STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385152	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Post Acute	515 Grant Street Cottage Grove, OR 97424

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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 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. Based on interview and record review it was determined the facility failed to notify the physician of the resident's discharge to the hospital for 1 of 1 sampled resident (#39)reviewed for hospitalizations. This placed residents at risk for delayed treatment. Findings include: Resident 39 admitted to the facility in 10/2024 with diagnoses including heart disease and kidney disease. A 6/8/25 Progress Note indicated Resident 39 was sent to the hospital for nausea, diarrhea, general malaise, cold sweats, and dizziness. A review of Resident 39's clinical record revealed no indication the resident's physician was notified. On 6/25/25 at 11:44 AM, Staff 19 (Nurse Practitioner) stated she was not informed Resident 39 was sent to the hospital on 6/8/25. On 6/26/25 at 1:20 PM, Staff 2 (DNS) acknowledged Resident 39's physician was not notified when the resident was sent to the hospital.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review it was determined the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 1 of 2 sampled residents (#38) reviewed for personal property. This placed residents at risk of loss or theft of property. Findings include: Resident 38 was admitted to the facility in 2/2025 with diagnoses including anxiety and reduced mobility. A 2/13/25 admission MDS revealed Resident 38 was cognitively intact. A 3/9/25 Grievance Concern Problem Identification and Follow-Up form indicated Resident 38 reported a concern with six packs of cigarettes missing. Steps taken revealed social services reviewed and discussed options for tracking cigarettes which came into the facility. Resident 38 did not want to store her/his cigarettes at the nurse's station because many of the locks can be opened with any key. There was no evidence of the cigarettes, so the facility would not refund or replace the cigarettes for Resident 38. Social services would place an order for maintenance to investigate the lock issue. Administration review revealed there was no evidence of Resident 38's cigarettes existence. On 6/23/25 at 9:06 AM, Resident 38 stated the facility's rule was to store residents' smoking materials in a locked box at the nurses' station. Residents kept a key, and staff opened the box when she/he wanted to smoke. Resident 38 stated the keys distributed to residents would open all the locked boxes. Resident 38 stated in 3/2025 she/he had six packs of cigarettes missing out of the locked boxes. On 6/25/25 at 11:31 AM, Staff 13 (CNA) stated Resident 38 reported to her she/he was missing six packs of cigarettes from the lock box. Staff 13 assisted Resident 38 with the grievance form. On 6/25/25 at 11:46 AM, Staff 14 (Social Services Assistant) stated the facility did not allow unsupervised smokers to keep their smoking materials in a lock box in their rooms. Residents were to bring their key to the nurses' station, and a staff member opened the lock box and gave residents their smoking materials and when they were done residents return their smoking materials to the nurses' station. On 6/25/25 at 11:44 AM, and 12:06 PM, The drawer at the nurses' station was observed to have a lock on it. Staff 5 (MDS Coordinator) opened the drawer, which was not locked. A clear box with multiple sections was observed to have locks which opened upward. A key was in the drawer on top of the clear box. The key opened multiple boxes. Staff 1 (Administrator) stated the key was a master key if needed. On 6/27/25 at 7:21 AM, Staff 1 (Administrator) stated she would expect for staff to keep the drawer locked where the cigarettes are stored. Staff 1 stated the facility continued to work on fixing the cigarette storage as it does not work.