STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385161	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Freewater Health & Rehabilitation Center	120 Elzora Street Milton Freewater, OR 97862

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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 0600 Level of Harm - Minimal harm or potential for 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. Based on interview and record review it was determined the facility failed to protect the resident's right to be free from abuse for 1 of 4 sampled residents (#11) reviewed for abuse. This placed residents at risk for abuse and psychosocial harm. Findings include: The facility's Abuse Policy, updated in 3/2025, defined abuse as the willful infliction of injury with resulting physical harm, pain or mental anguish. Physical abuse was defined as hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing and shoving.Resident 10 admitted to the facility in 2018 with diagnoses including stroke and dysphagia (inability to swallow). Resident 10's MDS Quarterly dated 11/7/24 revealed a BIMS score of 99, indicating the assessment could not be completed. Resident 10's Care Plan revised on 12/29/24, revealed she/he had verbal and physical aggression toward others and behaviors such as pulling or knocking things off walls and counters and unsafe behaviors during mealtime. Care plan interventions included providing distractions, to monitor and cue the resident at all times during meals. Resident 11 admitted to the facility in 2023 with diagnoses including hypertension and atrial fibrillation (an irregular, fast heartbeat).Resident 11's MDS Quarterly dated 8/23/24 revealed a BIMS score of 14, indicating no cognitive impairment. The MDS indicated Resident 11 had no behavioral issues. On 9/23/24, the State Survey Agency (SSA) received a FRI which indicated on 9/22/24, Resident 10 grabbed a beverage bottle from Resident 11's cup holder and threw it at Resident 11. The bottle struck Resident 11 in the face, hit the resident's eyeglasses and she/he sustained a small cut on the bridge of her/his nose. The report indicated all staff were in resident rooms providing care to other residents. On 8/6/25 at 2:53 PM, Staff 12 (CNA) stated she remembered Resident 10 and Resident 11 had several altercations because Resident 10 accused Resident 11 of stealing her/his wallet and wanted to fight. She stated the incidents went from bad to worse and at some point Resident 10 was placed on one on one supervision but did not recall when that occurred. She recalled Resident 10 assaulted people, tried to run over staff's toes, turned hall lights off and on and threw things. On 8/7/25 at 9:08 AM, Staff 15 (RN) stated Resident 10 was aggressive, knocked pictures and objects off the walls, cursed at residents and was sexually inappropriate with staff. She stated she witnessed interactions between Resident 10 and Resident 11 where they cursed and threatened each other. She stated after the 9/22/24 incident, Resident 10 was placed on one on one supervision. Residents 10 and 11 were not interviewed due to their discharge from the facility. A risk management report was initiated by nursing staff on 9/22/24 which noted Resident 11 was observed to have a cut on her/his nose and first aid was provided. Review of Resident 10's nursing notes from 6/2024 through 9/2024 revealed she/he initiated several incidents with Resident 11 and other residents at the facility, including throwing punches at Resident 11 and staff. No physical harm to residents was determined in each of the incidents. On 8/7/25 at 11:05 AM, Staff 1 (Administrator) confirmed the incident occurred on 9/22/24.

