STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER: Green Valley Rehabilitation Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1735 Adkins Street Eugene, OR 97401	

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 35855 Based on interview and record review it was determined the facility failed to provide the risk and benefits for the use of an antipsychotic medication to a resident/responsible party prior to administration for 4 of 5 sampled residents (#s 55, 87, 164, and 165) reviewed for medications. This placed resident responsible parties at risk for lack of informed consent. Findings include: 1. Resident 55 admitted to the facility in 7/2024 with diagnoses including pulmonary embolism (blockage of a lung artery). A review of the 9/2024 MAR instructed staff to administer sertraline (to treat depression) one time a day for depressive episodes with a start date of 7/27/24. The MAR instructed staff to administer lorazepam (to treat anxiety) every four hours as needed for nausea and agitation with a start date of 8/29/24. No information was found in the record to indicate the resident or responsible party were provided risk and benefits information for the use of sertraline or lorazepam. On 9/13/24 at 8:36 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated they knew there was a system issue related to the provision of risks and benefits information. 41455 2. Resident 87 admitted to the facility in 3/2024 with diagnosis which included bipolar (mood swings) disorder. A 6/15/24 Quarterly MDS revealed Resident 87 was cognitively intact. The 8/2024 MAR indicated Resident 87 received duloxetine (antidepressant medication) daily since 7/30/24 related to her/his bipolar depression. Review of Resident 87's clinical record indicated no documentation the resident or responsible party were provided risk and benefit information for the use of duloxetine. On 9/10/24 at 4:39 PM Staff 4 (Unit Manager-LPN) acknowledged Resident 87 was not provided the the risk and benefits for the use of duloxetine. (continued on next page)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	26991 3. Resident 164 readmitted to the facility in 8/2024 with a diagnosis of surgical repair of leg fractures. An 8/31/24 NSG (Nursing) Admission/Readmission Evaluation form revealed Resident 164 was cognitively intact. A 9/2024 MAR revealed Resident 164 was to be administered haloperidol (antipsychotic medication to treat mental health disorders) PRN for restlessness. No doses were administered. The MAR also indicated she/he was to be administered Ativan (antianxiety medication) PRN for nausea, anxiety, and restlessness. One dose was administered on 9/9/24. Resident 164's clinical record revealed no consents were obtained related to the haloperidol and Ativan. On 9/10/24 at 8:59 AM Staff 22 (Social Services) stated the social service staff were to obtain consents for psychotropic medications. If the resident admitted to the facility and social services was not in the building, the nursing staff did not obtain consents. Staff 22 acknowledged consents were not obtained for Resident 164's psychotropic medications. 4. Resident 165 admitted to the facility in early 9/2024 with a diagnosis of a stroke. A 9/6/24 NSG (Nursing) Admission/Readmission Evaluation form revealed Resident 165 was alert and oriented to person and situation. The form indicated Resident 165's family was present on admission. A 9/2024 MAR revealed Resident 165 was to be administered Lexapro (for anxiety and depression) daily. The MAR indicated Lexapro was administered daily starting on 9/7/24. Resident 165's clinical record revealed no consent was obtained for the use of Lexapro. On 9/10/24 at 8:59 AM Staff 22 (Social Services) stated she was responsible for obtaining consents for psychotropic medications. Staff 22 also stated the nursing staff did not obtain consents for psychotropic medications prior to administering psychotropic medications to residents. Staff 22 acknowledged a consent was not obtained from Resident 165 or her/his representative prior to medication administration.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 26991 Based on interview and record review it was determined the facility failed to ensure a safe system for a resident's self-administration of medication for 1 of 6 sampled residents (#44) reviewed for accidents. This placed residents at risk for adverse medication reactions. Findings include: Resident 44 admitted to the facility in 2021 with a diagnosis of heart disease. An 4/22/24 annual MDS revealed Resident 44 was cognitively intact. A 5/12/23 Self-Administration of Medication form revealed Resident 44 was assessed to be capable of self-administration of medications. The form did not indicate which medications Resident 44 was able to self-administer. A care plan initiated 9/2023 revealed Resident 44 was not able to walk and propelled in a wheelchair with staff assistance. The care plan also indicated Resident 44 self-administered over-the-counter supplements which were kept at her/his bedside. The care plan did not identify which medications she/he could self-administer. A 9/2024 MAR revealed Resident 44 had orders to self-administer supplements which were kept at the resident's bedside. A 9/6/24 Provider Note revealed Resident 44 had an old skin graft donor site to the left thigh. The resident reported she/he put Desitin on the site by accident and the site worsened significantly. Progress Notes revealed on 9/6/24 Resident 44's thigh donor site was assessed to be open, had slough, and bled. The note indicated the wound nurse evaluated the site. On 9/7/24 the site was much better but Resident 44 reported the site was still very painful. On 9/8/24 at 12:09 PM Resident 44 stated she/he applied Desitin to her/his skin donor site and it worsened. On 9/9/24 at 8:42 AM and 9/10/24 an unlocked shelf in Resident 44's room was observed to have one bottle of rubbing alcohol (disinfectant), one bottle of hydrogen peroxide (disinfectant), and nine bottles of oral supplements. The shelf was on the wall at the foot of the resident's bed. On the window sill next to Resident 44's bed one tube of Desitin (barrier cream) was observed. On 9/10/24 at 11:47 AM Staff 17 (CMA) stated medications were not to be left at the bedside unless a resident had physician orders to self-administer specific medications. Staff 17 stated Resident 44 had a lot of medications in her/his room. On 9/10/24 at 12:00 PM with Resident 44 and Staff 5 (LPN Resident Care Manager) Staff 5 stated Resident 44 was assessed and had orders for two different supplements to be kept at the bedside. Staff 5 acknowledged there were multiple bottles of supplements, creams and liquid disinfectants in Resident 44's room. Staff 5 stated the medications were to be locked in a secure area and were not. Staff 5 also stated Resident 44 applied Desitin to her/his donor site and it worsened but was now better.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49677 Based on interview and record review it was determined the facility failed to provide a response to Resident Council grievances for 1 of 1 resident group reviewed for grievances. This placed residents at risk for a decline in psychosocial well-being. Findings include: A grievance policy revised 3/2023 indicated the grievance officer (administrator) would take immediate action to prevent further potential violations of any resident right while a grievance was investigated. Review of Council Minutes notes dated 7/16/24 revealed : -CNAs: No improvement-getting worse. - Council members also wanted reimbursement for lost or stolen items and voiced concern about menus not being followed. -Call light response time was awful. -Head phones being used 8/2024 Council Agenda notes revealed: -CNAs not knocking on bathroom doors -CNAs have attitudes -Meals were up to 1.5 hours late -Resident laundry being delivered to wrong rooms. During a resident council meeting on 9/10/24 at 2:51 PM, residents stated the facility staff did not respond to concerns or grievances voiced by resident council. Residents voiced the following concerns: 1. Staff wore earphones on (NOC) night shift. 2. Day shift CNAs used their phones and ignored resident call lights. 3. Not enough help or staff to meet their needs and long call light responses up to 60 minutes. 4. Residents unanimously reported they received no follow-up for their concerns or grievances. 5. Clothing and personal items were missing, and no staff addressed the concerns. 6. A lack of variety of snacks. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 1:02 PM Staff 7 (Activities Director) stated there were several changes in administrators (three in the last year) and this made it more difficult for consistency with communication between staff members regarding who was responsible to respond to grievances. Staff 7 stated for the last six months grievances were given to department heads who were not aware of what to do with them. The grievance process did not propagate from the department heads to the administrator. Staff 7 also stated residents voiced their discouragement with the lack of acknowledgement, and it negatively impacted their mood and sense of dignity. An 8/2024 online grievance log revealed a brief description of grievances, but the form did not have a follow-up section and did not identify who would address the concern. On 9/13/24 at 1:44 PM, Staff 7 confirmed there was no follow-up section included on the online grievance log. On 9/12/24 at 3:02 PM Staff 1 confirmed there were no grievance resolutions.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was assisted with formulating an advance directive for 1 of 3 sampled residents (#164) reviewed for advance directives. This placed residents at risk for lack of end-of-life choices being honored. Findings include: Resident 164 admitted to the facility in 2022 with a diagnosis of chronic kidney disease. A 7/30/24 IDT (Interdisciplinary Team) Care Plan Conference/Welcome Meeting Form revealed Resident 164 was able to voice her/his needs but was cognitively impaired. The form also indicated she/he wanted to formulate an advance directive with the assistance of her/his friend. Progress Notes from 7/30/24 to 9/9/24 did not include a follow up note to indicate staff communicated with Resident 164 or her/his friend to assist with formulating an advance directive. On 9/10/24 at 4:01 PM Staff 3 (Social Services) stated she recalled Resident 164 verbalizing she/he wanted to formulate an advance directive. Staff 3 indicated if assistance was provided it would be documented in the progress notes. Staff 3 indicated she would provide documentation if she/he had any additional information. No additional information was provided. 50930