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to ensure appropriate information was communicated to the receiving health care institution or provider prior to a resident being transferred to the hospital for 1 of 1 sampled resident (#39) reviewed for hospitalization. This placed the resident at risk for unassessed needs. Findings include: Resident 39 admitted to the facility in 10/2024 with diagnoses including heart disease and kidney disease. A 6/8/25 Progress Note indicated Resident 39 was sent to the hospital for nausea, diarrhea, general malaise, cold sweats, and dizziness. No evidence was found in Resident 39's clinical record to indicate the facility provided the following prior to Resident 39 being transferred to the hospital: -Contact information of the practitioner who was responsible for the care of the resident. -Advance directive information. -Medications (including when last received). On 6/27/25 at 10:19 AM, Staff 2 (DNS) stated but she was unable to provide documentation to confirm the facility provided appropriate information to the receiving health care institution or provider prior to Resident 39's transport to the emergency department on 6/8/25.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review it was determined the facility failed to complete timely MDS assessments for 4 of 8 sampled residents (#s 20, 21, 32, and 33) reviewed for MDS and unnecessary medications. This placed residents at risk for unassessed needs. Findings include: 1. Resident 20 was admitted to the facility in 1/2025 with diagnoses including reduced mobility and muscle wasting. A review of Resident 20's clinical record revealed her/his Discharge Return Not Anticipated MDS assessment was in progress and overdue by nine days on 6/24/25. On 6/26/25 at 9:59 AM, Staff 5 (MDS Coordinator) stated she was very busy for the last two to three weeks and was behind on her work and confirmed Resident 20's MDS was late. On 6/27/25 at 7:15 AM, Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for staff was to have the MDSs completed timely. 2. Resident 21 was admitted to the facility in 7/2020 with diagnoses including kidney disease and heart failure. A review of Resident 21's clinical record revealed her/his Annual MDS assessment was in progress and overdue by 13 days on 6/26/25. On 6/26/25 at 9:59 AM, Staff 5 (MDS Coordinator) stated she was very busy for the last two to three weeks and was behind on her work and confirmed Resident 21's MDS was late. On 6/27/25 at 7:15 AM, Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for staff was to have the MDSs completed timely. 3. Resident 32 was admitted to the facility in 12/2024 with diagnoses including Multiple Sclerosis (a chronic, autoimmune disease that affects the brain and spinal cord). A review of Resident 32's clinical record revealed an 4/5/25 Quarterly MDS completed on 4/21/25. On 6/26/25 at 10:05 AM, Staff 5 (LPN MDS Coordinator) stated Resident 32's 4/5/25 Quarterly MDS was completed on 4/21/25. Staff 5 acknowledged the 4/5/25 Quarterly MDS was completed late and should have been completed by 4/18/25. 4. Resident 33 was admitted to the facility in 2/2023 with diagnoses including schizoaffective disorder (a mental illness characterized by a combination of psychotic symptoms, similar to schizophrenia, and mood disorder symptoms, like mania or depression). a. A review of Resident 33's clinical record revealed a 2/20/25 Annual MDS completed on 3/24/25. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 10:05 AM, Staff 5 (LPN MDS Coordinator) stated Resident 33's 2/20/25 Annual MDS was completed on 3/24/25. Staff 5 acknowledged the 2/20/25 Annual MDS was completed late and should have been completed by 3/5/25. b. A review of Resident 33's clinical record revealed a 5/23/25 Quarterly MDS completed on 6/9/25. On 6/26/25 at 10:05 AM, Staff 5 (LPN MDS Coordinator) stated Resident 33's 5/23/25 Quarterly MDS was completed on 6/9/25. Staff 5 acknowledged the 5/23/25 Quarterly MDS was completed late and should have been completed on 6/5/25.

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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 Based on interview and record review it was determined the facility failed to complete a Significant Change MDS assessment (SCSA) within the required 14 days after a determination of a significant change of condition of a resident for 1 of 1 sampled resident (#39) reviewed for hospitalizations. This placed residents at risk for unassessed care needs. Findings include: Resident 39 admitted to the facility in 10/2024 with diagnoses including heart disease and kidney disease. Resident 39's 4/14/25 Quarterly MDS indicated the resident was cognitively intact and was on hospice. On 6/25/25 at 10:11 AM, Staff 5 (LPN/MDS Coordinator) confirmed Resident 39 graduated from hospice on 5/30/25. Staff 5 stated she did not discuss this with Resident 39 and acknowledged she did not complete a SCSA. On 6/26/25 at 1:20 PM, Staff 2 (DNS) confirmed Resident 39 was discharged from hospice on 5/30/25 and acknowledged the facility failed to complete a SCSA for Resident 39.