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 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. Based on interview and record review it was determined the facility failed to report an injury of unknown origin to the appropriate State agency within state mandated timelines for 1 of 3 sampled residents (#13) reviewed for accidents and falls. Findings include: Resident 13 was admitted to the facility in 4/2025 with diagnoses including acute post-hemorrhagic anemia (a condition where a person experiences a rapid decrease in red blood cells and hemoglobin due to significant blood loss) and dysphagia (difficulty swallowing). Resident 13's MDS Quarterly dated 7/7/25 revealed a BIMS score of 4, indicating severe cognitive impairment. Resident 13's care plan dated 7/13/25 revealed she/he was completely dependent for transfers and required a two person assist with a Hoyer sling. On 7/29/25 and 7/30/25, two public complaints were received by the State Survey Agency (SSA) which stated Resident 13 had received an injury of unknown origin on her/his chest area and the resident experienced significant bruising, swelling at the chest area and was not sent to the hospital for several days after the injuries were apparent.NO FRI's were received by the SSA regarding the injury. On 8/6/25 at 12:31 PM, Staff 4 (RN) stated he came to work for day shift on 7/25/25. He stated another nurse asked him to examine Resident 13's chest area, and stated the resident's left breast area was swollen to three times the size of the right breast, was engorged and hard to palpate. He noticed a lump on the side of the breast that was firm to the touch and stated the resident had bruising on the left side of her/his abdomen. Staff 4 stated he was told the resident was transferred with the sit to stand, screamed while being transferred and the incident was reported to the evening shift nurse. At that point Staff 4 stated he went to his office and sent a note to Staff 1 (Administrator) and Staff 2 (DNS) because he thought the injury should be reported. Staff 4 stated at that point Staff 1, Staff 2 and Staff 3 (RNCM) took it from there. On 8/7/25 at 10:45 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (RCM) were notified of the findings they did not report Resident 13's injury of unknown origin to the SSA.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, it was determined the facility failed to respond to a change of condition related to anticoagulant use for 1 of 3 sampled residents (#13) reviewed for change of condition. This placed residents at risk for adverse side effects of anticoagulant use. Findings include: According to Drugs.com https://www.drugs.com/, serious side effects of anticoagulant medication include bleeding, with common adverse reactions including anemia, hemorrhage, and nausea.Resident 13 was admitted to the facility in 4/2025 with diagnoses including acute post-hemorrhagic anemia (a condition where a person experiences a rapid decrease in red blood cells and hemoglobin due to significant blood loss) and dysphagia (difficulty swallowing). Resident 13's MDS Quarterly dated 7/7/25 revealed a BIMS score of 4, indicating severe cognitive impairment. Resident 13's care plan dated 7/13/25 revealed she/he was completely dependent for transfers and required a two person assist with a mechanical lift (Hoyer sling). The care plan also indicated the resident received an anticoagulant (blood thinner) for her/his anemia. On 7/29/25 and 7/30/25, two public complaints were received by the State Survey Agency (SSA) which stated Resident 13 had received an injury of unknown origin on her/his chest area and the resident experienced significant bruising, swelling at the chest area and was not sent to the hospital for several days after the injuries were apparent. Both complainants stated the resident was on anticoagulant medication (blood thinner) and should have been sent to the hospital immediately after the significant bruising was discovered. On 8/5/25 at 5:14 PM, Witness 1 (Complainant) stated paramedics were called to the facility on 7/29/25 and the facility reported Resident 13's hemoglobin level was low and the resident was lethargic. Witness 1 was told the resident was involved in a Hoyer accident on 7/24/25 and sustained bruising on her/his arm. Witness 1 stated no other information was provided by staff. When Resident 13 arrived at the ED, Witness 1 stated he observed the resident had significant bruising across her/his chest, upper abdomen and back, the bruises on the resident's upper abdominal area were black, dark purple and blue and wrapped around to the resident's back. Witness 1 stated the injuries looked like an injury where someone was hit by a car.if there's any sort of trauma and someone's on a blood thinner, she/he needed to go out when it happened. You don't know what's going on internally, she/he could have had significant injury to her/his organs. On 8/6/25 at 8:45 AM, Witness 2 (Complainant) stated nursing staff at the facility observed Resident 13 on 7/26/25 immediately after the day shift nurse came on and received report from the NOC nurse. Witness 2 stated the nurses observed the resident's