

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Forest Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 Pacific Avenue Forest Grove, OR 97116	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>42271</p> <p>Based on observation, interview and record review it was determined the facility failed to follow physician's orders related to oxygen administration for 5 of 7 sampled residents (#s 13, 15, 16, 17 and 19) reviewed for respiratory care. This placed residents at risk for respiratory complications. Findings include:</p> <p>1. Resident 13 was admitted to the facility in 9/2024, with diagnoses including chronic respiratory failure with hypoxia (lack of oxygen) and heart failure.</p> <p>Resident 13's 9/20/24 Physician's Orders indicated staff was to administer oxygen continuously at 1 liter per minute via nasal cannula.</p> <p>Resident 13's 12/2024 TAR revealed staff documented the resident was on oxygen continuously at 1 liter per minute via nasal cannula.</p> <p>On 12/17/24 at 10:48 AM, observations of Resident 13's oxygen concentrator with Staff 3 (LPN/RCM) revealed Resident 13's oxygen was set at 2 L/min. Staff 3 acknowledged the resident's physician orders were not followed.</p> <p>On 12/17/24 at 2:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged physician orders were not followed and expected staff to follow physician orders.</p> <p>2. Resident 15 was admitted to the facility in 11/2024, with diagnoses including chronic obstructive pulmonary disease (COPD) and emphysema (chronic lung disease).</p> <p>Resident 15's 12/11/24 Physician's Orders indicated staff was to administer oxygen continuously at 2 liters per minute via nasal cannula.</p> <p>Resident 15's Weights and Vitals Summary from 12/1/24 through 12/19/24 revealed 12 entries which revealed the resident was on room air (no oxygen was administered).</p> <p>On 12/17/24 at 10:55 AM, observations of Resident 15's oxygen concentrator with Staff 3 (LPN/RCM) revealed Resident 15's oxygen was set at 1.5 liters per minute. Staff 3 acknowledged the physician orders were not followed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/17/24 at 2:15 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged physician orders were not followed and expected staff to follow physician orders.</p> <p>3. Resident 16 was readmitted to the facility in 12/2024, with diagnoses including acute respiratory failure with hypoxia (lack of oxygen) and transient cerebral ischemic attack (stroke).</p> <p>Resident 16's 12/6/24 Physician's Orders indicated staff were to administer continuous oxygen at 1 liter per minute per nasal cannula.</p> <p>Resident 16's 12/2024 TAR revealed staff were monitoring the resident's oxygen levels, but were not documenting the amount of liters per minute of oxygen the resident was receiving.</p> <p>On 12/17/24 at 10:58 AM, observations of Resident 16's oxygen concentrator with Staff 3 (LPN/RCM) revealed Resident 16's oxygen was set at 1.5 liters per minute. Staff 3 acknowledged the physician orders were not followed.</p> <p>On 12/17/24 at 2:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged physician orders were not followed and expected staff to follow physician orders.</p> <p>4. Resident 17 was admitted to the facility in 12/2024, with diagnoses including congestive heart failure and acute respiratory failure with hypoxia (low oxygen).</p> <p>Resident 17's 12/13/24 Physician's Orders revealed no orders for oxygen.</p> <p>Resident 17's 12/16/24 Daily Skilled Charting Form revealed the resident continued with oxygen via nasal cannula.</p> <p>On 12/17/2024 at 10:51 AM, observations of Resident 17's oxygen concentrator with Staff 3 (LPN/RCM) revealed Resident 17's oxygen was set at 2.5 liters per minute. Staff 3 acknowledged the physician orders were not followed.</p> <p>On 12/17/24 at 2:15 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged physician orders were not followed and expected staff to follow physician orders.</p> <p>5. Resident 19 was admitted to the facility in 9/2024, with diagnoses including chronic obstructive pulmonary disease and dysphagia (difficulty swallowing) following cerebrovascular disease (stroke).</p> <p>Resident 19's 12/17/24 physicians order revealed staff were to administer oxygen continuously at 2 liters per minute via nasal cannula.</p> <p>Resident 19's 12/2024 TAR revealed staff administered oxygen at 2 liters per minute nasal cannula.</p> <p>On 12/17/2024 at 10:50 AM, observations of Resident 19's oxygen concentrator with Staff 3 (LPN/RCM) revealed Resident 19's oxygen was set at 1.5 liters per minute. Staff 3 acknowledged the physician orders were not followed.</p> <p>On 12/17/24 at 2:15 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged physician orders were not followed and expected staff to follow physician orders.</p>		