was one of the male CNAs Resident 8 allowed to give her/him personal care but he continued to have a female CNA provide personal care if able. On 6/14/24 at 11:44 AM Staff 2 stated he verbally reviewed Resident 8's grievance related to male CNAs with her/him, but acknowledged there was no written resolution and Resident 8's preference was not on her/his care plan. 35855 2. Resident 90 was admitted to the facility in 2023 with diagnosis of neck fracture. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/6/23 the State Survey Agency (SSA) received a public complaint which indicated a staff member stated to Resident 90 to sit down and behave herself/himself or they are going to get her/him and staff threw her/his personal items when making her/his bed. A 7/9/23 at 8:49 PM a Nursing Note indicated Resident 90 reported to Staff 11 (LPN) that staff were throwing things and behaving rudely. Resident 90 began crying and expressed a desire to leave the facility. On 6/10/24 at 2:20 PM Resident 90 stated a staff members was upset and threw her/his personal items around the room. Resident 90 also stated the staff member had been rude on multiple occasions during her/his stay at the facility. On 6/11/24 at 10:53 AM Staff 1 (Administrator) stated Staff 11 did not report the concern from the 7/9/24 nursing note and no investigation or grievances was completed for Resident 90. On 6/12/24 at 8:26 AM Staff 10 (Former Social Services Director) stated Resident 90 reported staff being rude and throwing items. Staff 10 informed the resident's concerns to Staff 1 (Administrator). Staff 10 acknowledged she placed a grievance form on Resident 90's table but did not assist the resident with completing. In an interview on 6/14/24 at 10:27 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated the expectation would be for staff to call Staff 1 immediately if there was a report of staff throwing things or being rude. Staff 1 stated the process was if the resident wanted to file a grievance they would complete an investigation. The minimum would have been a grievance. 26991 3. Resident 83 was admitted to the facility 11/23/24 with a diagnosis of heart disease. Resident 83's room history revealed she/he resided on the Illinois unit and was later discharged from the facility. A 12/2/23 Admission MDS revealed Resident 83 was cognitively intact. On 12/12/23 Staff 43 (Former RN) reported to the State Survey Agency Staff 32 (CNA) did not treat residents with respect, including Resident 83. Staff 43 stated Resident 83 filed a grievance and management did nothing about the incident. On 6/10/24 at 6:56 PM Staff 43 stated Staff 15 was often rude to residents. Resident 83 filed a grievance and nothing was done. On 6/12/24 at 12:17 PM Staff 15 stated residents reported they did not like the manner in which Staff 32 treated them. Staff 15 stated she/he offered residents grievance forms if they had concerns. On 6/12/24 at 8:51 AM Staff 44 (CNA) stated Staff 32 was gruff and rude to residents. Staff 44 stated she observed the interactions and in the past it was reported to management. Staff 44 stated she would not want her mother treated in the manner Staff 32 treated residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 9:35 AM Staff 30 (LPN Resident Care Manager) and Staff 27 (LPN Resident Care Manager) stated they heard there were issues with Staff 32 and her/his interactions with residents. Staff 27 was not sure which residents had concerns. Management was to address issues if complaints were filed. Staff 27 also stated she thought Staff 32 was moved from different units, including Illinois unit, due to staff to staff interactions and not staff to resident interactions. On 6/12/24 at 9:47 AM Staff 2 (DNS) stated Staff 32 was removed from different units due to resident reports of interactions related to Staff 32. The interactions were not abuse it was more related to Staff 32's attitude. On 6/12/24 10:48 AM Staff 1 (Administrator) stated he did not have a grievance or investigation related to Staff 32 and Resident 83. On 6/12/24 at 10:57 AM Staff 45 (Former Staffing) stated she had to move Staff 32 from multiple units do to residents' reports of mistreatment. Staff 45 stated management was aware of the issue related to Staff 32 but did not address the concerns. 4. Resident 84 was admitted to the facility in 2023 with a diagnosis of diabetes. Resident 84's room history revealed she/he resided on the Illinois unit and was later discharged from the facility. A 12/2/23 Admission MDS revealed Resident 84 was cognitively intact. On 12/12/23 Staff 43 (Former RN) reported to the State Survey Agency Staff 32 (CNA) did not treat residents with respect, including Resident 84. Staff 43 stated Resident 84 filed a grievance and management did nothing about the incident. On 6/10/24 at 6:56 PM Staff 43 stated Staff 32 was often rude to residents. Resident 84 filed a grievance and nothing was done. On 6/12/24 at 9:35 AM Staff 30 (LPN Resident Care Manager) and Staff 27 (LPN Resident Care Manager) stated they heard there were issues with Staff 32 and her/his interactions with residents. Staff 27 was not sure which residents had concerns. Management was to address issues if a complaint was filed. Staff 27 also stated she thought Staff 32 was moved from different units, including Illinois unit, due to staff to staff interactions and not staff to resident interactions. On 6/12/24 at 9:47 AM Staff 2 (DNS) stated Staff 32 was removed from different units due to residents' reports of interactions related to Staff 32. The interactions were not abuse it was more related to Staff 32's attitude. On 6/12/24 at 10:19 AM Staff 32 denied treating residents in a undignified manner and denied being moved to different units related to her interactions with residents. On 6/12/24 at 10:48 AM Staff 1 (Administrator) stated he did not have a grievance or investigation related to Staff 32 and Resident 84. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 10:57 AM Staff 45 (Former Staffing) stated she had to move Staff 32 from multiple units due to residents' reports of mistreatment. Staff 45 stated management was aware of the issue but did not address the concerns. Staff 45 stated Resient 84 filed a complaint about Staff 32. 5. Resident 86 was admitted to the facility in 2023 with a diagnosis of diabetes. Resident 86's room history revealed at one time she/he resided on the Illinois unit and later was discharged from the facility. A 9/21/23 Admission MDS revealed Resident 86 was cognitively intact. On 12/12/23 Staff 43 (Former RN) reported to the State Survey Agency Staff 32 (CNA) did not treat residents with respect, including Resident 86. Staff 43 stated Resident 86 filed a grievance and management did nothing about the incident. On 6/10/24 at 6:56 PM Staff 43 stated Staff 32 was often rude to residents. Resident 86 filed a grievance and nothing was done. On 6/12/24 at 9:35 AM Staff 30 (LPN Resident Care Manager) and Staff 27 (LPN Resident Care Manager) stated they heard there were issues with Staff 32 and her/his interactions with residents. Staff 27 was not sure which residents had concerns. Management was to address issues if a complaint was filed. Staff 27 also stated she thought Staff 32 was moved from different units, including Illinois unit, due to staff to staff interactions and not staff to resident interactions. On 6/12/24 at 9:47 AM Staff 2 (DNS) stated Staff 32 was removed from different units due to residents' reports of interactions related to Staff 32. The interactions were not abuse it was more related to Staff 32's attitude. On 6/12/24 10:19 AM Staff 32 denied treating residents in a undignified manner and denied being moved to different units related to her/his interactions with residents. On 6/12/24 10:48 AM Staff 1 (Administrator) stated he did not have a grievance or investigation related to Staff 32 and Resident 86. On 6/12/24 at 10:57 AM Staff 45 (Former Staffing) stated she had to move Staff 32 from multiple units due to residents' reports of mistreatment. Staff 45 stated management was aware of the issue but did not address the concerns. Staff 45 stated Resident 86 filed a complaint about Staff 32. 