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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 Based on observation, interview, and record review it was determined the facility failed to complete a baseline care plan within 48 hours of a resident's admission for 1 of 1 sampled resident (#32) reviewed for pressure ulcers. This placed residents at risk for unmet wound care needs. Findings include: Resident 32 was admitted to the facility in 12/2024 with diagnoses including Multiple Sclerosis (a chronic, autoimmune disease that affects the brain and spinal cord). A review of a 1/1/25 Skin & Wound Evaluation revealed Resident 32 was admitted with a Stage 3 pressure ulcer wound (a full-thickness skin loss, where the wound extends through the skin and into the fat tissue). A 6/24/25 review of Resident 32's care plan revealed no evidence of a baseline care plan for her/his Stage 3 pressure ulcer wound. On 6/24/25 at 2:38 PM, an observation of Resident 32's wound revealed a wound consistent with a Stage 3 pressure ulcer wound. On 6/26/25 at 12:43 PM, Staff 3 (LPN Care Manager) stated when a resident was admitted with a pressure ulcer wound, a care plan focused on current wound(s), with a goal and interventions geared towards wound care and healing must be initiated upon admission. Staff 3 stated Resident 32 was admitted with a Stage 3 pressure ulcer wound and she acknowledged Resident 32 did not have a baseline care plan for her/his pressure ulcer wound. On 6/27/25 at 8:34 AM, Staff 2 (DNS) stated MDS assessments must be completed timely.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 2. Resident 38 was admitted to the facility in 2/2025 with a diagnoses including hypertensive heart disease with heart failure (a condition where the heart cannot pump blood effectively). Physician orders with a start date of 3/15/25 instructed staff to obtain Resident 38's weight every day shift on Saturdays for weight monitoring. A review of Resident 38's weights report revealed from 3/29/25 through 6/2/25, Resident 38's weight was documented on the report as obtained out of 12 times physician ordered. The 5/2025 TAR instructed staff to obtain weekly weights every day shift every Saturday for weight monitoring with a start date of 3/15/25. The TAR was documented as NA three times, a weight of 172 one time, and a code six one time. There was no legend for what NA was defined as. Code six was indicated as glucose. Physician orders with a start date 6/20/25 instructed staff to obtain Resident 38's weight every day shift for cardiac monitoring. The 6/2025 TAR instructed staff to obtain weekly weights every day shift every Saturday for weight monitoring. The TAR was documented as NA three times and a weight of 171 one time. The 6/2025 TAR instructed staff to obtain daily weights every day shift for cardiac monitoring with a start date of 6/20/25. From 6/20/25 through 6/24/25, there were checks documented three times with no weights documented and the code of two documented twice, which indicated Resident 38 refused to have her/his weight obtained. A 6/23/25 Progress Note revealed to obtain a daily weight every day shift for cardiac monitoring. No documentation of Resident 38's weight was recorded on the note. On 6/26/25 at 8:39 AM, Staff 12 (Agency LPN) stated she documented weights on the TAR or under vitals in resident's clinical record. Staff 12 stated she did not recall that she documented NA on the TAR for Resident 38's weights. If a resident refused to have weight obtained, she would typically not document NA. On 6/27/25 at 7:20 AM, Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation of staff would be to complete physician ordered weights and document weights or refusals of weights in the resident's clinical record. Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 7 sampled residents (#s 33 and 38) reviewed for medication and pain medications. This placed residents at risk for adverse side effects and unmet needs. Findings include: 1. Resident 33 was admitted to the facility in 2/2023 with diagnoses including schizoaffective disorder (a mental illness characterized by a combination of psychotic symptoms, similar to schizophrenia, and mood disorder symptoms, like mania or depression). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's Physician Orders revealed an 4/5/25 order for Austedo 12 mg twice a day prescribed to treat drug induced dyskinesia (a movement disorder characterized by involuntary, repetitive, and sometimes jerky or writhing movements, often triggered by certain medications). The 5/2025 MAR revealed Resident 33 did not receive Austedo on the following days: -5/12/25 AM dose. -5/13/24 AM and PM doses. -5/14/25 AM and PM doses. -5/15/25 AM dose. Review of Medication Administration Notes between 5/12/25 and 5/15/25 revealed Resident 33 was out of Austedo, and the pharmacy was contacted on 5/14/25. A 6/25/25 review of the 6/2025 MAR revealed Resident 33 did not receive Austedo on the following days: -6/14/25 PM dose. -6/15/25 PM dose. -6/16/25 PM dose. -6/17/25 AM dose. -6/18/25 through 6/24/25 AM and PM doses. A review of Medication Administration Notes between 6/14/25 and 6/24/25 revealed Resident 33 was out of Austedo, and the pharmacy was contacted on 6/17/25. A 6/17/25 Medication Administration Note revealed Resident 33 stated she/he could feel the effects of not taking the Austedo. A 6/20/25 Medication Administration Note revealed Resident 33's PCP was notified of the missing doses of Austedo. A 6/25/25 Progress Note revealed Resident 33's PCP was informed of the missing doses of Austedo, and the orders were received to hold the Austedo until the medication was delivered from the pharmacy. On 6/26/25 at 10:51 AM, Staff 2 (DNS) stated Resident 33's medication Austedo was not available from 5/12/25 until the PM dose on 5/15/25 and there was no documentation the PCP was notified. Staff 2 stated Resident 33's Austedo was not available from 6/14/25 until 6/25/25 and stated the PCP was notified on 6/20/25. Staff 2 stated her expectation was to order medications a week prior to running out of the medication so residents did not run out of medication. Staff 2 stated the PCP should be notified as soon as Resident 33's medication was not available.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review it was determined the facility failed to provide appropriate pain management for 2 of 2 sampled residents (#s 33 and 39) reviewed for pain management. This failure resulted in Resident 39 not receiving her/his scheduled narcotic pain medications for three days which caused the resident to suffer from narcotic withdrawal, increased pain, and an avoidable hospitalization. This placed residents at risk for narcotic withdrawal and increased pain. Findings include: 1. Resident 39 admitted to the facility in 10/2024 with diagnoses including heart disease and kidney disease. Resident 39's 4/14/25 Quarterly MDS indicated the resident was cognitively intact. Resident 39 received scheduled pain medication and PRN pain medications. Resident 39 had frequent pain, which occasionally affected her/his sleep and ADLs. On 4/23/25 Resident 39 was admitted to hospice. On 6/23/25 at 11:25 AM, and 6/27/25 at 9:15 AM, Resident 39 stated two weeks ago, the facility ran out of her/his prescribed morphine. Resident 39 reported being informed by multiple staff members her/his medication had not been reordered. As a result, she/he went several days without receiving her/his pain medication. Resident 39 stated she/he had been taking morphine for an extended period of time and believed she/he should have been gradually titrated off the medication, rather than cut off. Resident 39 reported experiencing nausea, vomiting, and diarrhea, which led to her/him being sent to the hospital. When asked about her/his pain level when the medication was not available she/he stated The pain I can take, it was the diarrhea that I could not tolerate. The resident indicated her/his pain was unmanaged and she/he was also concerned about her/his blood sugars being all over the place. A 4/23/25 Hospice Physician Order instructed staff to administer morphine sulfate (narcotic pain medication) 0.75 ml three times a day for pain and give 0.75 ml every hour PRN for pain and shortness of breath. Review of a 6/8/25 Progress Note indicated Resident 39 experienced symptoms of opiod withdrawl including: elevated blood pressure, nausea, diarrhea, general malaise, cold sweats, and dizziness. Staff reported the facility ran out of Resident 39's prescribed morphine on 6/7/25 in the morning and were unable to administer the resident's pain medication. Resident 39 experienced symptoms consistent with opioid withdrawal. Staff called the on-call provider to request a medication refill, but they did not respond. Resident 39 was transferred to the hospital for further evaluation and treatment. A 6/2025 MAR revealed the following: -morphine was not administered on 6/7/25 at 3:00 PM and 11:00 PM. -morphine was not administered on 6/8/25 at 700 AM, 3:00 PM, and 11:00 PM. -hydralazine 25 mg was administered on 6/8/25 for elevated blood pressure. -morphine was not administered on 6/9/20 at 7:00 AM, and 3:00 PM. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A 6/8/25 Emergency Department Provider Note indicated Resident 39 admitted to the emergency department with fatigue, nausea, vomiting, diarrhea, cold chills and sweats. Resident 39 stated her/his symptoms had been ongoing for the last 24 hours. Resident 39 stated she/he took morphine due to pain related to lower extremity amputations. The resident stated the nursing facility ran out of her/his morphine two days ago. Resident 39's nurse called and confirmed the situation. It appeared completely feasible that the resident was experiencing opioid withdrawals since the last dose was approximately 48 hours prior. Resident 39 was provided an order for oxycodone 5 mg because the facility did not have morphine available. A 6/8/25 Progress Note indicated Resident 39 returned from the hospital with an order for oxycodone 5 mg to be administered every four hours PRN for pain. Resident 39's Pain Level Summary indicated the following on 6/9/25: -12:55 AM, pain level 8/10. -9:45 AM, pain level 8/10. -12:13 PM, pain level 6/10. -3:56 PM, pain level 9/10. -11:22 PM, pain level 3/10. On 6/24/25 at 3:50 PM, Staff 20 (LPN) stated the facility ran out of resident 39's morphine on 6/7/25. She informed the oncoming nurse and assumed the refill would be requested. The next day, she noticed the medication was not reordered and believed the resident was experiencing opioid withdrawal symptoms, including cold sweats, elevated blood pressure, and elevated blood sugar levels. Staff 20 reported leaving three messages for the on-call provider, but did not receive a response. She stated it was typical for the on-call provider not to respond to messages. Staff 20 stated the morphine was typically stocked in the back up medication stock, but administration required approval, which she described as difficult to obtain. Staff 20 added that on 6/8/25 she contacted the hospital, informed them the facility was out of Resident 39's morphine and asked if they could write a short-term prescription. On 6/24/25 at 4:13 PM, Staff 22 (LPN) stated 6/6/25, was when she first noticed Resident 39 was running low on her/his morphine. She reported that no specific staff member was designated to re-order medications and the facility frequently ran out of medications over the weekend. On 6/7/25 during shift change Staff 22 was informed Resident 39 experienced symptoms consistent with opioid withdrawal and was transferred to the hospital. Upon the resident's return, Staff 22 noted the resident was prescribed oxycodone, but not morphine. She stated Resident 39 appeared withdrawn and was not at her/his baseline. Staff 22 further stated the resident's medication was not refilled in a timely manner and acknowledged that it just fell through the cracks. On 6/25/25 at 2:45 PM, Staff 25 (Prescribing Technician) confirmed the facility called the pharmacy on 6/8/25 to request a refill of Resident 39's morphine prescription. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/25/25 at 3:18 PM, Staff 23 (Prescribing Technician) and Staff 21 (Pharmacist) stated on 6/9/25 at 8:17 AM, the facility requested a refill for Resident 39's morphine and the medication was delivered to the facility the evening of 6/9/25. On 6/26/25 at 1:20 PM, Staff 2 (DNS) and Staff 24 (Regional Nurse Consultant) reviewed Resident 39's 6/2025 MAR and narcotic log. Staff 2 and Staff 24 confirmed the facility failed to administer seven doses of resident 39's morphine. Documentation indicated the medication was unavailable or not administered. Staff 2 stated the facility's expectation was for nurses to follow the established medication reordering process. Staff 2 acknowledged multiple staff failed to reorder Resident 39's medication in a timely manner. Staff 2 acknowledged Resident 39's hospitalization could have been avoided if the facility had provided timely pain management. Staff 2 confirmed the facility had ongoing issues with communication from the on-call provider and this caused a delay in residents obtaining medication refills. 2. Resident 33 was admitted to the facility in 11/2023 with diagnoses including polyosteoarthritis (osteoarthritis that affects five or more joints in the body simultaneously). A public complaint was received on 3/25/25 which alleged Resident 33 did not receive her/his scheduled pain medication from 3/21/25 through 3/23/25. A review of Physician Orders revealed a 2/22/24 order for Lyrica (a pain medication) twice a day in the morning and in the evening. The 2/2025 MAR revealed Resident 33 did not receive Lyrica starting 3/21/25 evening dose through 3/24/25 morning dose. Medication Administration Notes from 3/21/25 through 3/24/25 revealed Resident 33 was out of Lyrica. A 3/23/25 Progress Note revealed Resident 33 needed a new script for Lyrica and