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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. 35855 Based on interview and record review it was determined the facility failed to notify the physician or resident representative regarding refusals and changes in condition for 3 of 7 sampled residents (#s 55, 86 and 165) reviewed for medications, change of condition and catheter care. This placed residents at risk for delay in treatment. Findings include: 1. Resident 55 admitted to the facility in 7/2024 with diagnoses including chest pain. A review of the 9/2024 TAR instructed staff to administer a lidocaine patch to the affected area one time a day for pain. From 9/1/24 through 9/9/24 Resident 55 refused the patch nine times out of nine opportunities. No documentation was found in Resident 55's clinical record the physician was notified of the refusals from 9/1/24 through 9/9/24. On 9/10/24 at 4:51 PM Staff 1 (Administrator) confirmed the physician was not notified at any time from 9/1/24 through 9/9/24 regarding the lidocaine patch refusals. 41455 2. Resident 86 admitted to the facility in 3/2024 with diagnosis including UTI and paraplegia (impairment in lower extremities). A 6/18/24 revised care plan indicated to monitor Resident 86 for signs and symptoms of discomfort related to her/his catheter care. A 9/8/24 progress note by Staff 38 (LPN) indicated during routine incontinent care Resident 86's catheter was dislodged during the early morning hours and she/he was transported to the hospital to have the catheter reinserted. Staff 38 indicated she would defer to call Resident 86's emergency contact until later in the morning. On 9/8/24 at 11:36 AM Witness 5 (Complainant) stated she was not notified by the facility Resident 86 was sent to the hospital on 9/8/24. On 9/12/24 at 5:25 PM Staff 38 stated she did not want to notify the family in the middle of the night when Resident 86 went to the hospital to have her/his catheter reinserted. Staff 38 stated she spoke to the nurse on the next shift and conveyed family needed to be notified. On 9/13/24 at 8:35 AM Staff 4 (Unit Manager-LPN) acknowledged Resident 86's family should have been informed immediately when the resident went to the hospital. 26991 3. Resident 165 admitted to the facility in 9/2024 with a diagnosis of pneumonia. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note written by Staff 10 (LPN) revealed on 9/8/24 Resident 165 removed her/his oxygen, her/his oxygen levels dropped to the 70's several times at night, and staff made frequent checks on Resident 165. On 9/12/24 at 1:18 PM Staff 2 (DNS) stated if a resident's oxygen level dropped into the 70's Staff 2 expected nursing staff to stabilize the resident and then notify the resident's physician. A request was made to provide documentation Resident 165's physician was notified of the change of condition. No additional information was provided. On 9/12/24 at 7:01 PM Staff 10 stated Resident 165's oxygen level decreased all night the night of 9/8/24. Resident 165 was confused, removed the oxygen, and was a mouth breather. Staff 10 stated he placed the oxygen device near the resident's mouth and the oxygen levels improved. The oxygen levels continued to drop throughout the night because when Resident 165 turned in bed the oxygen tubing was accidentally removed. Staff 3 stated he did not notify Resident 165's physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34703 Based on observation, interview, and record review it was determined the facility failed to ensure residents' rooms were clean, in good repair and free of clutter for 5 of 5 sampled residents (#s 2, 62, 71, 98, and 162) reviewed for ADLs and environment. This placed residents at risk for lack of a homelike environment. Findings include: 1. Resident 2 admitted to the facility in 5/2016 with diagnoses including chronic pain. On 9/10/24 at 11:44 AM Resident 2's room was observed with the following: -Multiple tissue boxes, paperwork, cups, utensils, books, and a miniature arctic air conditioner on the bedside table. The air conditioner had approximately one half inch of brown dust on the vents and on the internal filters. -Food boxes, pop cans, and paperwork on the floor and the bedside table. Resident 2 stated she/he had the arctic air conditioner for three years and nobody cleaned it for her/him. Resident 2 stated she/he did not like her/his room so cluttered and asked staff to help clean her/his room, but nobody helped her/him. On 9/10/24 at 11:58 AM Staff 4 (Unit Manager-LPN) acknowledged the resident's air conditioner had thick dirt and dust on the vents and on the internal filters, and the resident's room was cluttered and did not appear homelike. 2. Resident 62 admitted to the facility in 6/2022 with diagnoses including chronic pain. On 9/8/24 at 12:30 PM Resident 62 stated housekeeping cleaned her/his bathroom, but it was still dirty with urine and dark brown debris around the toilet bowl and yellow-colored debris on the floor. Resident 62's bathroom was observed with urine and dark brown debris around the toilet bowl and yellow-colored debris on the floor. On 9/8/24 at 12:45 PM Staff 55 (RN) acknowledged Resident 62's bathroom had urine and dark brown debris around the toilet bowl, yellow-colored debris on the floor, and was not clean or homelike. 26991 3. Resident 98 admitted to the facility in 7/2024 with a diagnosis of a stroke. A 7/19/24 admission MDS revealed Resident 98 was cognitively intact. Resident 98's clinical record indicated she/he resided in her/his current room (room [ROOM NUMBER]A)since 8/26/24. Resident 71 admitted to the facility in 9/2023 with a diagnosis of a bone infection. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 9/5/24 annual MDS revealed Resident 98 was cognitively intact. Resident 71's clinical record indicated she/he resided in room [ROOM NUMBER] from 4/26/24 through 8/15/24. On 9/8/24 at 12:23 PM an area approximately 12 inches high by 12 inches wide of unpainted white wall patching material was observed on the wall below the window in room [ROOM NUMBER]. On 9/9/24 at 3:06 PM Staff 28 (Maintenance) stated weekly rounds were made of all resident rooms. If a wall was patched it was painted the next day and the patch was likely from rounds the previous week. On 9/12/24 at 10:35 AM Resident 98 stated the patch was on the wall since she/he moved into the room. On 9/12/24 at 10:50 AM Resident 71 stated there was a patch on the wall when she/he resided in room [ROOM NUMBER], and she/he just didn't look at it. 4. Resident 162 admitted to the facility in 4/2024 with a diagnosis of heart disease. Resident 162's clinical record revealed she/he resided in room [ROOM NUMBER] while in the facility. An 4/11/24 five day assessment revealed Resident 162 was cognitively intact. On 4/16/24 Resident 162 reported to the State Agency the window blind control wand was broken and the blinds could not be opened in room [ROOM NUMBER]. On 9/8/24 at 4:38 PM Resident 162 stated the window blind control wand was broken while she/he resided in room [ROOM NUMBER]. Resident 162 stated she/he reported the issue to staff, but did not recall the name of the staff. On 9/9/24 at 2:56 PM the blind in room [ROOM NUMBER] was observed with the control wand missing preventing adjustment. On 9/9/24 at 2:52 PM Staff 62 (Maintenance) looked at the maintenance log and stated there were no reports in 4/2024 related to a broken window blind control wand in room [ROOM NUMBER]. On 9/9/24 at 2:58 PM Staff 29 (CMA) verified the blind control wand was missing and the slats could not be easily adjusted to let sunlight into the room. Staff 29 stated a work order would be entered into the maintenance computer system to alert maintenance to replace the blind control wand. On 9/9/24 at 3:01 PM Staff 28 (Maintenance) stated maintenance staff conducted weekly room audits but the maintenance department was dependent on the nursing staff to report room concerns via the maintenance computer system.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50930 Based on observation, interview and record review it was determined the facility failed to provide a written grievance, resolution, or communication with a resident or representative for 3 of 17 sampled residents (#s 63, 98 and 162) and 1 of 2 units reviewed for dignity, food, staffing and accidents. This placed residents at risk for unresolved concerns. Findings include: 1. Resident 63 admitted to the facility in 5/2024 with diagnoses including heart failure and chronic kidney disease. Review of a 7/18/24 Discharge MDS indicated Resident 63 was cognitively intact. On 9/11/24 at 3:59 PM Staff 51 (Scheduler) stated Resident 63 reported a missing ring to staff on 8/13/24. She stated a sign was made to alert staff, and a written grievance was given to management. Observation of the sign mentioned by Staff 51 revealed the wording missing on 8/13/24 silver ring with this symbol (large image of a masonic symbol). Please give to nurse if found! Review of the 8/2024 grievance log revealed no grievances related to Resident 63. Review of Resident 63's 8/2024 and 9/2024 progress notes showed no entries regarding reports of a missing ring. On 9/12/24 at 11:38 AM Staff 1 (Administrator) stated she interviewed Resident 63 on 8/14/24 and had email communication with her/him regarding the missing ring. She stated the facility ordered a replacement ring, and acknowledged there were no grievances or documentation for the incident in Resident 63's chart. 26991 2. Resident 98 admitted to the facility in 7/2024 with a diagnosis of a stroke. A 7/19/24 admission MDS revealed Resident 98 was cognitively intact. On 9/8/24 at 12:20 PM Resident 98 stated staff spoke rudely to her/him during the 9/8/24 night shift. Resident 98 reported to Staff 10 (LPN) the CNA told her/him that she/he got upset too easily. Resident 98 stated she/he felt like no one saw or heard her/him. On 9/12/24 at 12:30 PM Staff 1 (Administrator) stated if a resident had a concern about how staff treated her/him a grievance form should be completed in order for administration to verify if the situation occurred. Staff 1 stated she was not aware of a concern related to the manner in which staff provided care to Resident 98. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 1:03 PM and 9/12/24 at 7:41 PM Staff 10 stated Resident 98 reported the CNA did not help her/him quickly enough. Staff 10 stated the CNA answered Resident 98's call light and left to find another CNA to assist with Resident 98's care. As the CNA left the room Resident 98's roommate requested to use the bathroom and since the roommate was a one-person assist the CNA assisted the roommate before helping Resident 98. Resident 98 reported the staff did not care for her/his needs and took too long. Staff 10 stated he spoke to the CNA to improve her/his communication skills but did not fill out a grievance. On 9/12/24 at 12:14 PM Staff 13 (Agency CNA) stated she did not recall Staff 10 communicating with her regarding Resident 98. 3. Resident 162 admitted to the facility in 4/2024 with a diagnosis of heart disease. An 4/15/24 Progress Note indicated Resident 162 called the police to report concerns including she/he was served moldy food. An 4/16/24 five day MDS assessment revealed Resident 162 was cognitively intact. On 9/10/24 at 9:28 AM Staff 1 (Administrator) stated she was aware of Resident 162's report of moldy food but did not have a grievance form related to the issue. Staff 1 stated she was not the administrator in 4/2024. On 9/9/24 at 3:45 PM Staff 23 (Former Administrator) stated Resident 162 called the police. Staff 23 stated the facility immediately threw out all the perishable snacks and investigated the incident. Staff 23 stated a grievance form was completed and placed in the grievance binder. Refer to F812 example 1 for additional information. 35855 4. On 9/3/24 a public complaint was received which indicated staff did not provide timely incontinence care, and a resident's call light was unplugged intentionally. On 9/10/24 at 2:31 PM Witness 4 (Staff) stated when she came onto shift one day in 9/2024 she found one resident with missing blankets, one resident's call light was unplugged in room [ROOM NUMBER], and several rooms including Rooms 1A, 1B, 21, 25A, 25B, 26A, and 26B had residents who did not receive incontinent care all night and had skin breakdown. Witness 4 informed the nurse and it was her understanding Staff 33 (LPN) completed a grievance. At times residents had to stay up in their wheelchairs when there needed to be six to 10 full bed changes because there were not enough linens to complete the bed changes. A review of the 9/2024 Grievance Report Log revealed one grievance listed on 9/9/24 completed by Staff 3 (Social Worker) for a care concern for room [ROOM NUMBER]. No grievances were found for Witness 4's concerns related to resident care. On 9/13/24 at 2:56 PM Staff 1 (Administrator) stated there was only one grievance which was turned in so far in 9/2024. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/24 at 3:05 PM Staff 33 (LPN) stated Witness 4 notified the Unit Manager about the concerns. Staff 33 stated there were five residents who were not in great shape. Some of the residents had a pad change but not a fitted sheet and they were disorganized. Staff 33 stated some residents pulled out their call light cords. On 9/13/24 at 3:12 PM Staff 4 (LPN Unit Manager) and Staff 5 (LPN Unit Manager) stated Staff 33 completed the grievance related to the concerns of residents who did not receive timely incontinent care. The grievances then typically went to Staff 1 or Staff 2 (DNS).

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34703 Based on interview and record review it was determined the facility failed to protect residents' right to be free from physical abuse by staff for 1 of 1 sampled resident (#82) reviewed for abuse. Resident 82 was mistreated by staff resulting in physical injury. Findings include: Resident 82 admitted to the facility in 1/2024 with diagnoses including stroke. A 1/19/24 Admission MDS indicated Resident 82 was moderately impaired with decision making due to aphasia (unable to formulate language). Resident 82 was able to answer yes or no questions and used thumbs up for yes, and thumbs down for no. A 7/24/24 FRI indicated Staff 74 (CNA) showered Resident 82 and bumped the resident's foot on the wall while exiting the shower room. Staff 74 left the hall and left Resident 82 sitting in the shower chair. Staff 75 (CNA) reported the resident's toe was bleeding and no report or communication was given to her. On 9/11/24 at 3:44 PM Staff 34 (LPN) stated Staff 74 was the shower aide on 7/24/24 and gave Resident 82 a shower. Staff 34 stated a staff member did not show up for work and Staff 74 was reassigned to provide direct care to residents. Staff 34 stated Staff 74 became angry, pushed Resident 82's shower chair hard out of the shower room causing the resident's toe to hit the door. Staff 34 stated the toenail was lifted off the toenail bed and was bleeding badly. Staff 34 stated Staff 74 left Resident 82 in the room alone without a call light and did not report to another CNA she was leaving. On 9/11/24 at 4:02 PM Staff 5 (Unit Manager-LPN) and Staff 6 (Unit Manager-LPN) stated Staff 34 reported Staff 74 was pulled from the bath aide position to care for residents, became angry, injured the resident's toe on the shower room door, and left the facility without reporting to another CNA. Staff 5 stated Staff 74 left the resident alone in her/his room in the shower chair without a call light. On 9/11/24 at 4:33 PM Staff 75 (CNA) stated on 7/24/24 she provided showers for residents. Staff 75 stated Staff 74 arrived to help complete showers. Staff 75 stated Staff 74 was told she would be pulled from showers to provide care to residents. Staff 75 stated Staff 74 became angry, walked out of the shower room with Resident 82 still in the shower with the water running and no call light, and started yelling down the hall. Staff 75 stated she came into the hall to see what happened and observed Staff 74 pull the shower chair roughly and hit the resident's toe on the shower room door. Staff 75 stated the resident's toe was bleeding badly. Staff 75 stated Staff 74 pushed the resident into her/his room and left her/him alone with only a towel on and without a call light. On 9/11/24 at 4:38 PM Staff 2 (DNS) stated Staff 74 did not complete a proper hand-off or report to another CNA she was leaving the floor before she left. Staff 2 acknowledged Resident 82's toe was hit on the shower room door as a result of Staff 74's mistreatment of Resident 82.

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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. 35855 Based on interview and record review it was determined the facility failed to report timely to the State Survey Agency for an allegation of elopement for 1 of 7 sampled residents (#93) reviewed for accidents. This placed residents at risk for elopement. Findings include: Resident 93 was admitted to the facility in 6/2024 with diagnoses including dementia, stroke, alcohol abuse and seizures. A FRI dated 9/9/24 indicated on 9/6/24 Resident 93 left the facility, and it was reported to the State Agency on 9/9/24. On 9/13/24 at 8:37 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated staff did not report the elopement to the facility administration staff until 9/9/24. Refer to F689

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34703 Based on interview and record review it was determined the facility failed to thoroughly investigate an injury for 1 of 9 sampled residents (#82) reviewed for abuse and accidents. This placed residents at risk for neglect of care. Findings include: Resident 82 admitted to the facility in 1/2024 with diagnoses including stroke. A 7/24/24 FRI indicated Staff 74 (CNA) showered Resident 82 and bumped the resident's foot on the wall while exiting the shower room. Staff 74 left the facility prior to the end of her shift and left Resident 82 sitting in the shower chair. Staff 75 (CNA) reported the resident's toe was bleeding and there was no report or communication given to staff about the resident being left alone. A 7/25/24 facility Investigation completed by Staff 5 (Unit Manager-LPN) specified the following summary of Resident 82's injury on 7/24/24: after Resident 82 was assisted with a shower Staff 74 bumped the resident's foot on the wall while exiting the shower room, but did not realize the resident had an injury to her/his toe. Staff 74 left the resident in her/his room with another CNA. Staff 75 observed the resident's toe bleeding and notified the nurse. Education was provided to Staff 74 to avoid future injury to residents and to ensure reporting to the nurse if an injury occurred. Education was also provided for proper hand-off with teammates when leaving the facility. The investigation provided did not include an interview with the resident, nurses and other CNAs involved. On 9/11/24 at 3:44 PM Staff 34 (LPN) stated Staff 74 was the shower aide on 7/24/24 and gave Resident 82 a shower. Staff 34 stated a staff member did not show up for work and Staff 74 was reassigned to provide direct care to residents. Staff 34 stated Staff 74 became angry, pushed Resident 82's shower chair hard out of the shower room causing the resident's toe to hit the door. Staff 34 stated the toenail was lifted off the toenail bed and was bleeding badly. Staff 34 stated Staff 74 left Resident 82 in the room alone without a call light and did not report to another CNA she was leaving. On 9/11/24 at 4:38 PM Staff 5 (Unit Manager-LPN) acknowledged the investigation did not include an interview with the resident, other CNAs involved or the nurses on duty. 50930