6. Resident 87 was admitted to the facility in 2023 with a diagnosis of heart disease. A 9/23/23 quarterly MDS revealed Resident 87 was cognitively intact. Resident 87's room history revealed she/he resided on the Illinois unit and later was discharged from the facility. On 12/12/23 Staff 43 (Former RN) reported to the State agency Staff 32 (CNA) did not treat residents with respect, including Resident 87. Staff 43 stated Resident 87 filed a grievance and management did nothing about the incident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/24 at 6:56 PM Staff 43 stated Staff 32 was often rude to residents. Resident 87 filed a grievance and nothing was done. On 6/12/24 at 9:35 AM Staff 30 (LPN Resident Care Manager) and Staff 27 (LPN Resident Care Manager) stated they heard there were issues with Staff 32 and her/his interactions with residents. Staff 27 was not sure which residents had concerns. Management was to address the issues if a complaint was filed. Staff 27 also stated she thought Staff 32 was moved from different units, including Illinois unit, due to staff to staff interactions and not staff to resident interactions. On 6/12/24 at 9:47 AM Staff 2 (DNS) stated Staff 32 was removed from different units due to resident reports of interactions related to Staff 32. The interactions were not abuse it was related to Staff 32's attitude. On 6/12/24 at 10:19 AM Staff 32 denied treating residents in a undignified manner and denied being moved to different units related to interactions with residents. On 6/12/24 10:48 AM Staff 1 (Administrator) stated he did not have a grievance or investigation related to Staff 32 and Resident 87. On 6/12/24 at 10:57 AM Staff 45 (Former Staffing) stated she had to move Staff 32 from multiple units due to residents' reports of mistreatment. Staff 45 stated management was aware of the issue but did not address the concerns. Staff 45 stated Resident 87 filed a complaint about Staff 32.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 35855 Based on observation, interview, and record review it was determined the facility failed to assess the use of a physical restraint for 1 of 1 sampled resident (#57) reviewed for restraints. This placed residents at risk for potential abuse or neglect. Findings include: Resident 64 was admitted to the facility in 2023 with diagnosis of brain damage and anxiety. A 9/26/23 Fall Risk Evaluation indicated Resident 64 experienced multiple falls in the past three months. Resident 64 exhibited balance issues while standing and had a seizure disorder. Resident 64 was at risk for falls. A 10/14/23 care plan indicated Resident 64 experienced decreased mobility and was at risk for falls. Interventions included a fall mat to the right side of the bed, anticipate her/his needs, bed against the wall and to ensure commonly used items were in reach. A 4/5/24 MDS assessed Resident 64 with no physical restraints in place and had no falls since the resident's last MDS assessment. Resident 64 was rarely understood. On 6/12/24 at 9:13 AM, and on 6/13/24 5:42 AM, and at 8:05 am Resident 64 was observed in bed with a scoop mattress (A concave-shaped bed that prevents users from rolling off and falling.) There was no documentation in Resident 64's clinical record to indicate the resident's scoop mattress was assessed for a potential physical restraint. In an interview on 6/14/24 at 10:32 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated it would be expected for an evaluation to be completed for the use of a scoop mattress.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 26991 Based on observation, interview, and record review, it was determined the facility failed to report a resident to resident altercation for 2 of 11 sampled residents (#s 20 and 91) reviewed for abuse. This placed residents at risk for ongoing abuse. 1. Resident 20 was admitted to the facility in 2020 with a diagnosis of heart disease. A 12/16/23 Annual MDS revealed Resident 20 was cognitively impaired. Resident 20's Care Plan initiated 12/10/21 revealed Resident 20 propelled in a wheelchair. Review of Resident 20's clinical record revealed there were no resident to resident altercations identified in 11/2023. Resident 30 was admitted to the facility in 2020 with a diagnosis of seizures. Resident 30's Care Plan initiated in 2020 revealed Resident 30 was physically aggressive towards others due to a head injury. Staff were to intervene if the resident showed agitation to prevent escalated behaviors. A 12/20/23 Psychotropic Medication Review revealed Resident 30 had aggressive behavior. Review of Resident 30's clinical record revealed in 11/2023 she/he was not in a resident to resident altercation On 6/10/24 at 6:56 PM Staff 43 (Former LPN) stated around the last week of 11/2023 Resident 30 hit Resident 20. The documentation should be in the residents' clinical record. Staff 43 stated the management team did not update the residents' care plans to ensure the incident did not reoccur. On 6/11/24 at 1:23 PM Staff 6 (CNA) stated she did not witness when Resident 30 hit Resident 20 but recalled the incident. Staff 6 stated Resident 20 was confused, able to propel and cleaned the hall railings throughout the facility. Resident 30 did not propel but often hit at staff. Staff 6 stated if Resident 20 was within Resident 30's reach and Resident 30 was agitated, Resident 30 would hit. On 6/11/24 at 10:32 AM Staff 2 (DNS) stated he did not have an incident report related to a resident to resident incident for Resident 20 and Resident 30. On 6/11/24 at 1:26 PM Staff 41 (RN) stated he did not observe the incident when Resident 30 hit Resident 20 but heard about it. On 6/11/24 01:29 PM Staff 28 (LPN) stated she recalled an incident when Resident 30 hit Resident 20. She recalled the information on the nursing report. Staff 28 stated Resident 30 was more aggressive at that time and if Resident 20 was within reach Resident 30 could hit her/him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 2:00 PM Staff 30 (LPN Resident Care Manager) stated she recalled an incident when Resident 30 hit someone. She did not recall who Resident 30 hit but did not see any notes in the residents' files. On 6/11/24 at 4:02 PM Staff 50 (LPN) stated she recalled Resident 30 hit Resident 20 but did not witness the incident. She also recalled Resident 30 was placed on 1:1 (one staff monitors one resident) due to the incident. On 6/11/24 at 5:19 PM Staff 47 (CNA) stated she heard on night shift Resident 30 hit Resident 20. Resident 30 was 1:1 for about three days to ensure Resident 30 did not hit other residents. On 6/12/24 at 8:51 AM Staff 44 (CNA) stated at the end of 11/2023 Resident 20 was cleaning the rails in the hall. Resident 30 hit Resident 20 when Resident 20 was within reach. Staff 44 stated the incident was reported to a nurse, but she did not recall the nurse. On 6/12/24 at 3:38 PM Staff 1 (Administrator) stated it was his expectation for staff to report resident to resident incidents. He was not aware of an incident when Resident 30 hit Resident 20. 47001 2. Resident 91 was admitted to the facility in 8/2022 with diagnoses including intervertebral disc displacement of the spine. An 8/19/22 MDS assessed Resident 91 as moderately cognitively impaired. A Grievance Form dated 3/19/23 alleged three CNAs were rude and short with Resident 91 and one CNA pushed Resident 91 causing pain. The Grievance Summary Report was completed by Staff 24 (former Administrator), and indicated interviews were completed with the CNA who wrote the grievance, the RN who spoke with Resident 91 and with Resident 91. In the Greivance Summary Report, Resident 91 alleged two CNAs were rude to him and said he was, too heavy. No other interviews were provided and the was no evidence the allegation of one of the CNAs pushed Resident 91 resulting in pain was addressed. In the Grievance Summary Report indicated Resident 91's concern was resolved, and she/he was not harmed and was happy knowing Staff 23 (former agency CNA) was not returning to the facility. On 6/12/24 at 2:44 PM Staff 25 (former DNS) stated she did not recall the incident with Resident 91, but stated it was her understanding Staff 23's contract was canceled due to poor attendance and a poor attitude. On 6/13/24 at 10:24 AM Staff 23 denied the allegation. Staff 23 stated the facility canceled her contract on 3/21/23 without interviewing her. On 6/13/24 at 11:15 AM Staff 24 stated she did not recall the incident with Resident 91. On 6/13/24 at 2:01 PM Staff 22 (former Staffing Coordinator) stated she was not involved in the decision to cancel Staff 23's contract. Staff 22 stated she had never received a complaint about Staff 23, and she was an, excellent CMA who did not call in. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/24 at 11:48 AM Staff 1 (Administrator) acknowledged he was unable to evidence the allegation of abuse from Resident 91 was investigated or reported to the State. Staff 1 stated he would have, handled it differently.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 38140 Based on observation, interview and record review it was determined the facility failed to comprehensively assess residents related to behaviors for 1 of 2 sampled residents (#25) reviewed for behavioral health assessments. This placed residents at risk for unassessed behavioral emotional healthcare needs and services. Findings include: Resident 25 admitted to the facility in 2017 with a diagnoses including Schizoaffective Disorder (mental health and mood condition). Resident 25's 5/6/24 Annual MDS assessed her/him with moderately impaired cognition. Resident 25 was assessed with no behaviors exhibited. On 6/12/24 at 10:43 AM Resident 25 was observed to sit in the hallway, repetitively grab and abruptly move her/his coffee cup, talk to her/himself and stated fuck you to a staff who walked past her/him. On 6/13/24 at 9:08 AM Resident 25 was observed to sit in the hallway, push and pull her/his bedside table, talk to her/himself and said fuck you to Staff 2 (DNS) as he attempted to give a Resident 25 a high-five greeting. On 6/13/24 at 10:21 AM Staff 6 (CNA) stated Resident 25's present behaviors included swearing at people, clashing with her/his roommate as they both will mimic and yell at each other, pick at and smear feces, resist care by shouting and hitting staff. On 6/13/24 at 3:29 PM Staff 42 (CNA) stated Resident 25 continued to often pull feces from her/his body and smeared on her/himself, resist care by hitting and pulling on staff, yelling, swinging and swearing at others. On 6/14/24 at 12:37 PM Staff 1 (Administrator) and Staff 2 acknowledged they expected resident assessments to be comprehensive and behaviors were expected to be assessed accurately.