an order refill request was placed in the provider's binder on 3/23/25. A review of the pain monitor from 3/21/25 through 3/24/25 revealed Resident 33's pain level varied from 0/10 to 10/10. A review of the 3/2025 CNA Pain Task documentation revealed Resident 33 experienced pain from 3/21/25 through 3/24/25 which was unchanged with non-pharmacological interventions. On 6/23/25 at 8:23 AM, Resident 33 stated she/he had constant pain in her/his shoulders and lower back. Resident 33 stated the facility ran out of her/his medications often and she/he would go without pain medications until the pharmacy delivered the pain medications. Resident 33 stated without pain medications, her/his pain level gets to 10/10. On 6/25/25 at 1:39 PM, Staff 17 (LPN) stated medications should be ordered when there was a week left so the resident did not run out of medications. Staff 17 stated the facility did not always have an effective system for ordering medications. (continued on next page)

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	385152	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Post Acute	515 Grant Street Cottage Grove, OR 97424

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/26/25 at 10:51 AM, Staff 2 (DNS) stated Resident 33's Lyrica was not available starting the evening dose on 3/21/25 through the morning dose on 3/24/25. Staff 2 stated during this time Resident 33's pain level got up to 9-10/10 but no new orders for pain control were obtained and Resident 33's as needed Tylenol was not administered. Staff 2 stated the CNA task documentation showed non-pharmacological pain control interventions were tried including distraction, repositioning, and rest, but the non-pharmacological pain interventions were not effective. Staff 2 stated her expectation would be the nurse should call the provider for a temporary order in the interim until the Lyrica arrived.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined the facility failed to provide palatable food to 1 of 1 kitchen and 2 of 4 (#s 4 and 33) residents reviewed for food and kitchen tasks. This placed residents at risk for weight loss and reduced quality of life. Findings include: 1. A review of the 6/25/25 lunch menu revealed the facility was to provide: spaghetti with meatballs, herb green beans, and garlic bread sticks. On 6/25/25 at 11:44 AM kitchen meal service was observed. Pasta, meat sauce, garlic bread sticks, and green beans were observed to be served from the steam table. Pasta was observed to be served with tongs, appeared overcooked, and broke apart as it was served. A test tray was requested. On 6/25/25 at 12:22 PM, the test tray was sampled: -herb green beans tasted metallic and were bland. -garlic bread stick was doughy with no garlic flavor. -spaghetti noodles were mushy, soft, and overcooked. -meat sauce was flavorful but the meatball had no flavor. On 6/25/25 at 12:29 PM, Staff 9 (Dietary Manager) was asked to test the meal. Staff 9 stated the pasta was soft, the herb green beans did not taste like anything, the garlic bread stick had no garlic flavor and may have softened while it sat in the steam table. On 6/25/25 at 2:33 PM, Staff 1 (Administrator) stated she would not want to have overcooked pasta to be an everyday occurrence but she has eaten the pasta and generally liked it. Staff 1 stated she expected herb green beans to be herb, would expect the garlic bread to have garlic on it. 2. Resident 4 was admitted to the facility in 10/2024 with diagnoses including quadriplegia (paralysis of all four limbs). On 6/23/25 at 9:09 AM, Resident 4 stated she/he did not care for the food; the vegetables were overcooked and bland with no flavor. On 6/25/25 at 12:22 PM, the test tray was sampled: -herb green beans tasted metallic and were bland. -garlic bread stick was doughy with no garlic flavor. -spaghetti noodles were mushy, soft, and overcooked. -meat sauce was flavorful but the meatball had no flavor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 12:29 PM, Staff 9 (Dietary Manager) was asked to test the meal. Staff 9 stated the pasta was soft, the herb green beans did not taste like anything, the garlic bread stick had no garlic flavor and may have softened while it sat in the steam table. 