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 26991 Based on interview and record review it was determined the facility failed to ensure the Office of the State Long-Term Care Ombudsman was notified of resident hospitalization s for 2 of 2 sampled residents (#s 95 and 262) reviewed for hospitalization s. This placed residents at risk for lack of access to an advocate to inform them of their options and rights. Findings include: 1. Resident 95 admitted to the facility in 7/2024 with a diagnosis of cancer. A Progress Note dated 7/6/24 revealed Resident 24 requested to be sent to the hospital for shortness of breath. Emergency services were called and the resident was transferred to the hospital. Resident 95's clinical record revealed no documentation to indicate the State Long-Term Care Ombudsman was notified. On 9/12/24 at 11:36 AM Staff 63 (Medical Records) stated she worked in her current position for eight years and never sent a message to the State Long-Term Care Ombudsman. On 9/12/24 at 11:54 AM Staff 56 (Regional RN) stated medical records staff were to send resident discharge information to the ombudsman office. 35855 2. Resident 262 admitted to the facility in 8/2024 with diagnoses including anxiety and a leg fracture. The Admission MDS with and ARD of 8/26/24 revealed Resident 262's BIMS score was 15 which indicated she/he was cognitively intact. An 8/28/24 Nursing Note indicated Resident 262 had a pain level of 10 on a scale from zero to 10. The on-call physician was notified and suggested to call the hospital emergency department to notify them Resident 262 would be sent to the hospital for disimpaction (procedure to remove trapped stool from the rectum). No documentation was found in Resident 262's clinical records to indicate a transfer notice with appeal rights was provided in writing to her/him or the Office of the State Long-term Care Ombudsman was notified of the resident's transfer to the hospital. On 9/12/24 at 11:36 AM Staff 63 (Medical Records) stated she did not complete ombudsman notifications. On 9/12/24 at 11:54 AM Staff 56 (Regional Nurse) stated medical records was designated to complete the ombudsman notifications.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 26991 Based on interview and record review it was determined the facility failed to provide a bed hold policy for 2 of 2 sampled residents (#s 95 and 262) reviewed for hospitalization . This placed residents at risk for lack of knowledge related to their right to return to the facility. Findings include: 1. Resident 95 admitted to the facility 7/2024 with a diagnosis of cancer. A Progress Note dated 7/6/24 revealed Resident 24 requested to be sent to the hospital for shortness of breath. Emergency services were called and the resident was transferred to the hospital. Resident 95's clinical record revealed no documentation to indicate Resident 95 or her/his representative were provided a bed hold policy at the time of discharge. On 9/12/24 at 11:19 AM Staff 22 (Social Services) stated she was not sure who provided residents with a bed hold policy when they were transferred to the hospital. On 9/12/24 at 11:25 AM Staff 58 (LPN) stated when a resident was sent to the hospital she was not sure who provided the resident or representative the bed hold policy. Staff 58 stated at other facilities where she worked the bed hold policy was at the nurses station but she did not see any bed hold policies at this facility. On 9/12/24 11:33 AM Staff 64 (Admissions) stated upon admission residents were provided a bed hold policy. Staff 64 stated Resident 95 did not complete the admission paperwork and a bed hold policy was not provided to her/him. Staff 64 stated if she was not in the facility the nurses had a bed hold policy in the admission paperwork and were to provide it to the resident. Staff 64 stated she did not see a bed hold policy in the resident's record. 35855 2. Resident 262 admitted to the facility in 8/2024 with diagnoses including anxiety and a leg fracture. The Admission MDS with and ARD of 8/26/24 revealed Resident 262's BIMS score was 15 which indicated she/he was cognitively intact. An 8/28/24 Nursing Note indicated Resident 262 had a pain level of 10 on a pain scale from zero to 10. The on-call physician was notified and suggested to call the hospital emergency department to notify them Resident 262 would be sent to the hospital for disimpaction (procedure to remove trapped stool from the rectum). No documentation was found in Resident 262's clinical records to indicate a bed hold policy was provided in writing to Resident 262 when she/he transferred to the hospital on 8/28/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 11:59 AM Resident 262 stated she/he did not remember or know anything about a bed hold policy. On 9/12/24 at 12:36 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed no bed hold notice was provided to Resident 262 on 8/28/24 when she/he transferred to the hospital.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34703 Based on observation, interview and record review it was determined the facility failed to revise care plans related to interventions for personal equipment for 3 of 12 sampled residents (#s 2, 86 and 164) reviewed for ADLs, medications and respiratory care. This placed residents at risk for unmet needs. Findings include: 1. Resident 2 admitted to the facility in 5/2016 with diagnoses including chronic pain. An observation on 9/10/24 at 11:44 AM revealed a mini arctic air conditioner on Resident 2's bedside table and a suction machine on the resident's night stand. A 7/4/24 care plan revealed no information regarding the air conditioner or the suction machine. On 9/10/24 at 11:58 AM Staff 4 (Unit Manager-LPN) acknowledged there was no information regarding the air conditioner or the suction machine on the resident's care plan. 41455 2. Resident 86 admitted to the facility in 3/2024 with diagnosis including depression and paraplegia (impairment in lower extremities). A 6/18/24 revised care plan indicated the following: -All staff were to involve Resident 86 in decisions about her/his care. -Resident 86 required extensive assistance by one staff for personal hygiene (which including shaving) and was dependent on staff for dressing. -Monitor Resident 86 for symptoms of depression including repetitive anxious or health-related concerns. No details related to interventions for Resident 86's anxiety or preferences for dressing or shaving were indicated. On 9/11/24 at 9:21 AM Staff 80 (CNA) stated Resident 86 needed to receive consistent encouragement to accept care due to her/his anxiety related to her/his depression. Staff 80 stated the resident accepted care and did not refuse if staff understood how to engage her/him. On 9/11/24 at 5:50 PM Resident 86 stated she/he preferred to be clean shaven and choose clothes when leaving the facility. On 9/12/24 at 11:10 AM Staff 8 (CNA) acknowledged shaving for Resident 86 did not occur daily because some staff did not know the resident and her/his preferences for personal hygiene were lacking in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 11:53 AM Staff 3 (Social Services) confirmed Resident 86's care plan should include specific anxiety interventions and details of her/his preferences for dressing and shaving. Refer to F758 Example #1 26991 3. Resident 165 readmitted to the facility in 8/2024 post-surgical reparir of leg fractures. An 8/31/24 hospice Admission Visit Summary revealed Resident 165 was to be administered haloperidol (antipsychotic medication) and Ativan (anti anxiety medication) PRN. A care plan initiated 8/2022 revealed no interventions related to the use of haloperidol and ativan. There were no interventions identified to monitor for medication adverse reactions, what triggered Resident 165's anxiety or need for the PRN medications. There were also no interventions identified to try prior to the use of the PRN haloperidol or Ativan. On 9/11/24 at 2:55 PM Staff 14 (LPN Resident Care Manager) stated social services usually updated care plans related to psychotropic medications and Resident 165's care plan was not updated. Refer to 758 Example #2b.

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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. 26991 Based on interview and record review it was determined the facility failed to ensure staff did not falsify documentation for 1 of 1 staff (#20). This placed residents at risk for adverse medication reactions. Findings include: On 6/25/24 the Past Noncompliance was corrected when the facility identified the cause of the incident and determined vital signs were not obtained by a CMA prior to medication administration resulting in a drop in blood pressure. The plan of correction included: -6/28/24 nurse and CMA education was provided related to the 10 rights of medication administration. -7/3/24 an audit was initiated for residents with blood pressure parameters -7/3/24 the facility reported Staff 20 (CMA) to the Oregon State board of Nursing. -7/3/24 education was initiated to all nurses and CMAs regarding standards and scope of practice related to their licensure and obtaining vital signs prior to medication administration. Resident 41 was admitted to the facility in 8/2023 with a diagnosis of paraplegia (inability to move legs). A 7/10/24 annual MDS revealed Resident 41 was cognitively intact. A 6/2024 MAR revealed Resident 41 was to be administered Baclofen (muscle relaxant) three times a day and the medication was to be held if her/his systolic blood pressure (top number) was less than 100. On 6/25/24 at 3:00 PM Resident 41's BP was documented to be 100/68 and the medication was documented as administered. An investigation initiated on 6/25/24 revealed Resident 41 was administered a muscle relaxant which was to be held if her/his systolic blood pressure was less than 100. Staff 20 documented the blood pressure to be 100/68 for the 3:00 PM dose and the medication was documented as given. Staff 19 (LPN) was notified by a CNA Resident 41's blood pressure was 89/65. When Staff 19 questioned Staff 20 if she took Resident 41's blood pressure Staff 20 stated she looked at the morning blood pressure and guessed what the blood pressure would be at 3:00 PM. On 9/12/24 at 3:38 PM Staff 20 acknowledged she did not obtain Resident 41's blood pressure at 3:00 PM and just made up a blood pressure to enter into the MAR. Refer to F760