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 35855 Based on interview and record review it was determined the facility failed to document and conduct a Significant Change MDS assessment within the required timeframe for 1 of 2 sampled residents (#57) reviewed for change of condition. This placed residents at risk for unassessed needs. Findings include: Resident 57 was admitted to the facility in 2023 with diagnoses including stroke. A 11/13/23 Admission MDS indicated the following: -Cognitively intact. -No depression concerns. -Set up or clean-up assistance for upper body dressing. -Supervision or touching assistance for personal hygiene. -Occasional bladder incontinence. -No falls since admission, but a history of falling in the last month. A 5/15/24 Quarterly MDS revealed the following: -Moderately impaired. -Feeling down and depressed two to six days in the seven-day look back period. -Partial moderate assistance for upper body dressing. -Substantial to maximal assistance for personal hygiene. -Frequent bladder incontinence. -Two or more falls since prior assessment. -Hypoglycemic (low blood sugars). The 5/29/24 care plan revealed -Requires substantial assist of one staff for personal hygiene. -Had a new diagnosis of diabetes. -At risk for falls (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation in Resident 57's clinical record which indicated a significant change assessment was considered or ruled out. In an interview on 6/14/24 at 11:00 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated they would look into why a significant change MDS was not completed. No additional information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38140 Based on interview and record review it was determined the facility failed to ensure residents were referred to the appropriate state-designated authority for a Level II PASARR (Pre-Admission Screening and Resident Review) evaluation (evaluation for individuals with a mental disorder or intellectual disability) for 1 of 1 sampled resident (#25) reviewed for PASARR's. This placed residents at risk for not receiving specialized mental health services. Findings include: Resident 25 admitted to the facility in 2017 with diagnoses including schizoaffective disorder (serious mental condition with breakdowns in thoughts, emotions, and behaviors), bipolar disorder (extreme mood swings) and Post-Traumatic Stress Disorder (mental condition with intense emotional and/or physical reaction). Resident 25's 5/6/24 Annual MDS indicated she/he was not considered to have a serious mental illness and therefore no Level ll PASARR was completed. A review of Resident 25's Electronic Health Record revealed there was no Level ll PASARR referral or evaluation completed. In an interview on 6/14/24 at 10:38 AM Staff 36 (Social Services Director) stated she was aware of Resident 25's mental health diagnoses and challenging behaviors. She confirmed Resident 25 did not have a Level ll PASARR evaluation or referral for an evaluation completed. On 6/14/24 at 12:37 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the lack of a completed Level ll PASARR and an effective system for referrals was needed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure a baseline care plan was developed for 2 of 12 sampled resident (#s 134 and 335) reviewed for dialysis, accidents, and medications. This placed residents at risk for unmet care needs. Findings include: 1. Resident 134 was admitted to the facility 12/2/23 with a diagnosis of kidney disease. A 12/2/24 hospital After Visit Summary revealed Resident 134 was to receive dialysis three times a week and her/his first scheduled treatment was 12/4/23. Review of Resident 134's baseline care plan revealed there was no information related to when she/he was scheduled for dialysis or the type and location of Resident 134's dialysis access. On 6/11/24 at 2:06 PM Staff 30 (LPN Resident Care Manager) stated a base line care plan was developed by the nurse who did the initial admission paperwork and by the resident care managers as they reviewed the resident's hospital paperwork. Staff 30 acknowledged a baseline care plan for dialysis was not initiated even though it was on the admission orders. 47001 2. Resident 335 was admitted to the facility on [DATE] with diagnoses including left femur (thigh bone) fracture after a fall and dementia. A review of Resident 335's medications revealed a 6/7/24 order for psychotropic (medications that affect a person's mental state) medications quetiapine fumarate and sertraline. A 6/10/24 BIMS (brief interview for mental status) Evaluation indicated Resident 335 had severe cognitive impairment. A /10/24 review of Resident 335's care plan revealed no evidence of a fall, dementia or use of psychotropic medication care plan. On 6/10/24 at 1:08 PM Resident 335 was observed standing beside her/his bed, using the bed side table for support. On 6/10/24 at 2:03 PM Resident 335 was observed ambulating to the door to her/his room. On 6/11/4 at 9:39 AM Staff 31 (CNA) stated Resident 335 was not at risk for falls. On 6/11/24 at 9:45 AM Staff 33 (CNA) stated she did not usually work with Resident 335 and did not know Resident 335. On 6/11/24 at 9:45 AM Staff 34 (CNA) stated she did not get report and did not know Resident 335. (continued on next page)

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	385149	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	2201 NW Highland Avenue Grants Pass, OR 97526

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 9:47 AM Staff 35 (CNA) stated Resident 335 was at risk for falls, does not remember to use her/his call light and would ambulate in her/his room without assistance. On 6/11/24 at 10:22 AM Staff 31 (Director of Rehabilitation) stated Resident 335 had impaired balance, was a high fall risk, had impaired cognition and poor safety awareness. On 6/11/24 at 10:51 AM Staff 27 (LPN Unit Manager) and Staff 30 (LPN Unit Manager) stated the admission nurse was responsible for the baseline care plan and the Unit Managers would follow up to validate the baseline care plan was completed within 72 hours of admission. Staff 30 stated Resident 335 was at risk for falls and should have had a care plan in place for being at risk for falls. On 6/11/24 at 1:25 PM Resident 335 was observed transferring her/himself form the chair to the bed. On 6/11/24 at 1:36 PM Resident 335 was observed ambulating in her/his room without pants on, a CNA assisted Resident 335. On 6/11/24 at 3:51 PM Staff 42 (CNA) stated she did not know Resident 335 and as far as she knew, Resident 335 was not at risk for falls. On 6/13/24 at 3:25 PM Staff 27 stated Resident 335 had a diagnosis of dementia and was taking psychotropic medications. Staff 27 acknowledged Resident 335 should have, but did not, have a baseline care plan for the dementia diagnoses or for the the psychotropic medications. On 6/14/24 at 11:54 AM Staff 2 (DNS) stated he expected the baseline care plan to be in place within 48 hours of admission, and the baseline care plan should include fall risk, psychotropic medications and dementia diagnosis. Staff acknowledged Resident 335's baseline care plan was not completed within 48 hours of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on interview and record review it was determined the facility failed to revise and update a care plan intervention for 6 of 11 sampled residents (#s 16, 19, 21, 25, 49 and 51) reviewed for medications care planning, dental and respiratory. This placed residents at risk for unmet of care needs. Findings include: 1. Resident 16 was admitted to the facility in 2023 with diagnoses including anxiety and depression. A 10/17/23 Nursing Note revealed the provider add the diagnosis of schizophrenia to Resident 16's dignosis list. Resident 16 is prescribed aripiprazole (an antipsychotic medicine that is used to treat schizophrenia)for this condition. A 10/25/23 Psych Consultants report revealed Resident 16 was seen from a facility referral and Resident 16 stated My mind is straight. Resident 16 then stated she/he saw black bugs flying in her/his room and saw them crawling on the window blinds. Resident 16 stated people think she/he was seeing things, but she/he knows they are there. Resident 16 was diagnosed with depression and schizophrenia. Resident 16 denied a history of mental health treatment or hallucinations. Resident 16 needed ongoing assessment for her/his mood and cognitive states as well as psychotherapy to address difficulties with paranoia and hallucinations. A 6/11/24 care plan revealed Resident 16 was diagnosed with schizophrenia. The care plan was not updated for approximatly eight months after the diagnosis of schizophrenia. In an interview on 6/14/24 at 10:50 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated the expectation of staff would be to update Resident 16's care plan sooner than 6/11/24 when she/he was diagnosed in 10/2023. 