

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 06/14/2024
NAME OF PROVIDER OR SUPPLIER Forest Grove Rehabilitation and Care Center		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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46053</p> <p>Based on interview and record review, it was determined the facility failed to treat residents with dignity and respect for 1 of 2 sampled residents (#32) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include:</p> <p>Resident 32 was admitted to the facility in 2/2021 with diagnoses including ventricular tachycardia (irregular heartbeat) and chronic obstructive pulmonary disease (a disease that causes obstructed airflow from the lungs).</p> <p>Resident 32's 2/13/24 Annual MDS indicated she/he was cognitively intact.</p> <p>A facility investigation created and signed by Staff 2 (Interim Administrator) on 4/11/24 indicated Staff 8 (LPN) lifted Resident 32's left arm to remove her/his jacket, obtain her/his blood pressure and apply a lidocaine patch. Per the investigation, Staff 8 did not stop when Resident 32 told her the action caused her/him increased pain in her/his left shoulder. This action resulted in Staff 8 being placed on administrative leave while the facility completed an internal investigation.</p> <p>On 6/10/24 at 12:52 PM Resident 32 stated she/he told staff about her/his shoulder pain prior to the incident because, I didn't want people to pull on it. She/he also stated, When she was lifting my arm I told her to stop because it hurt so bad. Resident 32 said she/he thought Staff 8 was in a hurry and needed to get it done.</p> <p>On 6/11/24 at 3:15 PM Staff 8 stated she forgot Resident 32 had pain in her/his left shoulder when she started to help her/him remove her/his jacket on 4/11/24. She said she apologized to Resident 32 and told her/him I forgot you had pain in your shoulder.</p> <p>A review of Resident 32's care plan initiated 3/1/24 revealed staff were advised to allow 'no' to be a response, follow through with what you say you will do, give choices whenever possible, avoid rushing cares, maintain calm demeanor and provide active listening.</p> <p>On 6/11/24 at 4:22 PM Staff 2 stated [Staff 8] no longer worked in the facility and was in a hurry and did not slow down when lifting Resident 32's arm. He added, She should have been more patient and listened to the resident. Staff 2 confirmed Resident 32 was already receiving a lidocaine patch for shoulder pain and acknowledged Staff 8, should have taken her time and not caused [Resident 32] more pain.</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46053</p> <p>Based on interview and record review it was determined the facility failed to provide a written Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) in a timely fashion for 1 of 3 sampled residents (#29) reviewed for Beneficiary Protection Notification. This placed residents at risk for unknown financial liabilities. Findings include:</p> <p>Resident 29 was admitted to the facility in 2/2024 with diagnoses including metabolic encephalopathy (a problem in the brain caused by chemical imbalances in the blood) and chronic obstructive pulmonary disease (a disease that causes obstructed airflow from the lungs).</p> <p>Resident 29's Admission Record indicated she/he was her/his own responsible party and her/his 2/27/24 Admission MDS revealed she/he was cognitively intact.</p> <p>A review of Resident 29's health record revealed her/his last covered day of Medicare Part A Service was 4/22/24. No evidence was found in Resident 29's medical record to indicate the facility provided her/him with a SNF ABN, Form CMS-10055.</p> <p>On 6/11/24 at 12:33 PM Staff 9 (Social Services Director) confirmed Resident 29's last covered day of Medicare Part A services was 4/22/24 and stated she issued it to the resident on 6/11/24. Staff 9 acknowledged she issued it late and stated it should have been issued to Resident 29 on or before her/his last covered day under Medicare Part A Service.</p> <p>On 5/3/24 at 10:37 AM Staff 1 (Administrator) stated, We should be giving residents 48 hour notice so they are aware of the change.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053</p> <p>Based on interview and record review it was determined the facility failed to provide assistance with incontinence care in a timely manner for 2 of 3 residents (#s 30 and 56) reviewed for ADLs. This placed residents at risk of delayed assistance with personal hygiene and increased risk of skin impairment. Findings include:</p> <p>1. Resident 30 was admitted to the facility in 7/2023 with diagnoses including acute systolic (congestive) heart failure (a type of heart failure that occurs in the heart's left ventricle) and type two diabetes mellitus (a disease that occurs when blood sugar is too high).</p> <p>Resident 30's 7/17/23 Admission MDS indicated she/he was cognitively intact, frequently incontinent of bowel and bladder and she/he required extensive physical assistance from two persons to use the toilet.