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34703 Based on observation, interview and record it was determined the facility failed to provide care and services to maintain good grooming for 3 of 4 sampled residents (# 62, 86 and 98) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: 1. Resident 62 admitted to the facility in 6/2022 with diagnoses including chronic pain. A public complaint was received on 5/2/24 which alleged Resident 62 received only four showers in the month of 5/2024. The In Room Care Plan instructed staff to shower Resident 62 on Mondays and Fridays. The Documentation Survey Report dated 5/1/24 through 5/31/24 revealed Resident 62 received three showers in the month of 5/2024. On 9/8/24 11:50 PM Resident 62 was observed lying in bed. The resident's hair appeared greasy, and body odor was present. On 9/8/24 at 12:50 PM Resident 62 stated she/he received four showers a month which was not enough. Resident 62 stated she/he was supposed to receive two showers a week but was not getting them. On 9/9/24 at 1:09 PM Staff 36 (CNA) and Staff 68 (CNA) stated there was not enough time or enough staff to get all showers completed for residents. On 9/10/24 at 3:09 PM Staff 35 (CNA) stated there was not enough staff to get showers completed for residents. On 9/13/24 at 8:33 AM Staff 5 (Unit Manager-LPN) confirmed Resident 62 was not receiving her/his showers as care planned. 41455 2. Resident 86 admitted to the facility in 3/2024 with diagnosis including depression and paraplegia (impairment in lower extremities). An 4/1/24 State Agency public complaint indicated Resident 86 was not assisted with bathing as needed since admission. A 3/2024 Documentation Survey Report indicated Resident 86 refused bathing on two out of eight days when Staff 81 (CNA) provided care. A 6/18/24 revised care plan indicated Resident 86 required extensive assistance by one staff for personal hygiene (including shaving) and two staff were needed to assist the resident with showers, but she/he preferred bed baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Shower/Bathe Self Wednesday and Sunday task indicated Resident 86 was scheduled for bathing on 9/8/24 and bathing was not applicable. On 9/11/24 at 9:21 AM Staff 80 (CNA) stated Resident 86 needed to receive consistent encouragement to accept care due to her/his anxiety related to her/his depression. Staff 80 stated the resident accepted care and would not refuse bathing if staff understood how to engage her/him. On 9/11/24 at 5:50 PM Resident 86 was observed seated in the dining room with quarter inch long facial hair. Resident 86 stated no staff offered to shave her/him on 9/11/24 and she/he preferred to be clean-shaven. On 9/12/24 at 11:10 AM Staff 8 (CNA) stated shaving for Resident 86 did not occur daily because some staff who cared for her/him were inconsistently assigned to Resident 86, did not know the resident and were overwhelmed as newer employees. Staff 8 stated Resident 86 accepted needed care when consistent staff provided care due to her/his anxiety. On 9/13/24 at 8:35 AM Staff 4 (Unit Manager-LPN) stated on 9/13/24 she asked a nurse to shave Resident 86 and acknowledged the resident's preference for shaving was not completed as expected. Staff 4 stated Staff 81 only worked at the facility for a short period of time and Resident 86 would only refuse bathing if staff did not know how to approach her/him. Staff 4 confirmed improved interventions for Resident 86's bathing and personal hygiene care were needed. 26991 3. Resident 98 admitted to the facility in 7/2024 with a diagnosis of a stroke. A 7/19/24 admission MDS revealed Resident 98 was cognitively intact, had a stroke, and required assistance with most ADLs. A bath task form from 8/11/24 through 9/10/23 revealed Resident 98 was to be showered two times a week. Resident 98 received one bed bath, one sponge bath, refused two showers, and not applicable was documented on two days. 8/2024 and 9/2024 Progress Notes included no rationale for the lack of bathing for Resident 98, or if additional attempts to bathe Resident 98 were made when the resident refused. On 9/10/24 at 11:12 AM Resident 98 stated she/he wanted her/his hair washed, but staff stated they did not have enough time. Resident 98 was observed to have oily hair. On 9/10/24 at 11:26 AM Staff 12 (CNA) stated Resident 98 was not scheduled to have a shower on 9/10/24, but the resident reported she/he did not smell good so Staff 12 provided Resident 98 a bed bath. Staff 12 stated it was hard to complete all work due to staffing issues. On 9/11/24 at 6:38 AM Staff 9 (CNA) stated on a shower task NA meant bathing did not occur. If a resident refused a bath staff were to document the refusal on the bath audit and give it to the nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 5:28 PM a request was made to Staff 2 (DNS) to provide documentation staff attempted to offer Resident 98 additional bathing opportunities. No additional information was provided. On 9/13/24 at 8:52 AM Staff 32 (LPN) stated the CNA was to inform the nurse if a resident refused bathing. Staff were to offer two more times and then a different CNA would approach the resident. If the resident continued to refuse bathing a note was to be made in the progress notes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41455 Based on observation, interview and record review it was determined the facility failed to provide meaningful activities for dependent residents for 2 of 2 sampled residents (#s 14 and 54) reviewed for activities. This place residents at risk for lack of social interaction and isolation. Findings include: 1. Resident 14 admitted to the facility in 2022 with diagnoses including dementia and depression. A 7/8/24 Annual MDS indicated it was very important for Resident 14 to do her/his favorite activity and go outside when the weather was good. Resident 14's mobility device included her/his wheelchair. A 7/8/24 IDT (interdisciplinary team) Care Plan Conference/Welcome Meeting Form indicated Resident 14 had outbursts due to her/his frustrations and no activities staff were in attendance at the care conference. The meeting activity note indicated Resident 87 has been spending [her/his] time resting/napping in bed, watching tv, using personal cell phone, reading, doing puzzle books, enjoys going outside when the weather is nice in [her/his] power chair, eating meals in [her/his] room and in the dining room and visiting with family and friends. A 7/21/24 revised care plan indicated Resident 14 had no interest in attending group activities and went outside with her/his power chair when the weather was nice and on independent outings to the store. An 8/14/24 through 9/9/24 Task: Activity Participation indicated Resident 14 did not go outside during the time period and attended no group activities. On 9/8/24 at 12:20 PM Resident 14 was observed engaged in no activities and stated she/he often sat in the hall with nothing to do. Resident 14 was observed sitting in the hall in her/his manual wheelchair and stated she/he was bored. On 9/9/24 at 1:38 PM Resident 14 was observed looking out the window on a nice day for an extended period of time while she/he was seated in her/his manual wheelchair by an outside door. On 9/10/24 at 8:48 AM Staff 7 (Activity Director) stated over the last three to four months Resident 14 attended group activities which was beneficial for her/him to continue. Staff 7 stated Resident 14's electric wheelchair was discontinued a month ago due to safety. Staff 7 acknowledged the resident's activity care plan should be updated and she/he should have received assistance to go outside during the last 30 days. On 9/12/24 at 12:02 PM Staff 3 (Social Services) stated resident care conferences lacked representation by activities in order to meet the needs of residents including Resident 14. 2. Resident 54 admitted to the facility in 12/2023 with diagnoses including depression and anxiety. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/31/23 Admission MDS indicated it was somewhat important for Resident 54 to engage in her/his favorite activity and very important to go outside when the weather was nice. Resident 54 had no limitations in her/his upper extremities. A 7/1/24 IDT (interdisciplinary team) Care Plan Conference/Welcome Meeting Form indicated no activities staff were in attendance, a discussion occurred related to crochet supplies, and Resident 54 wanted to be asked about activities. A 7/9/24 Activities/Recreation Quarterly/Annual Review indicated Resident 54 enjoyed listening to music, afternoon naps, and knitting, crocheting and sewing. On 9/8/24 at 3:29 PM Resident 54 remained in bed and stated no staff inquired about her/his activity interests, which included crocheting, and she/he requested activity options. On 9/9/24 at 4:05 PM Staff 82 (Activities Assistant) stated quarterly activity assessments may be missed or incomplete and not capture important information of residents. Staff 82 stated she was unaware of Resident 54's interest in crocheting even though a sewing group was recently added to the schedule. On 9/10/24 at 8:48 AM Staff 7 (Activities Director) stated when Resident 54 admitted to the facility it was difficult to engage residents and follow through because of the lack of staffing in the the activities department. On 9/12/24 at 12:02 PM Staff 3 (Social Services) stated resident care conferences lacked representation by activities in order to meet the needs of residents including Resident 54.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 41455 Based on interview and record review it was determined the facility failed to provide a qualified professional to direct the activities program for 1 of 1 facility reviewed for activities. This placed residents at risk for unmet physical, mental and psychosocial needs. Findings include: The 7/2024 Council Minutes indicated Staff 7 (Activities Director) recorded the minutes as the person responsible. On 9/10/24 at 8:48 AM Staff 7 (Activity Director) stated she worked for the facility in the activities department since 5/2023 and was promoted to the Director position in 7/2024 which included responsibility to organize the Resident Council. Staff 6 acknowledged she did not have an activities certification. On 9/13/24 at 1:07 PM Staff 1 (Administrator) confirmed the certification for Staff 7 was not completed as required.

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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. 41455 Based on interview and record review it was determined the facility failed to follow through on services to maintain hearing for 1 of 2 sampled residents (#86) reviewed for communication and sensory. This placed residents at risk for lack of adequate hearing. Findings include: Resident 86 admitted to the facility in 3/2024 with diagnoses including depression and paraplegia (impairment in lower extremities). A 5/7/24 IDT (interdisciplinary team) Care Plan Conference/Welcome Meeting Form indicated Resident 87 required hearing services which required orders for her/his ears to be cleaned. A 5/31/24 Quarterly MDS indicated Resident 86 had no hearing aids and her/his hearing was adequate. On 9/11/24 at 9:21 AM Staff 80 (CNA) stated Resident 86 had issues with her/his hearing. On 9/12/24 at 11:53 AM Staff 3 (Social Services) stated she was aware Resident 87 had ongoing wax build-up in her/his ears which was to be addressed through physician orders and acknowledged there was no follow-through by nursing to ensure the orders were in placeand services provided after the 5/7/24 care conference. On 9/13/24 at 8:35 AM Staff 4 (Unit Manager-LPN) confirmed she neglected to obtain the physician orders for Resident 87's ear wax removal.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 26991 Based on observation interview and record review it was determined the facility failed to ensure a pressure ulcer was assessed and provided treatment timely for 1 of 3 sampled residents (#98) reviewed for pressure ulcers. Findings include: Resident 98 admitted to the facility in 7/2024 with a diagnosis of a stroke. A 7/12/24 NSG (Nursing) Admission/Readmission Evaluation form revealed Resident 98 was admitted to the facility with no pressure ulcers. A 7/19/24 admission CAA revealed Resident 98 was at risk to develop pressure ulcers due to incontinence and assistance was required for repositioning. Staff were to reposition the resident every two hours. A 9/2/24 Direct Care Staff Daily Report revealed a RN worked on the the evening and night shifts. A 9/2/24 Progress Note revealed a CNA reported Resident 98 had an open area to her/his coccyx which was the size of the tip of a cotton swab. A request for orders was sent to the physician. Resident 98's clinical record revealed no comprehensive assessment of the pressure ulcer until 9/5/24. A 9/5/24 Wound Evaluation revealed Resident 98 had a Stage 3 (full thickness skin loss but bone, tendon, or muscle is not exposed) pressure ulcer. The ulcer was 0.66 cm long, 0.44 cm wide and was covered with 70 percent slough (dead tissue). The pressure ulcer was identified to be facility acquired. The note indicated the ulcer was cleaned and a foam dressing was applied. A wound consultant agreed with current treatment with an addition of an air mattress. A 9/2024 TAR revealed treatment was not documented as completed until 9/6/24. On 9/10/24 at 3:16 PM Staff 65 (LPN) stated she was the first nurse to assess Resident 98's pressure ulcer. Staff 65 stated she did not stage the ulcer or initiate a skin sheet because it was not in her/his LPN scope of practice to stage a pressure ulcer. On 9/11/24 at 10:33 AM Staff 14 (LPN Resident Care Manger) stated when a pressure ulcer was first identified it should be staged and measured. Staff 14 acknowledged the first comprehensive assessment and documented wound care was completed on 9/5/24 and not 9/2/24. On 9/13/24 at 8:59 AM with Staff 1 (Administrator), Staff 2 (DNS) and Staff 56 (Regional Consultant), Staff 2 stated if a RN was in the building the RN should assess a newly identified pressure ulcer.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview and record review it was determined the facility failed to ensure supervision for dysphagia, execute fall interventions, and execute elopement interventions for 3 of 8 sampled resident (#s 55, 93, and 164) reviewed for accidents. The facility failed to ensure a safe environment for residents on 1 of 1 unit (skilled) identified during random interviews. Resident 164 fell from an elevated bed resulting in fractured legs. Findings include: 1. Resident 55 admitted to the facility in 7/2024 with diagnoses including dysphagia (difficulty in swallowing) and dementia. Review of Resident 55's care plan revised on 7/29/24 revealed the resident had an ADL self-care performance deficit due to decreased mobility and generalized weakness. Interventions included to have Resident 55 in the dining room for meals with supervision. On 9/8/24 at 12:56 PM Resident 55 was observed in the dining room with pureed food on a plate. No staff were observed in the dining room. On 9/10/24 at 12:52 PM Resident 55 was observed in her/his room sitting on her/his bed with the bedside table in front of her/him. Resident 55 had pureed food on her/his plate with approximately half the food eaten. No staff were in the room or observed in the hallway within line of sight. On 9/11/24 at 1:10 PM Resident 55 was observed in her/his room with no staff in the room. Food was on Resident 55's plate with approximately half the food eaten. On 9/13/24 at 8:33 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated they expected staff to supervise Resident 55 as care planned. 2. A review of an undated Resident Leaving the Facility policy revealed the following: -Residents who leave the facility are expected to sign out in the sign out book. -Information needed in sign out book: method of contact and expected time of return. -Medications will be provided to the resident or responsible party taking the resident out. -Upon return the resident or responsible party will sign the resident back into the facility. A review of an undated Elopement Preventions Guidelines facility policy revealed the following: -Residents will have a physician order indicating if the resident can leave the facility. The order will indicate if the resident can leave independently or must have supervision. -Each resident who leaves the facility will sign out and sign in upon return. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

-If employee observes a resident leaving the premises, and the employee does not know if the resident has a physician order allowing the resident to leave independently the employee will stay with the resident and notify another employee to verify the resident has an order.

-An employee who intervenes in an elopement attempt will stay with the resident until other staff arrive to assist.

-If a resident cannot be located, staff will verify whether the resident was on an authorized leave or pass.

-If elopement was suspected the action checklist will be implemented.

Resident 93 admitted to the facility in 6/2024 with diagnoses including dementia, stroke, alcohol abuse and seizures.

A review of Resident 93's care plan dated 6/10/24 revealed she/he had an ADL self-care performance deficit, a communication problem due to dementia, and an alteration in neurological status due to dementia which required cueing and reorientation as needed. Resident 93 had a seizure disorder and was at risk for injury. The care plan indicated Resident 93 had a history of alcohol abuse and limited physical mobility.

The admission MDS with ARD of 6/15/24 revealed Resident 93 had a BIMS score of 15 which indicated the resident was cognitively intact. The cognitive loss CAA indicated Resident 93 had episodes of confusion. Resident 93 was not able to care for herself/himself for quite some time.

A review of signed physician orders dated 8/12/24 revealed Resident 93 was approved for therapeutic leave of absence with a responsible person and took prescribed medications.

A review of the MAR dated 9/2024 instructed staff to administer hydration of choice four times a day, and on 9/6/24 at 4:00 PM indication Resident 93 was not in facility.

A review of 9/6/24 Nursing Notes revealed the following:

-10:42 PM Resident 93 was not in the facility all evening shift which was reported to Staff 38 (LPN), and to follow protocol when Resident 96 was considered a missing person.

-11:19 PM Resident 93 had not returned to the facility since the morning of 9/6/24. Staff 38 contacted Staff 21 (RN-Staff Coordinator) who was the on-call weekend nurse. Staff 21 instructed to call him again if Resident 93 was not back in the facility by 5:00 AM on 9/7/24.