26991 2. Resident 19 was admitted to the facility in 2018 with a diagnosis of heart disease. On 6/10/24 at 4:09 PM Resident 19 was observed not to have two upper front teeth. Resident 19's 7/12/23 dental visit note revealed impressions were made for a removable partial denture. On 6/13/24 at 9:32 AM Staff 51 (CNA) stated Resident 19 had missing front teeth and Staff 51 was not aware Resident 19 had a partial. Staff 19 stated if a resident had a partial it was on the Kardex (CNA guide for resident specific Care) On 6/13/24 at 9:15 AM Staff 30 (LPN Resident Care Manager) stated Resident 19 had dental partials since 4/2024 but the care plan was not revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. A 3/31/24 Progress Note revealed Resident 51 was administered oxygen. On 6/10/24 at 12:39 PM Resident 51 was observed to wear a nasal canula (device that provides oxygen through a person's nose). Review of Resident 51's Care Plan initiated 6/2023 revealed there was no focus care area related to oxygen. On 6/11/24 at 2:25 PM Staff 27 (LPN Resident Care Manager) stated at times Resident 51 was administered oxygen but the care plan was not revised to reflect the resident's oxygen needs. Refer to F695 47001 4. Resident 21 was admitted to the facility on [DATE] with diagnoses including cervical vertebra (neck) fracture. A 4/5/24 Comprehensive MDS Assessment was signed completed on 4/10/24. On 6/11/24 at 8:34 AM Resident 21 stated she/he did not recall if she/he had a care conference since admission. A 6/11/24 medical record review revealed Resident 21 had a care conference on 4/4/24, the day after admission, and no other care conferences were located in the resident's record. On 6/12/24 Staff 36 (Social Service Director) stated new admissions have care conferences within three days of admission, before discharge, within in 14 days of admission if the resident is staying longer than 20 days and then every 90 days. On 6/12/24 at 1:49 PM Staff 27 (LPN Unit Manager) stated new admissions have care conferences within three days after admission, as needed and every 90 days. On 6/14/24 at 11:53 AM Staff 1 (Administrator) acknowledged new admissions need to have a care conference completed within seven days after completing the Comprehensive MDS Assessment. 5. Resident 49 was admitted to the facility on [DATE] with diagnoses including left rib fracture. A 5/11/24 Comprehensive MDS Assessment was signed completed on 5/21/24. On 6/10/24 at 1:32 PM Witness 8 (Resident Representative) stated she was unaware if Resident 49 had a care conference since admission. On 6/12/24 Staff 36 (Social Service Director) stated new admissions have care conferences within three days of admission, before discharge, within in 14 days of admission if the resident is staying longer then 20 days and than every 90 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 1:49 PM Staff 27 (LPN Unit Manager) stated new admissions have care conferences within three days after admission, as needed and every 90 days. On 6/14/24 at 11:53 AM Staff 1 (Administrator) acknowledged new admissions need to have a care conference completed within seven days after completing the Comprehensive MDS Assessment, by day 21. 38140 6. Resident 25 admitted to the facility in 2017 with diagnoses including a stroke. Resident 25's Quarterly MDS was completed on 11/5/23. Resident 25's 5/6/24 Annual MDS assessed her/him with moderately impaired cognition. On 6/11/24 at 8:26 AM Witness 5 stated he did not know if there was a change in staff, but we use to have quarterly care conference meetings and that seems like it's not happening any longer. Witness 5 could not recall the last time he contributed to Resident 25's care planning process or participated in a care conference meeting. No evidence was found in Resident 25's medical record to indicate options for alternate care conference meeting times, the reason for lack of resident representative participation, or steps taken to facilitate participation. No care conference meeting occurred between 1/17/24 to 6/11/24. On 6/14/24 at 10:38 AM Staff 36 (Social Service Director) stated she was responsible to schedule a care conference meeting for care planning in conjunction with each resident's comprehensive and quarterly MDS assessments. Staff 36 acknowledged it was six months since Resident 25's last care conference meeting, she contacted her/his representative the day prior to the care conference meeting and did not reattempt care conference meetings for resident representatives who were unable to attend. On 6/14/24 at 12:37 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged they expected care conference meeting to be held in conjunction with the Quarterly and Annual MDS assessments and resident representatives were expected to be involved if the resident was not able to advocate for themselves.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35855 Based on interview and record review it was determined the facility staff failed to follow professional standards of practice for a diagnosed mental disorder for 1 of 6 (#16) sampled residents reviewed for medications. Findings include: Resident 16 was admitted to the facility in 2023 with diagnoses including anxiety and depression. A 2/21/23 hospital History and Physical revealed Resident 16 was seen for right hip pain after sustaining a fall. A review of past medical history revealed no diagnosis of schizophrenia. Resident was on the medication aripiprazole (an antipsychotic medication used to treat depression and schizophrenia) and escitalopram (an antidepressant to treat depression and anxiety). A psychiatric evaluation revealed mood, behavior, thought content and judgement were normal. A 3/2023 MAR instructed Staff to administer aripiprazole one time a day for schizophrenia. A 3/6/23 Admission MDS indicated Resident 16 was cognitively intact with no hallucinations, delusions or behaviors exhibited during the seven day look back period. The assessment also indicated Resident 16 did not have a diagnosis of schizophrenia. The psychotropic care area indicated Resident was on aripiprazole an antidepressant and escitalopram for depression and anxiety. A 5/17/23 Antipsychotic Medication Informed consent revealed Resident 16 was physician ordered to take aripiprazole for depression and anxiety. Resident 16 experienced inconsolable fear and crying. A 9/6/23 Quarterly MDS indicated Resident 16 was cognitively intact with no hallucinations, delusions or behaviors exhibited during the seven day look back period. The assessment also indicated Resident 16 did not have a diagnosis of schizophrenia. A 9/2023 and 10/2023 Documentation Survey Reports revealed no documented behaviors for Resident 16. A 10/17/24 Nursing Note revealed the diagnosis of schizophrenia was added. Resident 16 was perscribed aripiprazole for this condition. A 10/25/23 Psych Consultants revealed Resident 16 was seen from a facility referral and Resident 16 stated My mind is straight. Resident 16 then stated she/he saw black bugs flying in her/his room and saw them crawling on the window blinds. Resident 16 stated people think she/he was seeing things, but she/he knows they are there. Resident 16 was diagnosed with depression and schizophrenia. Resident 16 denied history of mental health treatment or hallucinations. Resident 16 needed ongoing assessment for mood and cognitive states Resident 16 needed to participate in psychotherapy to address difficulties with paranoia and hallucinations. A 10/25/23 Lab result indicated Resident 16 had a UTI. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/30/23 hospital History and Physical revealed Resident 16 was seen for an irregular heart rate which varied from 40 to 200 beats per minute. Past Medical History revealed no diagnosis of schizophrenia. Resident 16 was on medications aripiprazole and escitalopram. A psychiatric evaluation revealed mood, behavior, and thought content were normal. No documentation was found in Resident 16's clinical records which indicated she/he had a history of schizophrenia. A Medical Diagnosis report revealed Resident 16 had a diagnosis of schizophrenia with classification as an admitting diagnosis which was created on 10/17/23. On 6/14/24 at 9:35 AM Resident 16 stated she/he could not remember when she/he was diagnosed with schizophrenia, but she/he was no longer taking the medication for it and whoever diagnosed her/him stated it would not be for long. On 6/14/24 at 10:12 AM Staff 37 (CNA) stated she never observed Resident 16 hallucinate or have delusions. Staff 37 stated at times she/he would report a CNA did not assist her/him when they had. In an interview on 6/14/24 at 10:36 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) Staff 1 stated Resident 16 previous caregiver stated Resident 16 was diagnosed with schizophrenia. Staff 1 also stated Resident 16 had symptoms for a long time and behaviors for an extended period. Staff 1 stated they would investigate additional history. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35855 Based on interview and record review it was determined the facility failed to follow physician orders and monitor for 5 of 14 sampled residents (#s 16, 33, 51, 133, and 134) reviewed for medications, antibiotics, dialysis, and edema. This placed residents at risk for adverse side effects and constipation. Findings include: 1. Resident 16 was admitted to the facility in 2023 with diagnoses including anxiety and depression. a. A 5/2024 MAR instructed staff to administer metoprolol tartrate (to treat high blood pressure) every 12 hours for heart health and to hold the medication if Resident 16's blood pressure was below 100/60 or heart rate was below 60. On the following days and shifts Resident 16's blood pressure was not within physician ordered parameters and she/he was administered metoprolol: 5/2/24 day shift, 5/4/24 day shift, 5/7/24 evening shift, 5/8/24 evening shift, 5/9/24 day shift, 5/10/24 evening shift, 5/15/24 evening shift, 5/16/24 day shift, 5/17/24 evening shift, 5/18/24 evening shift, 5/19/24 evening shift, 5/23/24 evening shift, 5/26/24 evening shift, and 5/28/24 evening shift. A 6/2024 MAR instructed staff to administer metoprolol tartrate every 12 hours for heart health and to hold the medication if Resident 16's blood pressure was below 100/60 or heart rate was below 60. Resident 16's blood pressure was not within physician ordered parameters and she/he was administered metoprolol on the following shifts: 6/2/24 evening shift, 6/3/24 day and evening shift, 6/4/24 day shift, 6/5/24 day shift, 6/8/24 day shift, 6/10/24 day shift, and 6/11/24 evening shift. On evening shift Resident 16 was administered medication when heart rate was below 60 on 6/10/24 and 6/11/24. A review of Resident 16's Heart Rate report revealed: Her/his Heart rate was not documented as obtained. -5/1/24 evening shift. -5/3/24 evening shift. -5/5/24 evening shift. -5/6/24 evening shift. -5/8/24 day shift. -5/11/24 day shift. -5/12/24 evening shift. -5/14/24 evening shift. -5/16/24 evening shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/19/24 day shift. -5/20/24 evening shift. -5/21/24 evening shift. -5/24/24 evening shift. -5/26/24 day shift. -5/27/24 evening shift. -5/29/24 evening shift. -5/30/24 evening shift. -6/1/24 evening shift. Heart rate below 60 beats per minute. -6/10/24 at 2:28 PM 59. -6/11/24 at 2:56 PM 59. A review of Resident 16's Blood Pressure report revealed: Her/his blood pressure not documented as obtained. -5/8/24 day shift. -5/12/24 evening shift. -5/16/24 evening shift. -5/19/24 day shift. -5/24/24 evening shift. -5/26/24 day shift -5/27/24 evening shift. -5/29/24 evening shift. -5/31/24 evening shift. -6/3/24 evening shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Her/his blood pressure was documented as below 100/60: -5/2/24 6:21 AM 103/52. -5/4/24 6:33 AM 98/55. -5/7/24 3:21 PM 107/56. -5/8/24 3:42 PM 115/56. -5/9/24 8:42 AM 101/52. -5/10/24 3:08 PM 116/52. -5/15/24 3:19 PM 105/55. -5/16/24 6:55 AM 114/55. -5/17/24 2:49 PM 105/59. -5/18/24 2:54 PM 107/57. -5/19/24 2:35 PM 104/58. -5/23/24 3:29 PM 101/58. -5/26/24 3:17 PM 106/47. -5/28/24 3:28 PM 108/51. In an interview on 6/14/24 at 10:19 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated if the physician did not specify if one measurement was out of parameter the staff should hold the medication. b. A 5/2024 MAR instructed staff to administer Furosemide as needed for fluid retention for weight gain of more than two pounds. No medication was administered in 5/2024 no documentation of weights were on the MAR to identify if there was a weight gain. A review of the Weight Summary report revealed in 5/2024 Resident 16's weight was obtained 12 instances out of 31 opportunities. From 5/4/24 to 5/5/24 Resident went from 152 to 154 a weight gain of two pounds. From 5/25/24 to 5/29/24 Resident 16 went from 150 pounds to 155 pounds a weight gain of five pounds. In an interview on 6/14/24 at 10:19 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated they would expect daily weights to be completed. 36494 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 33 was admitted to the facility in 8/2021 with diagnoses including diabetes. A physician order dated 1/16/24, indicated Resident 33 was to receive Senna (a laxative)two tablets two times daily. The 5/2024 and 6/2024 MARs indicated Resident 33 did not receive the medication 32 times from 5/1/24 through 6/11/24. On 6/12/24 at 7:28 PM Staff 18 (LPN) stated Resident 33 refused her/his Senna medication. Staff 18 stated she recorded refusals in the medical records and after multiple refusals, she would alert the physician. Staff 18 stated she was unsure if she reported Resident 33's refusals. On 6/13/24 at 10:16 AM Staff 27 (LPN Unit Manager) and Staff 30 (LPN Unit Manager) acknowledged Resident 33 refused her/his Senna medication on multiple occasions. Staff 27 and Staff 30 stated staff were expected to notify the physician after every refusal. 26991 3. Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. An Unwitnessed Fall investigation revealed Resident 51 slipped out of bed on 3/14/24. The investigation indicated neurological assessments were initiated. Progress Notes revealed the following: -3/14/24 no assessment documented related to a fall -3/15/24 no assessment related to a fall -3/16/24 Resident 51 previously fell and reported pain to the wrist and back. Pain medications were effective -3/18/24 Resident 51 did not have an injury from a previous fall and was able to walk without pain. Resident 51's clinical record did not contain neurological assessments after the 3/14/24 fall. On 6/10/24 at 12:25 PM Staff 30 (LPN Resident Care Manager) reviewed Resident 51's chart and acknowledged staff did not monitor the resident after her/his fall. On 6/11/24 05:09 PM Staff 2 (DNS) stated after a fall staff were to monitor a resident twice a day. A request was made to Staff 2 to provide neurological assessments for Resident 51's fall. No additional information was provided. Refer to F689 4. Resident 133 was admitted to the facility in 2023 with a diagnosis of infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 133's 11/2023 MAR revealed staff were to administer an antibiotic every four hours. The MAR revealed the resident did not receive antibiotics on five occasions. Resident 133's 12/2023 MAR revealed staff were to administer an antibiotic every four hours. The MAR revealed the resident was not administered the prescribed antibiotic on three occasions. On 6/13/24 at 7:41 AM Staff 28 (LPN) stated when a medication was administered staff had to enter yes in the electronic record and then save the response after the medication was administered. If a resident was not available or refused a medication the response was changed to refused, resident not available or see nurse's note. Staff 28 stated the MAR should not be blank for scheduled medications. On 6/13/24 at 2:35 PM Staff 2 (DNS) stated he would provide documentation if Resident 133 was not in the facility due to appointments to support the missed antibiotic administration. No additional information was provided. 5. Resident 134 was admitted to the facility in 2023 with a diagnosis of kidney disease. Progress Notes revealed the following: -12/9/23 Resident 134 had pain with urination and the resident's physician was notified A 12/11/23 Provider Note revealed Resident 134 had pain with urination and staff were to obtain a urine sample. Review of the resident's record revealed there were no results for a urine sample for the 12/11/23 orders. On 6/11/24 at 1:37 PM a request was made to Staff 2 (DNS) to provide results from the 12/11/23 physician order UA. No additional information was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 26991 Based on observation, interview and record review it was determined the facility failed to ensure a resident had glasses for 1 of 3 sampled residents (#20) reviewed for communication-sensory. This placed residents at risk for unmet vision needs. Findings include: Resident 20 was admitted to the facility in 2021 with a diagnosis of dementia. A 3/17/23 quarterly MDS indicated Resident 20 had adequate vision with corrective lenses. On 6/10/24 at 12:36 PM Witness 3 (Spouse) stated Resident 20 liked to read and wore glasses, but the glasses were broken. On 6/10/24 at 1:46 PM Resident 20 was observed to read and she/he did not wear glasses. Staff 52 stated Resident 20's glasses were broken for some time. On 6/12/24 at 2:36 PM Staff 53 (CNA) stated Resident 20's lens was missing since at least 12/2023. On 6/12/24 at 2:23 PM Staff 36 (Social Service Director) stated on 6/11/23 she just found an unsigned note on her desk reporting one of Resident 20's lens was broken. Staff 36 was not aware of of the issue and Resident 20 did not have any scheduled vision appointments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident's environment remained free from accident hazards for 3 of 6 sampled residents (#51, 57 and 63) reviewed for accidents. This placed residents at risk for accidents. Findings include: 1. Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. An Unwitnessed Fall investigation dated 3/14/24 revealed on 3/14/24 Resident 51 slipped out of bed. Interventions to prevent future falls included staff readjusted the mattress to ensure it was centered on the bed frame and nonslip material was to be applied under the mattress. A care plan updated 3/14/24 revealed to prevent falls Resident 51 was to have nonslip material applied to the bed mattress to ensure the mattress did not slip. A 3/20/24 quarterly MDS revealed Resident 51 was cognitively intact. On 6/10/24 at 12:25 PM Resident 51 stated her/his mattress did not fit the bed frame and caused her/him to fall. Resident 51 also stated staff did not provide her/him with a new mattress. On 6/11/24 at 4:51 PM with Resident 51's permission, Staff 53 (CNA) looked under Resident 51's bed and nonslip material was not observed. Resident 51's mattress was also observed to have bed brackets on the bed frame to keep the mattress in place but the mattress was too big and it was positioned on top of the brackets and not within the brackets. On 6/11/24 at 5:01 PM Staff 1 (Administrator) stated the mattress was too large and would be addressed. On 6/11/24 at 5:09 PM Staff 2 (DNS) stated the maintenance staff applied brackets to the bed frame to keep the mattress from slipping off the bed. Staff were to put nonslip material on the edge of the bed frame to prevent the mattress from slipping. 35855 2. Resident 57 was admitted to the facility in 2023 with diagnoses including stroke. A 11/22/23 care plan indicated Resident 57 was at risk for falls and a history of falls. Resident 57 exhibited impulsive behavior, often getting up out of bed without using the call light. Interventions included to ambulate Resident 57 during the day and evening, anticipate needs, call light in reach, bedside commode next to the bed and encourage its use, commonly used items in reach and a sign posted to remind Resident 57 to call for assistance before getting out of bed. A 5/15/24 MDS indicated Resident 57 was moderately impaired required one person supervision with transfers and had two or more falls since prior assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/6/24 Witnessed Fall investigation indicated Staff 40 (Housekeeper) observed Resident 57 attempting to transfer to the bathroom without assistance, using a front wheel walker. Resident 57 lost her/his balance and fell backwards against the bed. The resident sustained some bruising on mid back, possibly from a previous fall. At the time Resident 57 had on regular socks and not nonskid socks. Resident 57 was noted to have repeated falls, to be impulsive, and not wait for assistance. The root cause was attributed to poor safety awareness and cognitive impairment exacerbated by the use of regular socks. On 6/11/24 at 5:35 AM Resident 57 was in her/his bed. The bed was positioned against the wall and a fall mat lay on the floor beside it. The bedside table was out of reach, and no bedside commode was visible. Fall mat intervention was not indicated on the care plan. On 6/12/24 at 9:12 AM Resident 57 was in bed with the bed against the wall and no fall mat on the floor. The bedside commode was up against the wall by the door, away from the bed. At 12:06 PM Resident 57 was observed self-transferring from her/his wheelchair to the bed on her/his own. At 12:08 PM, Resident 57 mentioned not knowing what the sign on the bedside table said. On 6/13/24, at 5:41 AM and 8:03 AM Resident 57 was in bed with the bedside commode positioned next to the wall near the door not near the bed. A walker was placed beside the bed, while the wheelchair was approximately five feet away from the bed. At 12:25 PM the bed was rearranged, with the head of the bed now against the wall instead of the side. At 6/13/24 at 9:33 AM Staff 40 stated on 6/6/24, she witnessed Resident 57 attempting to get up from bed, grabbing the walker, and moving toward the bathroom. Resident 57 fell with upper body on the bed and lower body on the floor. Staff 40 yelled for assistance. Staff 41 (RN) arrived and questioned Staff 37 (CNA) about the absence of the bedside commode and fall mat near Resident 57's bed. In an interview on 6/14/24 at 10:19 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated would expect staff to follow the care plan. 49677 3. Resident 63 was admitted to the facility in 2024 with diagnoses including falls and anxiety. An 4/29/24 care plan indicated Resident 63 required a bedside commode for toileting. The 5/13/24, 5/22/24, and 5/29/24 Fall incident reports concluded Resident 63 fell while attempting to self-transfer in the bathroom. On 6/13/24 at 9:42 AM an observation of Resident 63's room revealed no bedside commode. Staff 44 (CNA) confirmed that a bedside commode would be helpful to prevent falls. On 6/13/24 at 11:01 AM Staff 59 (Resident Care Manager-LPN) acknowledged the care plan was not followed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 26991 Based on interview and record review it was determined the facility failed to ensure nutritional supplements were provided for 1 of 3 sampled residents (#19) reviewed for nutrition. This placed residents at risk for weight loss. Findings include: Resident 19 was admitted to the facility in 2018 with a diagnosis of diabetes. A 2/1/24 Nutritional Screen indicated Resident 19 was to be provided a diabetic nutritional supplement BID to prevent weight loss. An 4/2024 MAR revealed Resident 19 received a supplement BID through 4/7/24 and was out of the facility through 4/16/24. Resident 19's supplement was not restarted after 4/16/24. An 4/20/24 Nutritional Screen revealed Resident 19 was assessed and the plan was to continue with the current plan and to monitor the resident for weight loss. On 6/13/24 at 9:18 AM Staff 30 (LPN Resident Care Manager) stated the resident was hospitalized in 4/2024 and acknowledged the resident's supplement was not restarted upon readmission to the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 26991 Based on observation, interview, and record review, it was determined the facility failed to obtain orders for oxygen and clean a resident's oxygen equipment for 1 of 1 sampled resident (#51) reviewed for respiratory care. This placed residents at risk for unsanitary conditions and lack of monitoring. Findings include: Resident 51 was admitted to the facility in 2023 with a diagnosis of cancer. On 6/10/24 at 12:39 PM Resident 51 was observed to wear a nasal canula (device to administer oxygen through the nose). The back of Resident 51's oxygen concentrator (machine which takes air from the surroundings, extracts oxygen and filters it into purified oxygen) was observed to have a thick layer of dust over the vent. Resident 51's clinical record did not contain orders for oxygen. On 6/11/24 at 2:25 PM with Staff 55 (LPN) Resident 51's concentrator was observed to have a thick layer of dust on the vents. Staff 55 stated she was new to the facility but the equipment was to be cleaned weekly and the amount of dust on the vents indicated it was not cleaned for a long time. Staff 55 stated a nurse could initiate oxygen but needed to obtain orders from a physician for continued use. On 6/11/24 02:33 PM Staff 2 (DNS) verified there were no oxygen orders in the resident's clinical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure pain medications were available for 2 of 3 sampled residents (#85, and 339) reviewed for pain. This placed residents at risk for increased pain. Findings include: 1. Resident 85 was admitted to the facility in 2023 with diagnoses including arm and leg fractures. A 11/17/23 Pain Assessment revealed Resident 85 did not have pain at the time of the assessment but reported pain interfered with her/his sleep and social activities. A 11/22/23 admission MDS revealed Resident 85 reported constant pain for the last five days. A 11/2023 MAR and associated progress notes revealed the following: -Resident 85 was to be administered oxycodone every four hours while awake. From 11/24/23 through 11/27/23 Resident 85 was not administered the medication six times. -From 11/27/23 Percocet was to be administered every four hours. Notes indicated the medication was not available. -No additional medications were added for pain relief. Resident 85's pain levels from 11/24/23 through 11/28/23 ranged from four to nine (pain levels four to six=moderate pain, seven and greater=severe pain). A 11/27/23 Physical Therapy note revealed Resident 85 reported a pain level of six for her/his leg and a pain level of eight for her/his wrist. Resident 85 reported she/he was frustrated with not having proper pain medications. Resident 85's clinical record revealed she/he had surgery on 11/29/23 and returned the same day. On 6/10/24 at 6:56 PM Staff 43 (Former RN) stated Resident 85 was not administered pain medications as prescribed. On 6/13/24 at 2:01 PM Staff 27 (LPN Resident Care Manager) stated Resident 85 was admitted to the facility for a short period of time. Staff 27 stated she was aware the resident had pain and was scheduled for surgery in late 11/2023. Staff 27 was not aware of pain control issues and staff were able to pull pain medications from the emergency supply if the medications were not available in the medication cart. On 6/14/24 at 10:00 AM and 12:53 PM Staff 2 (DNS) stated Resident 85 was on multiple pain medications and in 11/2023 there was an oxycodone shortage. A request was made to Staff 2 to provide documentation additional pain medications were added to the resident's pain regimen when the medications were documented as not available. No additional information was provided. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47001 2. Resident 339 admitted to the facility on [DATE] at 11:45 AM with diagnoses including left femur (thigh bone) fracture. On 6/14/24 at 8:52 AM Witness 9 (Family Member) stated Resident 339 called on 6/13/24 during the night and stated she/he had not had any pain medications since admission. On 6/14/24 at 9:30 AM Resident 339 stated she/he requested pain medication on 6/13/24 after admission at 11:45 AM and during the night on 6/14/24 but did not receive any pain medications until 8:30 AM on 6/14/24. On 6/14/24 at 9:48 AM Staff 7 (CNA) stated she worked with Resident 339 during the night of 6/13/24 through 6/14/24. Staff 7 stated Resident 339 requested pain medications during the night and she informed the nurse. A review of Resident 339's 6/2024 MAR revealed Resident 339 had not received her/his pain medications until 6/14/24 at 8:09 AM. On 6/14/24 at 11:10 AM Staff 2 (DNS) stated the emergency medication kit had Resident 339's pain medications. At 11:55 AM Staff 2 stated every nurse had access to the emergency medication kit and Resident 339 should have received her/his pain medications when she/he requested it.

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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. 38140 Based on interview and record review it was determined the facility failed to ensure a resident who was a trauma survivor received trauma-informed care in accordance with professional standards of practice and account for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for 1 of 2 sampled residents (#25) reviewed for Behavioral-Emotional. This placed residents at risk for re-traumatization and a decrease in their quality of life. Findings include: Resident 25 admitted to the facility in 2017 with diagnoses including PTSD (Post-Traumatic Stress Disorder, mental condition with intense emotional and/or physical reaction). Resident 25's 5/6/24 Annual MDS assessed her/him with moderately impaired cognition and a PTSD diagnosis. Resident 25's 6/11/24 SS (social service) Post-Traumatic Checklist assessed her/him to experience anger outbursts, difficulty concentrating, unable to answer complicated questions and was irritable. Interventions for the verbal outbursts were to talk calmly or walk away. It was assessed as not helpful to keep talking to her/him. No other interventions or triggers were identified. Resident 25's SS Psychosocial Evaluation revealed in the section Describe Trauma: any time they may experience anxiety, sensitive to touch or noise or nightmares as the following: she/he does suffer from PTSD r/t [related] to trauma experienced while in the service. No other information was documented. On 6/13/24 at 10:21 AM Staff 6 (CNA) stated she obtained information to care for Resident 25 from the Kardex (care plan for CNAs), at report to each other during change of shift and I just know [her/him] because I've worked with [her/him] so long. Staff 6 stated Resident 25 experienced behaviors and certain things would set [her/him] off. On 6/13/24 at 3:29 PM Staff 42 (CNA) stated Resident 25 was often resistive to care and would hit or yell at staff. Staff 42 obtained her information to care for Resident 25 from the Kardex. Resident 25's 6/13/24 Kardex section for Behavior/Mood directed staff to provide the following: -Non-Medication Interventions in place routinely; -Approach in a slow non-threatening manner; -Remove to a safe environment PRN for increased behavior; -Remove to a quieter environment PRN to decrease over stimulation; -Do not force or rush care; -One on One PRN. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 25's PTSD care plan directed staff to provide the following: -Avoid continuing to talk to her/him when she/he expressed feeling stressed, upset, or overwhelmed, give her/him time to calm down; -Resident expressed feeling stressed, upset, or overwhelmed with the following behaviors or ways of responding: making verbal threats; -Resident preferred the approach from facility personnel when he/she felt upset, stressed, or overwhelmed: talk calmly or walk away; -Staff to avoid and resist re-traumatizing her/him with thoughtful approaches to care. No evidence was found in Resident 25's health record related to the development and implementation of individualized interventions, for assessed triggers of trauma which may re-traumatize the resident or identify ways to mitigate or decrease the effect of the trigger on the resident. On 6/14/24 at 10:38 AM Staff 36 (Social Service Director) stated she was aware of Resident 25's behaviors. Staff 36 was unaware of specific behaviors Resident 25 exhibited related to PTSD or what triggered the PTSD. Staff 36 stated to her knowledge the triggers were not assessed or care planned for individual residents. On 6/14/24 at 12:37 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the need for residents to have triggers identified for a PTSD diagnosis to prevent re-traumatization. Staff 2 acknowledged the resident care plans were expected to be resident centered for the individual.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35855 Based on observation, interview, and record review, it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include: A review of the Direct Care Staff Daily Reports (DCSDR) from 5/9/24 through 6/9/24 revealed no census documented on 6/5/24 day and evening shift, 6/6/24 evening shift, or 6/8/24 night shift. On 6/11/24 at 5:25 AM the DCSDR was observed posted by the nurses station. The night shift was blank for resident census, number of staff and hours worked. On 6/12/24 at 8:02 AM the DCSDR was observed to have 6/11/24 posted. No census was documented for evening shift or night shift. At 9:17 AM the 6/12/24 DCSDR was posted with no census documented on the day shift. In an interview on 6/14/24 at 10:22 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) reported it was expected to have an accurate DCSDR posted within one hour of a shift change.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was transported to dialysis for 1 of 1 sampled resident (#134) reviewed for dialysis. This placed residents at risk for worsening kidney function. Findings include: Resident 134 was admitted to the facility in 2023 with a diagnosis of kidney disease. 12/2/23 hospital orders revealed Resident 134 was to receive dialysis at a dialysis center on Mondays, Wednesdays, and Fridays. On 12/12/23 Staff 43 (Former RN) reported to the State Survey Agency the facility did not follow up with transportation for Resident 134 and On 12/11/23 (Monday) she/he missed a dialysis treatment. On 6/10/24 at 6:56 PM Staff 43 stated the facility was aware Resident 134 required transportation to the dialysis unit, the paperwork was submitted, but they did not transport the resident. On 6/20/24 via e-mail, Staff 2 (DNS) indicated Resident 134 did not go to dialysis. No additional information was provided for the rationale Resident 134 did not attend dialysis. On 6/21/24 Witness 10 (Dialysis RN) verified Resident 134 did not get dialysis treatment on 12/11/23 due to lack of transportation. Witness 10 stated if a resident resided in a nursing facility the facility was to assist the resident to and from the dialysis unit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35855 Based on interview and record review it was determined the facility failed to follow pharmacy recommendations for 4 of 6 sampled residents (#s 16, 33, 63, and 51) reviewed for medications. This placed residents at risk for adverse medication side effects. Findings include: 1. Resident 16 was admitted to the facility in 2023 with diagnoses including anxiety and depression. a. A 10/28/23 Recommendation Summary for Medical Director and DON indicated Resident 16 required a gradual dose reduction assessment. The recommendation proposed lowering the dosage of aripiprazole (antipsychotic medication treat depression and schizophrenia) from 10 milligrams to 7.5 millagrams. The physician did not sign or date the recommendation, or provide a clinical rationale for maintaining the current medication dosage. A 11/2023 and 12/2023 MARs instructed staff to administer aripiprazole 10 milligrams once a day from 11/7/23 through 12/22/23. During an interview on 6/14/24 at 10:49 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) expressed the recommendations should be implemented within the month. b. A 4/28/24 Nursing Recommendations from the pharmacy indicated Resident 16 was taking the antipsychotic aripiprazole. Standards of practice required an assessment for abnormal involuntary movement (AIMs) every six months and was due in 5/2024. A handwritten note next to the recommendation indicated completion, although it lacked a specific date. No other documentation was found in clinical records the AIMS evaluation was completed in 5/2024. In an interview on 6/14/24 at 10:49 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated the recommendations should be implemented in the month. 