</p> <p>Resident 30's 7/17/23 Care Plan revealed staff were directed to offer and assist [Resident 30] with using the toilet upon awakening; after meals; before rest/HS; NOC rounds and as [she/he] asks.</p> <p>On 6/10/24 at 10:17 AM Witness 1 (Case Manager) reported during an in-person visit with Resident 30 on 2/1/24, she observed her/him use her/his call light to request incontinence care. She stated three CNAs entered Resident 30's room at different times but did not provide her/him with incontinence care. She stated a fourth CNA arrived and provided Resident 30 with incontinence care. Witness 1 reported Resident 30 told her it was typical for her/him to wait approximately two hours for care to be provided after pressing her/his call button.</p> <p>On 6/12/24 at 12:56 PM Staff 27 (LPN) stated there are times where Resident 30 told her she/he had to wait a long time for caregivers to provide care.</p> <p>On 6/12/24 at 5:15 PM Staff 1 (Administrator) stated he was aware of complaints regarding long call light response times for incontinence care. He said he expected staff to respond to call lights in a timely fashion. He added, We will re-emphasize that again with them.</p> <p>47005</p> <p>2. Resident 56 was admitted to the facility on ,d+[DATE] with diagnoses including hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease).</p> <p>Resident 56's Care Plan dated 3/27/24 indicated the resident required two-person extensive assistance with toileting, one-to-two-person assistance with bed mobility and mechanical lift assistance with transfers out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/24 at 11:15 AM Resident 56 stated on 6/7/24 approximately 8:00 AM she/he pressed the call light for toileting assistance. Resident 56 stated about 15 minutes later, Staff 13 (CNA) came into her/his room to deliver the breakfast tray. Resident 56 informed Staff 13 she/he had a bowel movement and needed to be changed. Staff 13 stated she would return after delivering the trays but did not return. Resident 56 stated she/he waited over 90 minutes before calling the front receptionist to ask for assistance.</p> <p>On 6/12/24 at 10:25 AM Staff 14 (CNA) stated she was the CNA hall partner with Staff 13 who was assigned to Resident 56 on 6/7/24. Staff 14 stated she noticed Resident 56 had her/his call light on for a long time and she answered the resident's call light after completing all her morning ADL cares for her residents. Staff 14 stated Resident 56 was crying and very upset that she/he was left in her/his soiled brief for almost two hours.</p> <p>On 6/12/24 at 11:37 AM Staff 17 (Receptionist) stated she answered a phone call from Resident 56 who stated she/he had been waiting for nursing assistance for two hours. Staff 17 stated she walked down to the nurses' station to get assistance for Resident 56.</p> <p>On 6/12/24 at 12:10 PM Staff 13 stated she was assigned to Resident 56 on 6/7/24 and did not provide incontinence care in a timely manner. Staff 13 stated there was confusion on the room assignments and she was not aware she was assigned to Resident 56 until Staff 14 provided the incontinence care for the resident.</p> <p>On 6/13/24 at 11:44 AM Staff 2 (Interim Administrator) stated he expected that resident care would be provided in a timely manner and staff answered all the call lights regardless of room assignments.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>34702</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident received pressure ulcer treatments for 1 of 1 sampled resident (#4) reviewed for pressure ulcers. This failure resulted in Resident 4's pressure ulcer worsening. Findings include:</p> <p>Resident 4 admitted to the facility in 2017 with diagnoses including hypertension and diabetes.</p> <p>The undated facility Event Summary Report indicated the following:</p> <ul style="list-style-type: none"> -Resident 4 had a dressing in place dated 12/27/23 to her/his right ankle. -On 12/27/23 Staff 8 (LPN) measured Resident 4's wound on the right ankle and measurements were given to the Staff 12 (Former DNS) as requested. There was a dressing in place on the right ankle and Staff 8 measured the wounds and replaced the old bandage with a new one. -On 12/27/23 the wound measured 1.8 cm x 1.2 cm. -On 1/3/24 at approximately 1:30 PM Staff 11 (RNCM) and Staff 10 (LPN Resident Care Manager) completed wound rounds with the outside wound care provider. -On 1/3/24 the dressing was removed and revealed a Stage 3 pressure ulcer that measured 2 cm x 2.5 cm x 0.3 cm revealing a deterioration of the wound. <p>On 6/12/24 at 10:53 AM Staff 11 stated on 1/3/24 she completed wound rounds with Staff 10 and the outside wound care provider. Staff 11 stated Staff 8 measured the wound on 12/27/23 and provided the measurements to Staff 12. Staff 11 stated she did not recall the observation of the dressing and wound from 1/3/24.</p> <p>On 6/12/24 at 11:14 AM Staff 10 stated on 1/3/24 she completed wound rounds with Staff 11 and the outside wound care provider and Resident 4 had a dressing on her/his right ankle initialed by Staff 8 and dated 12/27/23. Staff 11 stated the dressing was saturated when it was removed, and the information was reported to Staff 12. Staff 10 further stated Staff 8 measured the wound on 12/27/23 and reported the measurements to Staff 12.