A review of 9/7/24 Nurses Notes revealed the following:

-5:12 AM, it was nearly 20 hours since Resident 93 left the facility and she/he did not returned all night. Staff 38 placed another call to Staff 21. Resident 96's emergency contact was called but there was no answer, and then local law enforcement was called on the non-emergent line to report Resident 93 missing. Details of Resident 93's recent alcohol use and volatile behaviors was provided, and law enforcement suggested to call local hospitals.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-5:33 AM Local hospitals were contacted, but with no results. -1:02 PM Resident 93 was on alert for behaviors. At approximately 8:00 AM on 9/7/24 local law enforcement arrived to let the facility know Resident 93 was located. Resident 93 was found with a non-functioning power wheelchair.The on-call nurse was alerted and assisted helping the resident back to the building. On 9/8/24 at 4:24 PM Resident 93 stated she/he was lost five miles away from the facility and the police found her/him. Resident 93 stated no one answered when she/he attempted to call. Resident 93 stated she/he was missing overnight, and no staff spoke to her/him about the incident. Resident 93 stated she/he was cold and uncomfortable and she/he missed all her/his treatments. Resident 93 stated she/he did not tell anyone she/he left the facility. Resident 93 felt like no one cared about her/him being missing. A Nursing Facility Reported Incident dated 9/9/24 indicated on 9/6/24 Resident 93 left the faciity on the evening shift around 11:00 PM and she/he did not sign out. The facility LPN called the emergency contact and local law enforcement. Law enforcement was able to find Resident 93 approximately six miles away from the facility in her/his powerchair with a failed battery in the morning on 9/7/24. Observations from 9/10/24 through 9/12/24 revealed Resident 93 in a manual wheelchair in the facility or outside on facility property. On 9/10/24 at 11:03 AM Staff 44 (LPN) stated Resident 93 was missing for 24 hours. At 2:00 PM on 9/6/24 she/he was not in the facility. At 10:00 PM he/she was still not back and typically Resident 93 would be back in the facility. Staff 44 stated Resident 93 was a danger to herself/himself and to other people. Resident 93 had become violent, aggressive and did not listen to rules. Staff 44 stated she did not check if Resident 93 had signed out in the book to notify staff of her/him leaving the facility. Staff 44 stated she was taught after eight to 10 hours of a resident missing the resident would be reported as a missing person. Staff 44 stated there was chaos on her shift and she left the information with the night nurse. On 9/10/24 at 11:21 AM Staff 32 (LPN) stated it was not uncommon for Resident 93 to leave the facility. Resident 93 had dementia and forgot to sign out. On 9/6/24 she/he left the facility around 7:00 AM. Usually if she/he left that early she/he came back around 12:00 PM or 1:00 PM. Staff 32 stated she was not concerned when Resident 93 had not returned to the facility at 2:00 PM and she notified the oncoming nurse. Staff 32 stated when Resident 93 returned to the facility she/he reported she/he had become lost. Staff 32 did not believe Resident 93 was safe to leave the facility. On 9/10/24 at 12:07 PM Staff 38 stated Resident 93 was absolutely not cognitively and physically able to be out in the community on her/his own. When Resident 93 first arrived at the facility Staff 38 took 15 to 20 minutes explaining a document so Resident 93 could understand what she/he was signing. Staff 38 stated when she was completed with her shift on 9/7/24 at 6:00 AM Resident 93 was not back to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/11/24 at 9:06 AM and 9/13/24 at 8:41 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated they were working on a discharge plan for Resident 93 and continued to work on the investigation for Resident 93's elopement. Staff 1 confirmed Resident 93 did not sign out of the facility when she/he left on 9/6/24. 26991 3. Resident 164 admitted to the facility 7/2022 with a diagnosis of high blood pressure. According to the National Library of Medicine, a comminuted fracture was a break or splinter of the bone into more than two fragments. Considerable force and energy was required to fragment bone, fractures of this degree occur after high-impact trauma such as vehicle accidents and falling from a high place. Fractures of this type which may happen with low pressure include cancer and weak bones. An 8/6/24 annual MDS revealed Resident 164 was previously assessed and care planned for cognitive loss. Resident 164 was assessed for further loss of vision, physical safety , ie (sic) Falls. A care plan was developed to minimize risks, promote socialization, and prevent falls. Resident 164 had limitations which included the inability to walk due to a femur fracture in 2022, decreased ROM to the shoulders and elbows, muscle weakness, reconditioning and balance abnormalities. Resident 164 had Cognitive: fear of falling and dementia with moderate cognitive impairment deficits. A care plan initiated 7/28/22 revealed Resident 164 was at risk for falls due to deconditioning, balance problems, incontinence, and her/his unawareness of safety needs. Interventions included ensuring Resident 164's commonly used items were within reach, bilateral bed canes, and non-skid footwear. 8/25/24 Progress Notes revealed Staff 18 (LPN) heard a resident scream from room [ROOM NUMBER]. Staff 18 entered the room and found resident 164 falling out of bed, her/his body was out of the bed but both arms were hanging onto the bed canes, and she/he was screaming for help. Resident 164's legs were bent in a kneeling position and the left leg was twisted under the bed side table. A large amount of blood was on the floor from a laceration to Resident 164's left leg (shin). Resident 164 reported severe pain and her/his bed was noted to be in the high position. The note indicated Resident 164's CNA visualized her/him 30 minutes prior to the fall. An 8/25/24 Unwitnessed Fall investigation revealed Resident 164 fell to the floor quite hard landing on both legs. Resident 164 reported she/he attempted to reposition. The investigation indicated the air mattress may have deflated when Resident 164 was close to the edge of the mattress. The air mattress was removed to prevent future slips out of bed. An 8/25/24 hospital New Consult Note Hospital Medicine summary revealed Resident 164 fell out of bed and had fractures of the left and right leg. The right leg fracture was comminuted. The imaging studies were suggestive of pathological fractures (fracture caused by weak bones) and metastatic cancer (cancer which spread). An 8/31/24 hospital Discharge Summary did not include a diagnosis of cancer. An 8/31/24 hospice Admission Visit Summary revealed Resident 164 had a fall from her/his raised hospital bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An 8/31/24 NSG (nursing) Admission/Readmission Evaluation form revealed Resident 164's reason for admission was a fall from a great height, broke both legs, and was to be admitted to hospice immediately. On 9/10/24 at 4:09 PM Staff 69 (CMA) stated Resident 164 kept her/his bed at least waist high so she/he could see the television better. It was never in the normal low position. Resident 164 was able to adjust her/his bed independently. Staff 68 (CNA) stated on 8/25/24 she was not assigned to Resident 164 when she/he fell . Staff 68 heard yelling and went to Resident 164's room. Staff 18 (LPN) was already in her/his room. Resident 164 reported she/he tried to reposition, her/his legs became stuck in a blanket and she/he fell . Resident 164's bed was high even for her/his normal high. Staff 68 stated when she worked with Resident 164 she tried to encourage her/him to lower the bed because it was always so high up, and propped pillows between the resident and the rail to prevent rolling out of bed. Resident 164 was able to use the bed controls to elevate the bed. The bed should never have been that high. Staff 68 stated Resident 164 did not have mats on the ground even when the bed was in a high position. On 9/10/24 at 8:25 PM Staff 74 (CNA) stated when she arrived on shift at 6:00 AM she observed Resident 164 in bed sleeping. Resident 164 was laying on her/his right side. Staff 18 stated she did not remember the height of Resident 164's bed but she/he liked to elevate the bed. There were no mats on the ground and the call light was activated. On 9/10/24 at 5:02 PM Staff 70 (CNA) stated she worked the day Resident 164 fell . She was in another room at the time and heard a noise and went to Resident 164's room. The nurse and CMA were already in the room. Resident 164 was hanging onto the bed rails and would not let go. eventually Resident 164 was lowered to the floor. Staff 70 stated when she entered the 164's room the bed was at least waist high. Resident 164 liked to have the bed high so she/he could watch television. The resident's bed was at least waist high the dayshe/he fell . Resident 164 was able to adjust the bed, did not have mats on the ground, and had an air mattress. On 9/10/24 at 5:12 PM Staff 71 (CMA) stated at approximately 6:45 AM she administered Resident 164 her/his medicine. Later she heard the nurse call for help. When she entered Resident 164's room the resident was holding onto her/his bed cane and was upright but not standing. Resident 164's legs were contorted and wrapped in a blanket. Resident 164 reported she/he tried to adjust her/his position, her/his legs fell over the side of the bed, and the momentum carried her/him off the bed. Resident 164's bed was pretty high and she/he liked it high so she/he could see the television better. Staff 71 stated she did not recall seeing pillows between the resident and the bed rails. On 9/11/24 at 10:53 AM Staff 5 (LPN Resident Care Manager) stated Resident 164 was at risk for falls and liked to keep her/his bed elevated. The resident had an air mattress. Staff 5 stated the standard of care was to keep the bed in a normal or low position and not high. Staff 5 stated she never reviewed the risks with Resident 164 of keeping her/his bed elevated. After the resident returned from the hospital the bed was care planned to be in a low position and mats on the floor. On 9/13/24 at 1:22 PM Staff 33 (LPN) stated Resident 164 liked to keep her/his bed high and not at a normal height of a bed. After Resident 164 fell staff educated other residents to keep their beds in a low position. Staff 18 stated the resident's bed height was the resident's choice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385156	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Rehabilitation Health Center	1735 Adkins Street Eugene, OR 97401

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/13/24 at 1:42 PM Witness 9 (Friend) stated Resident 164's bed was always high. Staff raised the bed to provide care and never lowered it. 50930 4. On 9/11/24 at 12:39 PM Staff 79 (LPN) stated there was an incident in 5/2024 involving Staff 77 (Former NA) who smoked methamphetamine (controlled stimulant medication) in the staff bathroom while working on shift, and continued to finish the shift after it was reported to management. She stated staff reported Staff 77 hallucinated on the unit, and there was a strong chemical smell in the staff bathroom. Review of Staff 77's 5/28/24 time punch record indicated she clocked in at 1:57 PM, clocked out at 5:53 PM, and did not clock in again until 6/1/24. On 9/12/24 at 6:14 PM Staff 78 (CNA) stated she was working evening shift (2:00 PM until 10:00 PM) on 5/28/24 with Staff 77 as her skilled unit hall partner. She stated Staff 77 was missing for a long stretch of time and was later seen walking down the hallway making swiping motions to her head, mumbling to herself, and shaking her head vigorously. Staff 78 stated when asked if Staff 77 was ok, she replied she was trying to get it off, get it off, there are screws in my head. Staff 78 stated she reported to her charge nurse and wrote a statement about the incident and gave it to management. On 9/13/24 at 12:53 PM Staff 1 (Administrator) stated she received a phone call on 5/28/24 about the reported incident. Staff 1 stated she told Staff 77 to go home and suspended her until an investigation was completed. Staff 1 stated it took two days to create an account with a drug testing center, and Staff 77's drug test results were negative on 5/30/24 so she did not do further investigation. Staff 1 acknowledged the complete investigation for this incident was the drug test dated 5/30/24.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49677

Based on observation, interview and record review it was determined the facility failed to provide adequate catheter and incontinent care for 3 of 15 sampled residents (#s 24, 86 and 164) reviewed for ADLs, accidents and catheter care. This placed residents at risk for unmet incontinent care needs. Findings include:

1. Resident 24 admitted to the facility in 6/2024 with a diagnosis of heart disease.

Resident 24's 6/13/24 annual MDS indicated she/he was cognitively intact.

On 9/8/24 at 11:35 AM Resident 24 reported she/he regularly waited 30 minutes for the call light to be answered by staff when she/he needed bowel and bladder care. She/he stated the delayed call light responses by staff caused significant frustration and emotional stress from waiting this length of time with a soiled brief.

On 9/9/24 at 8:44 AM call light response observations revealed the following:

-Resident 24's call light was activated at 8:44 AM. Staff went to her/his door at 9:06 AM and left the call light activated.

-At 9:09 AM staff went to Resident 24's room and turned the call light off.

-At 9:19 AM, Resident 24 was interviewed and stated she/he needed a brief change, and it was not changed. Resident 24 stated she/he often fell asleep while she/he waited for assistance with bowel and bladder care and this morning, when she/he awoke, her/his meal tray was on her/his table, the food was cold, and staff did not try and wake her/him to eat or to complete bowel and bladder care which was the reason she/he activated her/his call light.

A 9/10/24 at 11:20 AM interview with Staff 6 (CNA) confirmed Resident 24 did not refuse bowel and bladder care and only refused showers if her/his bowels were loose. Staff 6 confirmed she was also frustrated with the low staffing challenges because she could not offer the care the resident needed and deserved.

A 9/10/24 at 2:03 PM interview with Witness 7 (Complainant) confirmed Resident 24's bowel and bladder care often was delayed, and she/he was concerned about the integrity of Resident 24's skin because of the delayed ADL care. Currently Resident 24 did not have evidence of skin breakdown, but her/his anxiety was heightened due to waiting for help with a soiled brief. Witness 7 reported Resident 24 experienced this problem several times a week.

41455

2. Resident 86 admitted to the facility in 3/2024 with diagnoses including depression and paraplegia (impairment in lower extremities).

(continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 2/29/24 Admission Urinary Incontinence and Indwelling Catheter CAA indicated Resident 86 had an indwelling catheter on admission, staff were to check on the resident routinely in anticipation of her/his needs, and the care plan goal was for no trauma or infection related to the use of her/his indwelling catheter. A 7/26/24 physician orders revealed the facility was not to change Resident 86's new suprapubic catheter (tubing surgically inserted into the abdomen for urine drainage.) A 9/6/24 urology provider note indicated Resident 86 had her/his suprapubic catheter changed during an out of facility appointment and the balloon (used to hold the catheter in place) was reinflated. No nursing progress notes or assessment related to the replacement of Resident 86's suprapubic catheter on 9/6/24 were found. A 9/8/24 nursing progress note indicated Resident 86's catheter came out of his abdomen during routine care and she/he was sent to the emergency room to have her/his catheter reinserted. No nursing assessment or hospital notes were found related to the 9/8/24 emergency room visit and catheter reinsertion for Resident 86. On 9/12/24 at 5:25 PM Staff 38 (LPN) stated Resident 86's catheter balloon was already deflated when her/his catheter slipped out on 9/8/24 during routine care. Staff 38 stated she was unaware Resident 86's catheter was replaced on 9/6/24 and she/he was not monitored for her/his new catheter as she expected which could contribute to the issue that occurred on 9/8/24. Staff 38 stated after Resident 86 returned from the emergency roiagnom on [DATE] there was no paperwork from the hospital and she assumed there were no concerns with Resident 86's catheter procedure by the hospital. Staff 38 acknowledged Resident 86 was not monitored upon her/his return on 9/8/24. On 9/13/24 at 8:35 AM Staff 4 (Unit Manager-LPN) stated emergency room records should be obtained after a resident returns and confirmed Resident 86 should be specifically monitored related to her/his catheter after changes occurred. 26991 3. Resident 164 readmitted to the facility on [DATE] post-surgical repair of fractured legs. Resident 164's clinical record indicated she/he had an allergy to aloe. A care plan revised on 8/27/24 revealed Resident 164 had fragile skin and non-aloe wipes were to be used for incontinent care. On 9/10/24 at 2:15 PM Staff 35 (CNA) stated Resident 164's bottom was very red because staff did not use the correct wipes on her/his skin. Staff 35 stated Resident 164 was allergic to the aloe wipes and had to use a specific type of wipes. Staff 35 stated she worked with Resident 164 on 9/7/24 and the other staff did not use the non-aloe wipes. There were lots of aloe wipes in the room and she removed them. The special wipes were in the resident's closet but there was no sign on the door to remind staff not to use the aloe wipes. Staff 35 stated the hospice nurse was aware of the incident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 3:31 PM Staff 72 (LPN) stated she did not work with Resident 164 when she/he resided on the long term care side. Staff 72 stated when Resident 164 was readmitted to the skilled unit she did not know she/he required special wipes. The wipes were at the bottom of her/his closet. On 9/10/24 at 3:34 PM Witness 10 (Hospice Staff) stated the LPN who assessed Resident 164 on 9/7/24 made a note indicating Resident 164 required special wipes and when staff used the aloe wipes the resident was very painful. On 9/10/24 at 4:11 PM Staff 5 (LPN Resident Care Manager) stated on 8/31/24 she moved the resident's special wipes and put them in the closet. Staff 5 stated the sign may not have been moved to the resident's new room when she/he first readmitted to the facility . On 9/11/24 at 7:30 AM a sign on Resident 164's current room closet door read Do no use regular wipes on (Resident 164) please use pampers sensitive wipes. Ask unit manager if no wipes are available in room.

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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. 34703 Based on interview and record review it was determined the facility failed to provide respiratory care and services in accordance with physician orders and standards of practice for 3 of 5 sampled residents (#s 2, 55 and 87) reviewed for respiratory services. This placed residents at risk for unmet respiratory needs. Findings include: 1. Resident 2 admitted to the facility in 5/2016 with diagnoses including chronic pain. An observation on 9/10/24 at 11:58 AM revealed a suction machine on the resident's nightstand covered in dust. There was a yankauer (oral suctioning tool) lying on the nightstand covered with dust, and the canister (collects body fluids such as mucus) was half full of a yellowish liquid with white debris. A physician order dated 2/18/20 indicated to check the suction machine canister weekly on Saturday night, if used that week replace the canister every night shift every Saturday. On 9/10/24 at 11:44 AM Resident 2 stated she/he did not use the suction machine for three or four years. On 9/10/24 at 11:58 AM Staff 4 (Unit Manger-LPN) acknowledged the dirty suction machine and stated the resident had an order for a suction machine on 6/29/20 which was four years ago. Staff 4 acknowledged the resident did not use the suction machine for years and it should have been removed from the resident's room. 35855 2. Resident 55 admitted to the facility in 7/2024 with diagnoses including pulmonary embolism (PE, blockage of lung artery). A review of Resident 55's care plan revised on 7/29/24 revealed Resident 55 had altered respiratory status and difficulty breathing due to PE and was at risk for complications. Interventions included oxygen therapy as ordered and PRN. Oxygen settings were one to two liters PRN and keep oxygen saturation levels greater than 90 percent. A review of signed physician orders dated 8/7/24 instructed staff to administer oxygen one to four liters per minute and document oxygen saturations and liters per minute every shift with a start date of 7/26/24. A review of the 9/2024 TAR instructed staff to administer oxygen one to four liters per minute and to keep oxygen saturations above 90 percent. Staff were to document oxygen saturations and liters per minute every shift with a start date of 7/26/24. From 9/1/24 through evening shift 9/9/24 liters per minute were documented NA with no liter per minute documented. The TAR also instructed staff to administer one to four liters per minute and document oxygen saturations and liters per minute every shift for heart disease with a start date of 8/26/24. From 9/1/24 through evening shift of 9/9/24 the liters per minute was documented as NA with no liters per minute documented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations from 9/8/24 at 12:56 PM through 9/12/24 at 10:13 AM revealed no instances Resident 55 was administered oxygen. On 9/13/24 at 8:35 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated they would check on orders to determine if orders were PRN. At 11:39 Staff 2 provided a Hospice Medication List. The list instructed staff to provide one to four liters per minute of oxygen PRN, and titrate as needed for dyspnea with a start date of 8/24/24. The list was not a signed physician's order. 41455 3. Resident 87 admitted to the facility in 3/2024 with diagnoses including respiratory failure and congestive heart failure. A 6/28/24 revised care plan indicated Resident 87 was to receive medications and inhalers as ordered for altered respiratory status and to monitor for effectiveness and side effects. The 9/2024 MAR indicated Resident 87 was to orally inhale her/his Ipratropium-Albuterol (medication to address shortness of breath) solution three times a day as of 9/5/24 for five days. On 9/8/24 at 10:38 AM Resident 87's nebulizer (a device to convert medication into a fine mist to inhale) was observed placed directly on the top of her/his bedside table. On 9/10/24 at 11:19 AM Staff 17 (CMA) stated she worked throughout the facility and was not aware nebulizers for residents were to be stored with a protective barrier until 9/10/24. Staff 17 stated there were no instructions how Resident 87's nebulizer was to be cleaned or serviced although she believed it was necessary. On 9/10/24 at 4:39 PM Staff 4 (Unit Manager-LPN) acknowledged Resident 87's nebulizer should be cleaned after each use and instructions for storage and monthly maintenance of the device should be indicated as a task for nursing.

