

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Milton Freewater Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Elzora Street Milton Freewater, OR 97862	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43691</p> <p>Based on interview and record review it was determined the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 of 3 sampled residents (#s 7 and 17) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>1. Resident 7 was admitted to the facility in 6/2018, with diagnoses including dementia with behavior disturbances.</p> <p>Resident 7's 9/1/23 Care Plan indicated she/he had physical and verbal aggressive behaviors with instructions to intervene if this behavior escalated.</p> <p>Resident 17 was admitted to the facility in 3/2023, with diagnoses including hemiplegia (limited motor control of one side of the body).</p> <p>A 9/21/23 BIMs indicated Resident 17 had normal cognitive function.</p> <p>Resident 17 exhibited physical and verbal aggressive behaviors as indicated by her/his 9/1/23 care plan. Interventions included to intervene when the resident displayed these behaviors.</p> <p>On 11/3/23 a FRI was received by the State Survey Agency (SSA) which reported Resident 7 disturbed Resident 17's personal item which resulted in Resident 17 punching Resident 7. Immediate intervention was required to separate Resident 7 and Resident 17.</p> <p>The incident investigation from 11/3/23 included Resident 17 stating we were both hitting each other at first and then I hit him, I punched him in the face so he would stop.</p> <p>A 11/3/23 Progress Note stated Resident 17 and Resident 7 were witnessed by Staff 19 (RN) hitting each other.</p> <p>On 6/26/24 at 10:33 AM, Resident 17 stated she/he hit [Resident 7] in the face so [she/he] would stop bothering me and my things. [Resident 7] kept doing it. I figured if I kept hitting [Resident 7], they would stop.</p> <p>On 6/27/24 at 11:45 AM, Staff 19 stated she witnessed Resident 17 and Resident 7 yelling at each other and striking each other on 11/3/23.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 10:12 AM, Staff 2 (DNS) stated Resident 7 knew exactly how to push Resident 17 buttons which resulted in both residents hitting each other. Staff 2 confirmed Resident 7 and Resident 17 were involved in an incident of physical abuse on 11/3/23.</p> <p>2. Resident 7 was admitted to the facility in 6/2018, with diagnoses including dementia with behavior disturbances.</p> <p>Resident 7's 9/1/23 Care Plan indicated she/he had physical and verbal aggressive behaviors with instructions to intervene if this behavior escalated.</p> <p>Resident 17 was admitted to the facility in 3/2023 with diagnoses including hemiplegia (limited motor control of one side of the body).</p> <p>A 9/21/23 BIMs indicated Resident 17 had normal cognitive function.</p> <p>Resident 17 exhibited physical and verbal aggressive behaviors as indicated by her/his 9/1/23 care plan. Interventions included to intervene when the resident displayed these behaviors.</p> <p>On 11/6/23 a FRI was received by the State Survey Agency (SSA) which reported Resident 7 had disturbed Resident 17's personal item which resulted in Resident 17 approaching Resident 7, yelling at Resident 7 and attempting to strike Resident 7.</p> <p>The incident investigation included Resident 17 stating, I looked and saw [Resident 7] sitting at my doorway. I yelled at [her/him] to leave my stuff alone and hurried over. I do not deny, I stood up from my wheelchair and hit [Resident 7] on the right side of [her/his] face.</p> <p>On 6/24/24 at 1:06 PM, Staff 4 (CNA) stated she did not recall the specific dates of the incidents she had witnessed, but stated she witnessed Resident 7 and Resident 17 striking each other on 3 separate incidents during 2023.</p> <p>On 6/27/24 at 9:48 AM, Staff 18 (Housekeeping Manager) stated on 11/6/23 she heard an argument in the hallway and witnessed Resident 7 and Resident 17 yelling at each other, pushing each other and throwing punches at each other. Staff 18 stated immediate intervention was required to separate Resident 7 and Resident 17.</p> <p>On 6/27/24 at 10:12 AM, Staff 2 (DNS) stated Resident 7 knew exactly how to push Resident 17 buttons which resulted in both residents hitting each other. Staff 2 confirmed Resident 7 and Resident 17 were involved in an incident of physical abuse on 11/6/23.