3. Resident 33 was admitted to the facility in 2/2023 with diagnoses including depression. On 6/23/25 at 8:17 AM, and 6/26/25 at 9:44 AM, Resident 33 stated the food was terrible, cold, and sometimes the meat was too tough. Resident 33 stated she/he had the spaghetti for lunch on 6/25/25. Resident 33 stated the spaghetti, and the meatball did not taste good, were bland, and needed onions or some seasoning added. On 6/25/25 at 12:22 PM, the test tray was sampled: -herb green beans tasted metallic and were bland. -garlic bread stick was doughy with no garlic flavor. -spaghetti noodles were mushy, soft, and overcooked. -meat sauce was flavorful but the meatball had no flavor. On 6/25/25 at 12:29 PM, Staff 9 (Dietary Manager) was asked to test the meal. Staff 9 stated the pasta was soft, the herb green beans did not taste like anything, the garlic bread stick had no garlic flavor and may have softened while it sat in the steam table.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 3 halls (West Hall) and 1 of 1 sampled resident (#28) during random observations. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: 1. On 6/24/25 at 10:19 AM, Resident 44 was observed touching multiple items in the PPE cart located outside room [ROOM NUMBER] for approximately five minutes. The resident opened multiple drawers and made contact with a facemask, N95 mask, and a stethoscope. Staff 28 (CNA) was standing behind the resident during this time and did not redirect the resident or sanitize the PPE cart following the interaction. On 6/24/25 at 10:26 AM, Staff 14 (LPN) asked Staff 28 to not let Resident 44 touch items in the PPE supplies. Staff 28 then re-directed Resident 44 away from the PPE cart. Staff 14 acknowledged the incident did not align with infection control protocol. On 6/26/25 at 11:43 AM, Staff 26 (RN/Infection Preventionist) acknowledged Resident 44 touching items in PPE cart and staff not sanitizing the carts afterwards was not in alignment with infection control best practice. 2. On 6/24/25 at 10:33 AM, an ice chest and water pitcher were observed on a cart on the [NAME] Hall, positioned near a room under enhanced barrier precautions. The ice scoop was sitting in an uncovered container. On the lower shelf of the cart, there were two boxes of gloves, a box of straws, and an empty cup containing a white liquid substance. On 6/24/25 at 10:38 AM, Staff 27 (CNA) stated many residents pass by the water pitcher cart and it was difficult to ensure they did not place dirty items on the cart. Staff 27 acknowledged the presence of a soiled cup on the water pitcher cart and the uncovered ice scoop. Staff 27 stated it was a challenge to ensure residents did not place items on the cart throughout the day. On 6/25/25 at 9:02 AM, a water pitcher with an uncovered ice scoop was observed on a cart on the [NAME] Hall, positioned near a room under EBP. On 6/26/25 at 11:43 AM, Staff 26 (RN/Infection Preventionist) acknowledged the presence of dirty items sitting next to a clean water pitcher used to serve residents were not in alignment with infection control best practice. 3. Resident 28 was admitted to the facility in 5/2022 with diagnoses including heart failure and kidney disease. A 5/29/25 Physician order instructed staff to clean Resident 28's right heel and cover with foam dressing daily. A 6/9/25 Physician order instructed staff to provide wound care twice a day to Resident 28's buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/25 at 10:40 AM, No PPE signage was observed outside Resident 28's room. Multiple staff were observed to enter Resident 28's room to provide personal care without donning PPE. On 6/24/25 at 10:40 AM, Staff 12 (Agency LPN) confirmed Resident 28 had open wounds and she had just completed her/his wound care. Staff 29 (CNA) and Staff 30 (CNA) assisted her with Resident 28's dressing change. Staff 12 stated she was not aware the resident was supposed to be on EBP(enhanced barrier precautions). Staff 12 confirmed no signage was posted outside the resident's door. Staff 12 further added any nurse could post EBP signage. On 6/24/25 at 11:03 AM, Staff 29 stated she was not really sure when a resident should be on precautions because the facility did not always update resident care plans. Staff 29 stated the facility did not always post signage to indicate what kind of precautions residents were on. Staff 29 confirmed she did not wear PPE when assisting with wound care. On 6/24/25 at 11:06 AM, Staff 26 (RN/Infection Preventionist) observed Staff 12, Staff 29, and Staff 30 exiting Resident 28's room. Staff 26 stated Resident 28 should have enhanced barrier precautions signage posted due to Resident 28 having open wounds, but the signage was not posted. Staff 26 also observed Staff 12, Staff 29, and Staff 30 exiting Resident 28's room and confirmed they were not wearing PPE during wound care. Staff 26 acknowledged infection control measures were not followed. On 6/25/25 at 8:51 AM, Staff 12 stated she was not aware she needed to wear PPE before providing direct care to residents on enhanced barrier precautions.