36494 2. Resident 33 was admitted to the facility in 8/2021 with diagnoses including insomnia and anxiety. The 6/2024 MAR included a 10/18/23 order for temazepam (treats insomnia) one capsule to be administered at bedtime for insomnia. A 4/26/24 and 5/31/24 pharmacist Consultation Report recommended discontinuation of the temazepam. The report noted, No change. Resident assessed and was determined regimen is currently at the lowest optimal dose and continues to be beneficial for resident's psychiatric symptoms, outweigh any apparent risk. Discontinue the temazepam or change the temazepam from daily to Monday, Wednesday, Friday and Sunday. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacy recommendation was not signed until 6/11/24 and indicated to see if patient willing to discontinue the temazepm. On 6/12/24 at 1:56 PM Staff 48 (Consultant Pharmacist) stated she completed the monthly pharmacy reviews and she recommended a reduction to Resident 33's temazapen. Staff 48 stated common practice was a 30-day response time when a recommendation was given, but often took 60 days or longer to receive a response from the physician. On 6/13/24 at 10:16 AM and 11:10 AM, Staff 2 (DNS), Staff 27 (LPN and Unit Manager) and Staff 30 (LPN Unit Manager) stated Resident 33's temazapen was not followed up on promptly. Staff 2 stated he expected staff to follow up on pharmacy recommendations weekly to prevent oversights or delays. 26991 3. Resident 51 was admitted to the facility in 2023 with a diagnosis of Cancer. A 4/30/24 Pharmacy report recommended Resident 51's ferrous sulfate (supplement) should be discontinued because the resident's iron level was normal and docusate (treats constipation) because it was not an effective medication. A 6/2024 MAR revealed Resident 51 continued to be administered ferrous sulfate and docusate. On 6/11/24 at 2:33 PM a request was made to Staff 2 (DNS) to provide documentation Resident 51's physician declined 4/31/24 pharmacy recommendations. No additional information was provided. 49677 4. Resident 63 was admitted to the facility in 2024 with diagnoses including anxiety and asthma. A pharmacy review dated 4/29/24 recommended following the use of Symbicort (inhaler medication) Resident 63 was to rinse her/his mouth with water. The 4/2024 and 5/2024 MARs did not include the order to rinse Resident 63's mouth with water after using Symbicort. According to the 6/2024 MAR the facility documented the new orders for Resident 63 to rinse her/his mouth with water following use of Symbicort on 6/5/24. On 6/14/24 at 11:43 AM Staff 2 (DNS) confirmed the pharmacy recommendations were not implemented timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	2201 NW Highland Avenue Grants Pass, OR 97526

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 26991 Based on interview and record review it was it was determined the facility failed to ensure a medication error rate of less than 5%. The facility administration rate was 7.41% with two errors in 27 opportunities. This placed residents at risk for ineffective medication regimen. Findings include: 1. Resident 34 was admitted to the facility in 2019 with a diagnosis of chronic pain. A 10/3/23 Order revealed staff were to apply an external pain patch to both knees. A 4/4/24 quarterly MDS revealed Resident 34 was cognitively intact. On 6/11/24 at 8:21 AM Staff 56 (CMA) was observed to apply a medicated pain patch to Resident 34's right arm and right leg. On 6/12/24 at 8:18 AM Resident 34 stated she/he only used the patch on the right arm and leg and did not require it on the left knee. On 6/12/24 08:20 AM Staff 56 stated she applied the patch only in the locations Resident 34 preferred. On 6/12/24 at 9:19 AM Staff 30 (LPN Resident Care Manager) stated if a resident did not want the patch applied to the location ordered the order should be clarified. Staff 30 stated the patch was currently ordered to be applied to both knees. 2. Resident 10 was admitted to the facility in 2024 with a diagnosis of low thyroid levels. Epocrates Online (web based pharmacy resource) revealed levothyroxine (hormone replacement)should be taken 15 to 60 minutes before breakfast with a full glass of water at the same time daily. A 5/23/24 order revealed Resident 10 was to be administered levothyroxine once a day. There were no directions to give the mediation with or without food. On 6/13/24 at 7:58 AM Staff 12 (CMA) was observed to administer Resident 10 her/his thyroid medication. Resident 10 was observed in her/his room with her/his breakfast consumed. On 6/13/24 at 8:05 AM Staff 12 stated the nurses reported it did not matter if the thyroid medication was administered before or after meals. On 6/13/24 at 8:21 AM Staff 41 (RN) stated the night shift staff usually administered the thyroid medication before breakfast on an empty stomach. On 6/13/24 at 8:29 AM Staff 2 (DNS) stated thyroid medication should be given without food unless the resident could not tolerate the medication on an empty stomach.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35855 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 5 halls (200 hall) reviewed for infection control. This placed residents at risk for cross contamination. Findings include: On 6/14/24 at 10:08 AM, Staff 37 (CNA) was observed carrying dirty linens down the 200 hall and entering the soiled linen room. Staff 37 acknowledged not having bags in her pocket and was aware that linens should be placed in a bag before transport. In an interview on 6/14/24 at 10:26 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated the expectation of staff were to place dirty linen in a bag for transport from resident room to soiled linen room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was not administered an antibiotic without indication for 1 of 3 sampled residents (#86) reviewed for UTI. This placed residents at risk for drug resistant infections. Findings include: Resident 86 was admitted to the facility in 2023 with a diagnosis of UTI. A 10/7/23 Progress Note revealed Resident 86 had increased confusion. The physician was notified and Resident 86 was sent to the hospital for evaluation, treatment, and returned on 10/8/23. Resident 86's urine culture results dated 10/7/23 revealed there was a mixed growth of skin and or genital organisms indicating an improper collection. The form revealed a new sample was to be submitted if clinically indicated. A 10/2023 MAR revealed Resident 86 was administered antibiotics from 10/10/23 through 10/16/23 for an UTI. On 6/14/24 at 9:29 AM Staff 2(DNS) stated 72 hours after an antibiotic was started the facility staff were to review the test results to ensure an antibiotic was indicated. Staff 2 stated a 72 hour review was not documented in the resident 86's record and the 10/7/23 UA results did not indicate antibiotics should be administered.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35855 Based on interview and record review it was determined the facility failed to have a system in place to ensure CNA staff received 12 hours of in-service training annually for 3 of 5 randomly selected staff members (#s 3, 5, and 6) reviewed training. This placed residents at risk for lack of competent staff. Findings include: A review of the facility's staff training records revealed the following: -Staff 3 (CNA), hired 1/26/06 completed 10 hours of documented training from 1/25/23 through 1/25/24. -Staff 5 (CNA), hired 4/7/10, completed six hours of documented training from 4/27/23 through 4/27/24. -Staff 6 (CNA), hired 3/28/16, completed 10 hours of documented training from 3/28/23 through 3/28/24. In an interview on 6/14/24 at 10:23 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 39 (Regional Director of Clinical) stated it was expected the staff complete the 12 hours of annual training.