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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. 35855 Based on interview and record review the facility failed to provide pain medications as ordered for 1 of 4 sampled residents (#262) reviewed for pain management. This placed residents at risk for uncontrolled pain. Findings include: Resident 262 admitted to the facility in 8/2024 with diagnoses including a leg fracture and pain due to internal orthopedic prosthetic devices. The Admission MDS with an ARD of 8/26/24 revealed Resident 262's BIMS score was 15 which indicated she/he was cognitively intact. Resident 262 had frequent pain presence which effected her/his sleep quality and day-to-day activities occasionally, with a level of eight on a scale of zero to 10. A 9/2024 MAR instructed staff to administer oxycodone (to treat moderate to severe pain) 5 mg tablet every four hours PRN for moderate pain. If the pain level was below two, administer zero mg, pain level from two to five administer five mg, pain level five to 10 administer 10 mg. On 9/7/24 Resident 262 was administered 10 mg for a pain level of eight at 1:07 AM, at 5:14 AM she/he was administered 10 mg for a level of eight pain, and at 12:11 PM for a pain level of 10 pain. A 9/7/24 at 12:11 PM Administration Note by Staff 46 (CMA) revealed oxycodone every four hours PRN for moderate pain. If the pain level was below two, administer zero mg, pain level from two to five administer five mg, pain level five to 10 administer 10 mg. Resident 262 complained of pain. On 9/8/24 at 10:11 AM Resident 262 stated on 9/7/24 she/he activated her/his call light at 9:15 AM. Resident 262 stated a staff member finally came in and she/he notified them of the need for PRN pain medication. Resident 262 stated no one came back and she/he did not see any staff until 12:00 PM when they delivered her/his lunch. On 9/12/24 at 7:57 AM Witness 3 (Staff) stated Resident 262 was on PRN pain medication and she/he expected the medication every four hours and most staff who worked with her/him were aware. On 9/12/24 at 9:16 AM and 9/13/24 at 8:06 AM Staff 46 stated she did not remember 9/7/24 or if she received a request for PRN pain medication related to Resident 262. Staff 46 stated it could be crazy around here. Staff 46 stated the CNA may not have informed her for Resident 262's need for PRN pain medications. Staff 46 stated she was assigned both units and may have not been able to administer the medication. Staff 46 stated the facility was low on staff and staff were not robots. Staff 46 confirmed Resident 262 was consistent in requesting her/his PRN pain medications. On 9/13/24 at 8:44 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated the expectation was to provide pain medications as physician ordered and to follow through with PRN pain medication requests.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50930 Based on observation, interview and record review it was determined the facility failed to ensure residents received proper dialysis care and services after dialysis for 1 of 3 sampled residents (#58) reviewed for personal property. This placed residents at risk for dialysis complications. Findings include: Resident 58 admitted to the facility in 2/2023 with diagnoses including end stage renal disease (kidney disease) and dependence on renal dialysis (a process of removing waste products and excess fluid from the body). A review of a 6/19/24 Significant Change MDS indicated Resident 58 was cognitively intact. On 9/8/24 at 10:48 AM Resident 58 stated she/he had a fistula (surgically created passage in the arm connecting an artery to a vein) in her/his left arm and she/he had no issues with her/his dialysis treatment on every Tuesday, Thursday, and Saturday. She/he stated staff did not check her/his fistula or vitals upon return from dialysis. Resident 58's 11/8/23 care plan indicated the resident was receiving hemodialysis three times a week. The interventions included monitoring for infection at the fistula site as well as monitoring for bleeding and symptoms of kidney malfunction. The interventions also included checking the fistula thrill and bruit (vibration and rushing sound present in a fistula). The 6/2024 through 9/2024 MARs and TARs included no orders for monitoring for bleeding, infection, or kidney malfunction. The TARs indicated the order to check the thrill and bruit was discontinued on 6/11/24. Review of Resident 58's 6/2024 through 9/2024 progress notes revealed no documented refusals or missed dialysis appointments. Resident 58's records for 6/1/24 through 9/12/24 indicated the resident had 45 opportunities to go to the dialysis center. The resident's record revealed staff completed the pre-dialysis paperwork 35 times and the post-dialysis paperwork four times. On 9/13/24 at 9:49 AM Staff 18 (LPN) stated nursing staff filled out the pre-dialysis form in the computer and sent a printed copy with the resident to the dialysis center. She stated the post-dialysis form was completed on the computer after the resident returned to the facility. On 9/13/24 at 9:57 AM Staff 4 (Unit Manager-LPN) stated she monitored Resident 58's dialysis status through the forms nursing staff filled out on dialysis days. She stated the pre-dialysis forms got lost at times and the dialysis center had very poor communication with the facility. She stated the expectation was for nursing staff to fill out the pre and post-dialysis forms and to check for thrill and bruit every day Resident 58 went to the dialysis center. She acknowledged the missing pre and post-dialysis documentation and the lack of an order for checking the thrill and bruit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview and record review it was determined the facility failed to provide sufficient staffing to meet the needs of residents for 1 of 14 sampled residents (#24) and 2 of 2 units (Skilled unit and long-term unit) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. A review of an 4/15/24 Intake Information revealed a public complaint received by the State Agency indicated the facility was short-staffed for CNAs. Due to inadequate staffing CNAs could not provide showers for all the residents scheduled for the evening shift. A review of Council Minutes dated 4/19/24 revealed call light wait times were up to 30 to 45 minutes, especially on the night shift. A review of Council Minutes dated 7/16/24 revealed call light wait times were awful. A review of a 7/31/24 Intake Information revealed a public complaint received by the State Agency indicated the facility was short-staffed for both CNAs and nurses. There was difficulty for night nurses to provide care to residents and to complete nursing tasks. On day shift, CNA staff could not provide showers to all assigned residents. A review of a 9/3/24 Intake Information revealed a public complaint received by the State Agency indicated the facility was short-staffed, which caused outcomes such as untimely call light responses, late meal assistance for residents, and not all showers were completed. The following resident interviews occurred on 9/8/24: -10:06 AM Resident 262 stated she/he had to wait and wait and had an incontinent episode because of waiting. On 9/7/24 she/he activated her/his call light and she/he did not receive assistance for over two hours. -10:23 AM Resident 78 stated the facility was not good at answering call lights. Resident 78 felt staff ignored her/him on purpose. -10:48 AM Resident 58 stated the facility was slow in answering call lights. -11:32 AM Resident 29 stated call light wait times were questionable and when COVID-19 was active in the facility it took staff longer to answer call lights. -11:44 AM Resident 2 stated the facility was always short-staffed on all shifts and staff turnover was high. -11:59 AM Resident 44 stated call light wait times were 30 minutes and last week she/he had loose bowel movements several times. Resident 44 attempted to clean herself/himself and eventually a staff member came in and assisted. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:28 PM Resident 40 stated her/his breakfast tray was still on the bedside table. At times call light wait times were over 20 minutes. -1:01 PM Resident 97 stated there was not enough staff for the number of residents. Call light wait times were 30 minutes at times. Resident 97 stated there were no staff in the hallway around 9:00 PM. -3:32 PM Resident 54 stated in 8/2024 she/he waited over 30 minute to receive incontinent care. Staff indicated to Resident 54 she/he was not the only one who needed assistance. -4:16 PM Resident 73 stated she/he waited a long time for staff to answer call lights. At times Resident 73 had to call the facility via telephone to have a staff member come into her/his room. On 9/8/24 at 4:37 PM Staff 51 (Scheduler) stated staff did not have time to access snacks for diabetic residents. Staff 51 stated she did call light wait audits which were showing call light wait times of 50 minutes. On 6/18/24 there was a call light wait time of 55 minutes. On 9/9/24 observations revealed: -3:32 AM the call light monitor at the nurses' station indicated room [ROOM NUMBER]'s call light was on for 17 minutes. At 3:36 AM Staff 13 (Agency CNA) went into room [ROOM NUMBER] with a 21-minute call light wait time. -6:34 AM the call light monitor in the main dining room revealed room [ROOM NUMBER]-1 call light wait time at 31 minutes. At 6:42 room [ROOM NUMBER]-1 call light wait time was at 39 minutes. At 6:47 AM Staff 66 (CNA) and Staff 21 (LPN Staffing Coordinator) stated the facility typically had staffing issues when they had to rearrange the CNAs because staff called off for work. This delayed resident call light wait times. Staff 66 stated she did not normally work the section of room [ROOM NUMBER] and she did not know what was occurring, she just went in and answered the call light. On 9/9/24 at 7:40 AM Witness 2 (Staff) confirmed the staffing concerns from the 4/15/24 public complaint. Witness 2 stated there was a problem with staff calling off work with no repercussions. On 9/9/24 at 8:35 AM Staff 67 (CNA) stated the facility was short-staffed every day, and on evening shift she was assigned 11 to 14 residents. On 9/9/24 at 8:39 AM Resident 63 stated she/he waited 45 minutes for her/his call light to be answered. Resident 63 reported 30 minutes was the usual wait time. On 9/10/24 at 11:21 AM Staff 32 (LPN) stated resident acuity was high and in the last six months the facility had 100 resident falls. Staff 32 did not believe there was enough staff to provide the residents the needed care. CNAs complained they were behind and could not get their work done. Staff 32 stated there were a lot of staff who called off of work and there was no accountability for the staff missing work. On 9/10/24 at 2:51 PM during a resident council meeting residents had the following concerns: -Staff wearing earphones on night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Day shift CNAs looking at their phones and ignoring resident call lights. -Not enough staff to meet the needs of the residents. -Long call light response times; 30 to 60 minute wait. On 9/10/24 at 8:08 AM a call light monitor at the nurses station revealed room [ROOM NUMBER]-3 call light wait time was 20 minutes. On 9/10/24 at 2:31 PM Witness 4 (Staff) confirmed the 9/3/24 public complaint. Witness 4 stated there were concerns with staffing with too many call lights to answer, and showers not completed for residents. Witness 4 stated she could not take her breaks as she could not leave the residents with no one to cover while she was on break. Witness 4 stated she saw staff completing two-person transfers by themselves because there was not enough staff to complete the task with the required two people. Witness 4 stated there were no nurses on the floor who could help CNAs when there was a staff shortage. On 9/11/24 at 9:52 AM the call light monitor in the main dining room revealed room [ROOM NUMBER] call light wait time was 20 minutes. The resident in room [ROOM NUMBER] stated she/he was waiting for someone to close her/his window as she/he could not reach it. At 9:55 AM the call light wait time was 23 minutes. On 9/12/24 at 7:18 AM Staff 37 (CNA) stated at times she was unable to complete resident showers. Staff 37 stated the residents assigned were not balanced and some residents had a higher acuity than others, so if she was assigned many residents with high acuity then it was difficult to complete all the assignments. Staff 37 stated Sundays were the worst as many staff called off work and it was getting worse. On 9/12/24 at 7:35 Staff 39 (CNA) stated call light wait times was the biggest issue. When she came onto her shift at night the call light wait times were 25 to 30 minutes. On 9/11/24 there was one call light wait time which had maxed out on the system at 99 minutes. Staff 39 stated staffing shortages occurred off and on. In 4/2024 there was a large turn over in staff which caused a shortage and in 7/2024 there was a shortage in staff. On 9/12/24 at 7:57 AM Witness 3 (Staff) confirmed the 7/31/24 public complaint concerns. Witness 3 stated 9/11/24 was a good example of short staffing as they only had three CNAs on night shift and did not try to find additional staff. There was COVID-19 active in the facility, staff were rushed and there were long call light wait times. Call light wait times were up to 20 minutes when staff had to put on PPE. Pain medications were not provided to residents timely. On 9/12/24 at 10:27 AM the call light monitor in the main dining room indicated the call light wait time for room [ROOM NUMBER] was 24 minutes. On 9/13/24 the call light monitor at the nurses station revealed room [ROOM NUMBER]-1 call light wait time was 20 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 8:26 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated the facility had a norovirus (causes severe vomiting and diarrhea) outbreak in 4/2024, the facility had COVID-19 in the facility in 7/2024, 8/2024 and 9/2024, and confirmed there were staffing issues. 49677 2. Resident 24 admitted to the facility in 6/2019 with a diagnosis of heart disease. Resident 24's 6/13/24 annual MDS indicated she/he was cognitively intact. On 9/8/24 at 11:35 AM Resident 24 reported she/he regularly waited 30 minutes for her/his call light to be answered by staff when she/he needed bowel and bladder care. She/he stated the delayed call light responses by staff caused significant frustration and emotional stress from waiting that length of time with a soiled brief. A 9/9/24 at 8:44 AM call light observation revealed the following: -Resident 24's call light was activated at 8:44 AM. Staff went to her/his door at 9:06 AM and left the call light activated. -At 9:09 AM staff went to Resident 24's room and turned the call light off. -At 9:19 AM, Resident 24 was interviewed and stated she/he needed a brief change, and it was not changed. Resident 24 stated she/he often fell asleep while she/he waited for assistance with bowel and bladder care and this morning, when she/he awoke, her/his meal tray was on her/his table, the food was cold, and staff did not try and wake her/him to eat or to complete bowel and bladder care which was the reason she/he activated her/his call light. A 9/10/24 at 11:03 AM interview with Staff 3 (Social Service Director) revealed Resident 24, as well as other residents, complained on a weekly basis about call lights not being answered in a timely manner and care being delayed or not completed. Staff 3 confirmed delayed care was a common complaint with residents at the facility and as managers they audited the call lights. Staff 3 also stated today there was a 49-minute wait for a call light response on Resident 24's hall. A 9/10/24 at 11:20 AM interview with Staff 6 (CNA) confirmed she was frustrated with the low staffing challenges because she could not offer the care the resident needed and deserved. A 9/10/24 at 2:03 PM interview with Witness 7 (Complainant) confirmed Resident 24's bowel and bladder care often was delayed, and she/he was concerned about the integrity of Resident 24's skin because of the delayed ADL care. Currently Resident 24 did not have evidence of skin breakdown, but her/his anxiety was heightened due to waiting for help with a soiled brief. Witness 7 reported Resident 24 experienced this problem several times a week.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35855 Based on interview and record review it was determined the facility failed to staff a registered nurse for 8 consecutive hours per day 7 days per week for 7 out of 93 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: A review of the Direct Care Staff Daily Reports dated 4/1/24 through 4/30/24, 7/1/24 through 7/31/24, 8/8/24 through 8/31/24 and 9/1/24 through 9/8/24 revealed there were seven days without eight consecutive hours of registered nurse coverage on any shift in a 24 hour period. On 9/13/24 at 8:37 AM and 11:25 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated they would look at the RN coverage. No additional information was provided related to the required RN coverage.

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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 interview and record review it was determined the facility failed to post accurate and complete staffing information for 6 of 6 days reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include: On the following days and times the Direct Care Staff Daily Report revealed the following : -9/8/24 at 3:00 PM, all three shifts no census was documented for day and evening shift. -9/9/24 at 3:36 AM, 9/8/24 posting for the night shift did not have census documented. -9/10/24 at 9:58 AM, no census documented on day shift. -9/11/24 at 6:57 AM no census documented for day shift; 10:12 AM, no census documented on day shift. -9/12/24 at 10:01 AM, no census documented for day shift. 9/13/24 at 8:20 AM, no census documented for day shift. On 9/13/24 at 8:37 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) stated staff should document census each shift on the report.