</p> <p>On 6/12/24 at 11:22 AM Staff 8 stated she worked on 12/27/23 and Resident 4 had a dressing on her/his ankle. Staff 8 stated she removed the dressing and took measurements of the wound and provided the measurements to Staff 12. Staff 8 stated she did not remember if she put a new dressing on the wound after measuring it.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/14/24 at 11:17 AM Staff 12 stated she was working as the DNS on 12/27/23 and Staff 8 provided Resident 4's right ankle wound measurement. Staff 12 stated she emailed the measurements to a resident care manager, there was no follow up notification to the physician and no orders were put in place for the pressure ulcer. Staff 12 acknowledged she did not follow up on the wound and wound care was not implemented. Staff 12 stated on 1/3/24 the facility staff and wound care provider identified there were no treatments in place for the wound from 12/27/23 through 1/3/24. Staff 12 stated in-services were provided regarding pressure ulcer assessments and wound care on 1/3/24.</p> <p>On 6/14/24 at 11:33 AM Staff 2 acknowledged Resident 4's pressure ulcer to the right ankle measured 1.8 cm x 1.2 cm on 12/27/23, treatments were not put in place and physician orders were not obtained until 1/3/24. Staff 2 acknowledged the wound worsened and on 1/3/24 the wound measured 2 cm x 2.5 cm x 0.3 cm. Staff 2 stated an in-service was provided on 1/3/24.</p> <p>On 6/14/24 at 10:54 AM the facility provided information to indicate education and an in-service was provided to nursing staff related to the identified incident. The deficient practice was determined to be past non-compliance, corrected on 1/3/24.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>47005</p> <p>Based on Interview and record review was determined the facility failed to ensure CNAs received annual performance reviews for 5 of 5 randomly selected CNAs (#14, 18, 19, 20 and 21) reviewed for staff performance reviews. This placed residents at risk for lack of care by competent staff. Findings include:</p> <p>On 6/14/24 at 11:06 AM a review of facility personnel records with Staff 2 (Interim Administrator) indicated the following:</p> <ul style="list-style-type: none"> - Staff 14 (CNA) was hired on 8/20/20; no annual performance review was completed. - Staff 18 (CNA) was hired on 8/20/04; no annual performance reviews were completed. - Staff 19 (CNA) was hired on 11/12/10; no annual performance reviews were completed. - Staff 20 (CNA) was hired on 6/14/18; no annual performance reviews were completed. -Staff 21 (CNA) was hired on 11/5/21; no annual performance reviews were completed. <p>On 6/14/24 at 11:43 AM Staff 2 confirmed the annual performance reviews were not completed for Staff 14, Staff 18, Staff 19, Staff 20, or Staff 21. Staff 2 stated it was his expectation the annual performance reviews were completed annually.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>47005</p> <p>Based on interview and record review it was determined the facility failed to ensure the daily staff posting was accurate for 7 out of 30 days reviewed for staffing. This placed residents, the public and staff at risk for lack of accurate staffing information. Findings include:</p> <p>On 6/10/24 at 3:51 PM the Direct Care Staff Daily reports were provided from 5/7/24 through 6/10/24. The forms revealed seven instances where portions of the form were left blank or were incomplete. The incomplete information included census, number of staff working and number of hours worked.</p> <p>On 6/14/24 at 10:21 AM Staff 1 (Administrator) and Staff 22 (Corporate Consultant) acknowledged the Direct Care Staff Daily reports were incomplete for 7 out of 30 days. Staff 1 stated it was her expectation staff completed the daily staffing sheets at the beginning of each shift every day.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34702</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure appropriate medication storage temperatures were logged and maintained for 1 of 1 medication storage refrigerator reviewed for safe medication storage. This placed residents at risk for receiving medications with reduced efficacy. Findings include:</p> <p>On 6/13/24 at the medication refrigerator temperature logs were observed to be blank on the following dates:</p> <p>-5/3/24</p> <p>-5/10/24</p> <p>-5/11/24</p> <p>-5/12/24</p> <p>-5/13/24</p> <p>-5/18/24</p> <p>-5/19/24</p> <p>-5/20/24</p> <p>-5/21/24</p> <p>-5/26/24</p> <p>-5/27/24</p> <p>-5/28/24</p> <p>-5/31/24</p> <p>-6/1/24</p> <p>-6/2/24</p> <p>-6/3/24</p> <p>-6/4/24</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-6/9/24</p> <p>On 6/13/24 at 11:37 AM Staff 2 (DNS) acknowledged the blank temperature logs for the identified dates for the medication refrigerator and stated the expectation was for the nurse to complete the temperature logs.</p>