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure there was sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet care needs. Findings include:</p> <p>On 6/23/24 the facility had a census of 26 residents. On 6/27/24, Staff 2 (DNS) provided a list of residents who:</p> <ul style="list-style-type: none"> -Required two-person mechanical lift transfers: 13; -Required one or two-person extensive or total assistance for bathing: 21; -Required one or two-person extensive or total assistance for toileting: 18; -Required one or two-person extensive or total assistance for dressing: 22; -Required two person assistance at all times for all care: 3; -Had behavioral healthcare needs which required monitoring: 19; -Were at risk for elopement: 5. <p>Observations from 6/23/24 through 6/27/24 between the hours of 8:00 AM and 11:15 PM revealed multiple times when no CNA staff were visualized in the hallways for up to 30 minutes.</p> <p>On 6/23/24 at 12:34 PM, Resident 2 stated there were staffing issues on evening and night shift. Resident 2 stated, at times, there was only one nurse and one CNA scheduled which resulted in long call light response times.</p> <p>On 6/23/24 at 1:35 PM, Resident 27 stated the facility was often short staffed, especially at night. Resident 27 stated recently it took staff so long to answer her/his call light, she/he began crying. Resident 27 stated she/he was incontinent and often waited up to 30 minutes to have her/his brief changed. Resident 27 stated she/he no longer used the call light because the wait was so long and she/he got up by herself/himself even though she/he was not supposed to.</p> <p>On 6/23/24 at 2:16 PM, Resident 10 stated evening and night shift staffing was not good. Resident 10 stated she/he waited up to 30 minutes for her/his call light to be answered, at times.</p> <p>On 6/23/24 at 3:13 PM, Resident 26 stated she/he did not typically require pain medication but on this date she/he had pain and requested pain medication. Resident 26 stated it took one hour and five minutes before pain medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/24/24 at 1:33 PM, Witness 1 (Complainant) reported staffing was a consistent problem for a long time. Witness 1 stated there were times when only one nurse and one CNA worked the entire facility. Witness 1 stated the facility continued to admit residents even though they were unable to properly staff CNAs to meet the residents' needs.</p> <p>On 6/24/24 at 2:08 PM, Staff 4 (CNA) stated the facility recently had rough times regarding staffing. Staff 4 stated when the facility was short CNA staff, call lights were not answered timely, CNAs were unable to complete all of the residents' care and showers did not get completed. Staff 4 stated all shifts were impacted by a lack of staffing but evening and night shift were impacted the most.</p> <p>On 6/25/24 at 9:32 AM, Staff 10 (CMA) stated medications were administered to residents late. Staff 10 indicated it was hard to get medications administered to all residents timely as ordered.</p> <p>On 6/25/24 at 9:48 PM, Staff 5 (CNA) stated the facility had high acuity residents including many residents with dementia. Staff 5 stated nearly one-half of the residents required two person assistance for transfers using a mechanical lift and three residents required two person care at all times. Staff 5 stated there was one resident who was aggressive and could not be properly monitored when staffing was low and the resident wandered into everyone's room and started fights. Staff 5 stated some shifts were one to two CNAs short which resulted in an increase in falls and residents being upset due to long call light response times. Staff 5 stated at times she was assigned 13 to 14 residents which was a very heavy load.</p> <p>On 6/26/24 at 12:25 PM, Staff 9 (CMA) stated the morning medications were not all administered timely due to staffing.</p> <p>On 6/26/24 at 2:14 PM, Staff 2 (DNS) stated there were concerns with low staffing and low staffing could be mentally draining for staff. Staff 2 stated staff felt stressed there won't be enough staff. Staff 2 acknowledged there were multiple shifts that lacked adequate CNA coverage.</p> <p>On 6/26/24 at 4:45 PM, Staff 1 (Administrator) stated the facility was not doing well with staffing and acknowledged there were multiple shifts that lacked adequate CNA coverage.</p>