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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. 34703 Based on interview and record review it was determined the facility failed to obtain specialized physician appointments for 1 of 1 sampled resident (#62) reviewed for ADLs. This placed resident at risk for lack of specialized care. Findings include: A public complaint was received on 5/2/24 which alleged the facility failed to arrange the resident's nerve block procedure per physician orders. Resident 62 admitted to the facility in 6/2022 with diagnoses including chronic pain. A 1/13/23 physician order indicated the resident was to have a referral to neurology and cardiology for evaluation and a bilateral ultrasound guided glenohumeral injection (needle into the shoulder joint to deliver an injection). On 9/13/24 at 8:45 AM Staff 3 (Social Services) acknowledged the direction to schedule appointments was not addressed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26991 Based on observation, interview and record review it was determined the facility failed to obtain a resident's medication for 1 of 6 sampled residents (#164) reviewed for medications. This placed residents at risk for increased pain. Findings include: Resident 164 readmitted to the facility in 8/2024 with a diagnosis of post-surgical repair of leg fractures. A 9/2024 MAR revealed staff were to apply a fentanyl patch (narcotic pain medication) with a start date of 9/9/24. The MAR indicated the patch was not applied. On 9/11/24 at 8:39 AM Witness 11 (Pharmacy Technician) stated the pharmacy did not receive a valid prescription from the provider. On 9/9/24 the pharmacy requested a new prescription but did not yet receive it. On 9/11/24 at 8:44 AM Staff 31 (LPN) stated if a medication was not available from the pharmacy the CMA was to notify the nurse and the nurse would follow up with the pharmacy. On 9/11/24 at 8:49 AM with Staff 21 (LPN Staffing Coordinator) a fentanyl patch was observed in the automated medication dispensing system. Staff 21 stated if a resident did not have a medication, staff should see if the medication was available in the dispensing machine. If the medication was a narcotic staff would need to call the pharmacy to get permission to remove the medication. If staff had called the pharmacy on 9/9/24 to obtain authorization to remove the a fentanyl patch, they may have found out the pharmacy did not have a valid prescription. On 9/11/24 at 8:50 AM Staff 14 (LPN Resident Care Manager) stated she was not sure the reason staff did not follow up with the pharmacy on 9/9/24 when they did not have a fentanyl patch to administer to Resident 164.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41455 Based on interview and record review it was determined the facility failed to monitor residents on psychotropic medications for 2 of 5 sampled residents (#s 87 and 164) reviewed for psychotropic medications. This placed residents at risk for receiving unnecessary psychotropic medications. Findings include: 1. Resident 87 admitted to the facility in 3/2024 with diagnosis which included bipolar (mood swings) disorder. The 6/28/24 revised care plan indicated Resident 87 used psychotropic medications and to monitor effectiveness and side effects of the medications. The 8/2024 MAR indicated Resident 87 received duloxetine (antidepressant medication) daily as of 7/30/24 related to her/his bipolar depression. An 8/20/24 Psychotropic Medication Review indicated Resident 87's aripiprazole (antipsychotic medication) and quetiapine (antipsychotic medication) were reviewed and were ordered to address hallucinations, delusion and rejection of care. Duloxetine was also reviewed with no indication for the specific use of the medication. The 8/2024 Monitors indicated no monitor was in place for adverse reactions or behaviors related to Resident 87's antidepressant medication. On 9/8/24 at 10:38 AM Resident 87 stated she/he was depressed since she/he came to the facility. On 9/10/24 at 4:39 PM Staff 4 (Unit Manager-LPN) stated it was discussed with interdisciplinary team members the duloxetine was added to address Resident 87's continued depression and rejection of care. Staff 4 acknowledged the monitoring of side effects and behaviors related to Resident 87's duloxetine was not in place and improved documentation was needed to address the use of the resident's antidepressant. 26991 2. Resident 164 readmitted to the facility 8/2024 with a diagnosis of leg fractures. a. A 9/2024 MAR revealed staff were to administer Ativan (antianxiety) PRN. One dose was administered on 9/9/24. A care plan revised on 9/5/24 revealed Resident 164 was on hospice services. Staff were to administer medications as ordered. A care plan related to the use of an antianxiety medication was not developed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 164's clinical record revealed no documentation to indicate non-pharmacological interventions were provided prior to the Ativan administration. On 9/11/24 at 8:02 AM and 2:55 PM Staff 14 (LPN Resident Care Manager) stated a care plan with non-pharmacological interventions was not developed for Resident 64's PRN Ativan. Staff 14 acknowledged there were no interventions documented prior to the 9/9/24 medication administration. On 9/11/24 at 2:49 PM Staff 31 (LPN) stated she was not sure how to document non-pharmacological interventions for PRN psychotropic medications. Normally the monitor alerted staff to monitor residents for adverse side affects of psychotropic medications. b. A 9/2024 MAR revealed staff were to administer Ativan and haloperidol PRN. One dose of Ativan was administered on 9/9/24 and haloperidol was not administered. A care plan revised on 9/5/24 revealed Resident 164 was on hospice services. Staff were to administer medications as ordered. A care plan related to the use of antianxiety and antipsychotic medications was not developed. Resident 164's clinical record revealed no documentation to indicate staff monitored Resident 164 for side affects of the antianxiety and antipathetic medications. On 9/11/24 at 2:55 PM Staff 14 (LPN Resident Care Manager) stated staff were to monitor for medication side affects on the MAR. Staff 14 stated a monitor for Resident 164's Ativan and haloperidol was not developed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 26991 Based on interview and record review it was determined the facility failed to prevent a significant medication error for 1 of 6 sampled resident's (#41) reviewed for unnecessary medications. This placed residents at risk for adverse medication reactions. Findings include: On 6/25/24 the Past Noncompliance was corrected when the facility identified the cause of the incident and determined vital signs were not obtained by a CMA prior to medication administration resulting in a drop in blood pressure. The plan of correction included: -6/28/24 nurse and CMA education was provided related to the 10 rights of medication administration. -7/3/24 an audit was initiated for residents with blood pressure parameters. -7/3/24 the facility reported Staff 20 to the Oregon State board of Nursing. 7/3/24 education was initiated to all nurses and CMAsregarding standards and scope of practice related to their licensure and obtaining vital signs prior to medication administration. Resident 41 admitted to the facility in 8/2023 with a diagnosis of paraplegia (inability to move legs). A 6/2024 MAR revealed Resident 41 was to be administered Baclofen (muscle relaxant) three times a day and the medication was to be held if her/his systolic blood pressure (top number) was less than 100. On 6/25/24 at 3:00 PM Resident 41's BP was documented to be 100/68 and the medication was documented as administered. An investigation initiated on 6/25/24 revealed Resident 41 was administered a muscle relaxant which was to be held if her/his systolic blood pressure was less than 100. Staff 20 documented the blood pressure to be 100/68 for the 3:00 PM dose and the medication was documented as given. Staff 19 (LPN) was notified by a CNA Resident 41's blood pressure was 89/65. When Staff 19 questioned Staff 20 if she took Resident 41's blood pressure Staff 20 stated she looked at the morning blood pressure and guessed what the blood pressure would be at 3:00 PM. On 9/9/24 at 3:21 PM Staff 19 stated Resident 41 had chronic low blood pressure. Staff 19 stated a CNA took Resident 41's blood pressure at approximately 3:00 PM and her/his blood pressure was low and a huge drop from the morning blood pressure. On 9/12/24 at 3:38 PM Staff 20 acknowledged she did not obtain Resident 41's blood pressure at 3:00 PM and just made up a blood pressure to enter into the MAR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview and record review it was determined the facility failed to serve foods at appropriate temperatures and store and serve foods in a sanitary manner for 1 of 5 sampled residents (#162) reviewed for foods, 1 of 1 kitchen and 1 of 2 unit refrigerators observed. This placed residents at risk for foodborne illnesses. Findings include: 1. Resident 162 admitted to the facility in ,d+[DATE] with a diagnosis of heart disease. An [DATE] Progress Note indicated Resident 162 called the police to report concerns including she/he was served moldy food. An [DATE] five day MDS assessment revealed Resident 162 was cognitively intact. On [DATE] at 3:45 PM Staff 23 (Former Administrator) stated Resident 162 called the police because she/he alleged the facility served moldy food. Staff 23 stated the facility immediately threw out all the perishable snacks and investigated the incident. Staff 23 did not recall if they verified if the food was moldy. On [DATE] at 6:09 PM Staff 30 (LPN) stated she worked when Resident 162 called the police related to moldy food. Staff 30 stated she did not see the food but saw photos of the food. The photo was obviously taken in the facility dining room. The sandwich had green mold on it and the fruit cup had white bumps on it. The bumps which she saw were the bumps that form before food became moldy. 49676 2. A [DATE] Dietary Forms Service Line Temperature Log indicated chicken temperature was recorded at 139 degrees. A [DATE] Dietary Forms Service Line Temperature Log indicated poultry temperature was recorded at 151 degrees and the meatloaf was 155 degrees. On [DATE] at 3:11 PM recorded temperatures were reviewed with Staff 40 (Dietary Manager). Staff 40 indicated the chicken, poultry and meatloaf temperatures were holding temperatures but did not indicate the temperatures were verified for potentially hazardous food. She stated she did not have a system in place to verify the final cooking temperatures were met. 49677 3. A [DATE] at 9:37 AM interview with Staff 7 (CNA) revealed she reported the ICF unit refrigerator was in unsanitary condition, and the sandwiches had no label for expiration date. Staff 7 reported she did not use the food in the unit refrigerator as she was concerned it was expired and unsafe for consumption. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:46 AM observation of the unit refrigerator revealed eight sandwiches without date labels and one food-soiled and broken refrigerator shelf (previously taped together). An unsanitary sticky wooden corner shelf was food-soiled and holding peanut butter, syrup, bananas and crackers. The floor surrounding the refrigerator was soiled and sticky. An expired orange and a soiled washcloth sat on top of the refrigerator. On [DATE] at 9:18 AM observation of the unit refrigerator revealed no change from initial observation five days earlier except for addition of date labels on sandwiches. A [DATE] at 9:34 AM interview with Staff 60 (Infection Prevention Nurse) confirmed the wooden shelf was uncleanable and soiled with sticky food. He stated the shelf was uncleanable and unsanitary and he would replace it with a cleanable surface shelf. Staff 60 also confirmed the unsanitary condition of the refrigerator, surrounding floor, broken refrigerator shelf, expired orange, and soiled washcloth on top of the refrigerator.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 50930 Based on interview and record review it was determined the facility failed to ensure residents understood the meaning of an arbitration agreement (disputes resolved with a neutral party and not in court) for 3 of 3 sampled residents (#s 19, 163 and 262) reviewed for arbitration. This placed residents at risk for being uninformed of their legal rights. Findings include: 1. Resident 19 admitted to the facility in 8/2024 with diagnoses including a fracture of the left femur and chronic kidney disease. Review of an 8/7/24 Medicare 5-Day MDS indicated Resident 19 was cognitively intact. Review of a Patient and Facility Arbitration Agreement revealed Resident 19 signed the document on 8/29/24. On 9/11/24 at 10:16 AM Resident 19 stated she/he knew what arbitration meant but did not remember signing an agreement at this facility. On 9/12/24 at 4:37 PM Staff 59 (Admissions Coordinator) stated she told all new admissions they had the right to decline or agree and had 30 days to change their mind. She stated she explained the definition and process of arbitration and offered a copy to all admissions. She stated she gave all admissions her business card and told them to contact her with any questions. 2. Resident 163 admitted to the facility in 8/2024 with diagnoses including kidney failure and respiratory failure. Review of a 9/1/24 Medicare 5-Day MDS indicated Resident 163 was cognitively intact. Review of a Patient and Facility Arbitration Agreement revealed Resident 163 signed the document on 8/28/24. On 9/11/24 at 5:02 PM Resident 163 stated she/he remembered signing the arbitration agreement. Resident 163's spouse stated she/he had further questions about the agreement, and she/he was given a copy of the signed agreement but did not get an explanation about the process as requested. Resident 163's spouse stated she/he still did not know exactly what arbitration meant and was under the impression the facility would not take care of Resident 163 unless the agreement was signed. On 9/12/24 at 4:37 PM Staff 59 (Admissions Coordinator) stated she told all new admissions they had the right to decline or agree and had 30 days to change their mind. She stated she explained the definition and process of arbitration and offered a copy to all admissions. She stated she gave all admissions her business card and told them to contact her with any questions. 3. Resident 262 admitted to the facility in 8/2024 with diagnoses including respiratory failure and gout. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Rehabilitation Health Center	1735 Adkins Street Eugene, OR 97401

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an 8/26/24 Medicare 5-Day MDS indicated Resident 262 was cognitively intact. Review of a Patient and Facility Arbitration Agreement revealed Resident 262 signed the document on 8/23/24. On 9/11/24 at 5:12 PM Resident 262 stated she/he did not remember signing an arbitration agreement and arbitration was not explained to them at admission. She/He stated, when you're not feeling well and people tell you to sign a bunch of papers, you just get it done. On 9/12/24 at 4:37 PM Staff 59 (Admissions Coordinator) stated she told all new admissions they had the right to decline or agree and had 30 days to change their mind. She stated she explained the definition and process of arbitration and offered a copy to all admissions. She stated she gave all admissions her business card and told them to contact her with any questions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

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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** 35855 Based on observation, interview, and record review it was determined the facility failed to ensure appropriate use of PPE and failed to follow infection control standards for 2 of 2 units and 1 of 1 laundry room reviewed for infection control. The facility additionally failed to ensure the community use CBG glucometer was properly cleaned and sanitized between resident uses for 1 of 1 sampled resident (#20) reviewed during CBG checks. This placed residents at risk for the spread of infection and placed all residents who required CBG checks at risk for bloodborne illness. Findings include: 1. On 9/9/24 at 3:28 AM Staff 38 (LPN) was observed sitting on a stool across the hall from the nurses' station on the long-term side of the facility with no mask on. Staff 30 (LPN) was observed sitting at the nurses' station with no mask on. At 3:56 AM Staff 38 was observed coming out of an empty resident room with no mask on. Staff 38 stated COVID-19 caused some staffing issues, but CNA staff could still complete their work. On 9/13/24 at 11:14 AM Staff 1 (Administrator) Staff 2 (DNS) and Staff 56 (Regional Nurse) confirmed staff should wear masks while there was COVID-19 active in the facility. 2. On 9/10/24 at 8:49 AM the breakfast cart was observed coming onto the skilled unit. One tray was observed to have no cover on the plate and the food was exposed. At 8:54 AM Staff 67 (CNA) removed the tray from the cart. Staff 67 stated trays came out of the kitchen without covers on the plates. Staff 67 then delivered the tray to room [ROOM NUMBER]. On 9/10/24 at 9:00 AM Staff 60 (RN Infection Preventionist) stated the tray of food should have a cover when going down the hallway. If there was no lid the tray should not be delivered to the resident. 50930 3. Ongoing observations conducted on 9/8/24 through 9/12/24 between the hours of 3:00 AM and 6:30 PM revealed the following: - Multiple staff members with N95 masks worn improperly or not being worn while in resident care areas and while in COVID-19 positive rooms. - Personal Protective Equipment storage bins outside the rooms of COVID-19 positive residents were missing supplies from each bin. - Multiple staff not wearing proper eye protection while in COVID-19 positive rooms. On 9/12/24 at 4:44 PM Staff 60 (RN Infection Preventionist) stated the facility's current COVID-19 outbreak started on 8/9/24 and was present on both resident care units. He stated the expectation of all staff was to adhere to the Centers for Disease Control infection control guidelines including wearing eye protection when entering rooms that require eye protection and wearing a properly fitted N95 in the correct manner. He acknowledged staff were not always following these protocols when on the units. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an infection control audit of the laundry area on 9/11/24 at 12:50 PM the following was observed: - A wall mounted fan blowing from the dirty to the clean side of the laundry room with visible dirt caked on front grill and all fan blades. - The dirty linen room had no air circulation. - Wet towels around the base of one washing machine with water visibly leaking from a pipe going down the side of the washing machine. - One dryer with a broken heating element. - One washing machine with a broken door requiring the use of a wrench to loosen bolts to get the door open and to seal the door shut. On 9/11/24 at 4:24 PM Staff 54 (Account Manager) stated the broken washing machine was fixed multiple times without permanent resolution of the leaking water and broken door issues. She stated towels were placed around the base of the washing machine to keep the floor dry and staff safe from slipping. She stated the broken heating element for the dryer was fixed multiple times without permanent resolution, and staff used it for non-heat drying only. On 9/12/24 at 12:25 PM Staff 28 (Corporate Maintenance) stated the broken washer replacement parts were on order and that he adjusted the machine every few days to keep it operational. On 9/13/24 at 2:36 PM Staff 54 acknowledged the fan in the laundry room was broken and covered in dirt. She also stated there was very little air flow in the laundry area unless a breeze came through the open windows. 5. Resident 20 admitted to the facility in 2024 with diagnoses including diabetes and infection following a procedure. Review of an 8/23/24 Medicare 5-Day MDS indicated Resident 20 was cognitively intact. On 9/12/24 at 5:42 PM Staff 57 (CNA/Student Nurse) was observed using a CBG glucometer to check Resident 20's blood sugar level. Upon completion of the test, Staff 57 removed the test strip and put the CBG glucometer back into the medication cart drawer without sanitizing the device. On 9/12/24 at 5:45 PM Staff 33 (LPN) confirmed the proper infection control process was not followed by Staff 57 while using the CBG glucometer.