STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385155	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Grove Post Acute	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure PRN psychotropic medication orders were discontinued after 14 days for 1 of 5 sampled residents (#20) reviewed for unnecessary medications. This placed residents at risk for receiving unnecessary psychotropic medication and adverse side effects of psychotropic medication. Findings include:Resident 20 was admitted to the facility in 6/2025 with diagnoses including dementia and depression. A 6/11/25 physician order indicated Resident 20 was prescribed the following PRN psychotropic medications:-Quetiapine Fumarate 25 MG Oral Tablet an antipsychotic indicated for agitation.-Prochlorperazine Maleate 5 MG Oral Tablet an antipsychotic indicated for nausea.-Hydroxyzine HCl 10 MG Oral Tablet an anxiolytic indicated for anxiety or insomnia. There was no evidence found in Resident 20's medical record to indicate her/his physician documented a rationale for extended use of the PRN psychotropic medications past 14 days, or evaluated her/his PRN psychotropics since admission to the facility. A 7/11/25 pharmacy review of Resident 20's medications recommended the facility discontinue her/his PRN psychotropic medications for non use. The PRN psychotropic medications were discontinued on 7/22/25. On 7/4/25 at 1:21 PM Staff 3 stated she was unaware that PRN psychotropics were limited to 14 days. Staff 3 acknowledged Resident 20's PRN psychotropic medication orders went beyond 14 days without a documented rationale for extended use, or evaluation by a physician.

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 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. Based on observation, interview, and record review it was determined the facility failed to assess residents for smoking safety and provide supervision for smoking residents for 2 of 3 sampled residents (#s 57 and 78) reviewed for accidents. This placed residents at risk for smoking related accidents. Findings include: 1. The facility’s 8/2024 Smoking Policy for Independent and Supervised states residents who wished to smoke were to have a smoking evaluation upon admission or at the time they decided to smoke, to evaluate their ability to smoke safely. Resident 57 was admitted to the facility in 10/2024 with diagnoses including Chronic Obstructive Pulmonary Disease (a lung and airway disease that restricts breathing). Resident 57’s 10/20/24 Baseline Care Plan stated she/he was an independent and safe smoker. The 5/7/25 Quarterly MDS indicated Resident 57 was cognitively intact. A review of Resident 57’s clinical record revealed no indication a smoking assessment was completed. On 7/21/25 the facility provided a list of residents who smoked independently, and Resident 57 was included on the list. On 7/21/25 at 12:36 PM Resident 57 was observed disposing of her/his cigarette on a bucket lid and not in the designated receptacle. On 7/22/25 at 1:33 PM Resident 57 stated she/he was an active smoker and smoked independently since admitting to the facility. Resident 57 expressed she/he was never assessed or observed for smoking safety, and she/he was provided the facility smoking policy for her/his review and signature about two weeks ago. On 7/22/25 at 12:52 PM Staff 3 (LPN Resident Care Manager) stated, per facility policy, residents were assessed for smoking safety upon admission. Staff 3 acknowledged resident 57 smoked independently and the resident’s care plan indicated she/he smoked independently, but there was no evidence in the clinical record to indicate an assessment was completed. 2. The facility's 3/2020 Smoking Policy and Procedure stated, “Residents who do not meet the established criteria to smoke independently are provided assistance/supervision during all smoking activities. ” Resident 78 was admitted to the facility in 5/2022 with diagnoses including vascular dementia. Resident 78’s 5/21/22 Smoking Care Plan revealed the following: -The resident was allowed to smoke with supervision. -The resident's smoking supplies were to be stored in the medication room. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/25 at 11:30 AM Resident 78 was observed in her/his room with a pack of cigarettes stored inside her/his crossbody bag. On 7/21/25 at 12:29 PM Resident 78 was observed independently entering the smoking area with smoking supplies. Resident 78 proceeded to smoke a cigarette, which was lit by another resident in the smoking area. No staff were observed in the smoking area with Resident 78 while she/he smoked. On 7/21/25 at 3:37 PM Staff 13 (CNA) stated supervised smokers were required to keep their supplies “locked up at the nurses station.” On 7/21/25 at 4:03 PM Staff 14 (LPN) stated Resident 78 required supervision for smoking. Staff 14 further stated staff assigned to residents were care planned for supervised smoking were to conduct the following process: -Obtain the resident’s smoking supplies from the assigned nurse and accompany her/him to the smoking area. -Light the resident’s cigarette for her/him and provide one to one supervision from within the smoking area. On 7/21/25 at 4:34 PM Staff 3 (LPN Resident Care Manager) acknowledged Resident 19 was supposed to receive supervision with smoking and was not to have cigarettes stored in her/his room.