left breast area to be swollen almost four times the size the area normally was, the whole area was black and blue and bruised down to mid rib on the resident's back. The resident appeared to be in severe pain, so the day shift nurse immediately asked another nurse (Staff 4 - RN) to examine Resident 13. Staff 4 examined the resident's injuries, stated the resident looked as if she/he had fallen and should be sent out. Witness 2 stated Staff 2 (DNS) and Staff 3 (RNCM) were immediately notified, examined Resident 13 but decided not to send her/him to the hospital. Witness 2 stated the resident was given ice packs for the swelling and scheduled pain medication. Witness 2 later learned Resident 13's blood test results revealed critical levels, requiring hospitalization and blood transfusions. On 8/6/25 at 12:31 PM, Staff 4 stated he came to work for day shift on 7/25/25. He stated another nurse asked him to examine Resident 13's chest area, and stated the resident's left breast area was swollen to three times the size of the right breast, was engorged and hard to palpate. He noticed a lump on the size of the breast that was firm to the touch and stated the resident had bruising on the left side of her/his abdomen. Staff 4 stated he was told the resident was transferred with the sit to stand, screamed while being transferred and the incident was reported to the evening shift nurse. Staff 4 then saw Staff 1 (Administrator) and told Staff 1 he thought Resident 13 should be sent out due to the resident's bruising and pain. Staff 4 stated at that point Staff 1, Staff 2 and Staff 3 took it from there.On 8/6/25 at 4:17 PM. Staff 5 (LPN) confirmed she worked the evening shift on 7/24/25. She stated she wasn't made aware of the resident's injury until the CNAs told her the resident was transferred into her/his chair and to bed when they noticed the significant bruising. Staff 5 stated the CNAs stated the resident stated ouch when she/he was getting ready for dinner and later was seen leaning to the left side. She stated the bruise was already a deep, dark color, the whole left side flank from her/his armpit to the belly button and around to the back, almost to the spine. The breast was huge, hard and had a dark blue bruise. Staff 5 stated I should have sent [her/him] out when she observed the resident's injury. On 8/7/25 at 10:45 AM, Staff 2 (DNS) stated when she examined Resident 13 on 7/25/25, the bleeding had spread below the resident's breast area. She and Staff 3 examined the resident and did not

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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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, it was determined the facility failed to follow care planned interventions related to transfers for 1 of 3 sampled residents (#13) reviewed for safety. As a result, Resident 13 experienced an injury of unknown origin and internal bleeding, which required hospitalization and a blood transfusion. Findings include: Resident 13 was admitted to the facility in 4/2025 with diagnoses including acute post-hemorrhagic anemia (a condition where a person experiences a rapid decrease in red blood cells and hemoglobin due to significant blood loss) and dysphagia (difficulty swallowing). Resident 13's MDS Quarterly dated 7/7/25 revealed a BIMS score of 4, indicating severe cognitive impairment. Resident 13's care plan dated 7/13/25 revealed she/he was completely dependent for transfers and required a two person assist with a mechanical lift (Hoyer sling). On 7/29/25 and 7/30/25, two public complaints were received by the State Survey Agency (SSA) which stated Resident 13 received an injury of unknown origin on her/his chest area and the resident experienced significant bruising and swelling at the chest area. On 8/5/25 at 5:14 PM, Witness 1 (Complainant) stated paramedics were called to the facility on 7/29/25, where the facility reported Resident 13's hemoglobin level was low and the resident was lethargic. Witness 1 was told the resident was involved in a Hoyer accident on 7/24/25 and sustained bruising on her/his arm. Witness 1 stated no other information was provided by staff. When Resident 13 arrived at the ED, Witness 1 stated he observed the resident had significant bruising across her/his chest, upper abdomen and back, the bruises on the resident's upper abdominal area were black, dark purple and blue and wrapped around to the resident's back. Witness 1 stated the injuries looked like an injury where someone was hit by a car.if there's any sort of trauma and someone's on a blood thinner, she/he needed to go out when it happened. You don't know what's going on internally, she/he could have had significant injury to her/his organs. On 8/6/25 at 8:45 AM, Witness 2 (Complainant) stated nursing staff at the facility observed Resident 13 on 7/26/25 after the day shift nurse came on and received report from the NOC nurse. Witness 2 stated the nurses observed the resident's left breast area to be swollen almost four times the size the area normally was, the whole area was black and blue and bruising was observed down to mid rib on the resident's back. The resident appeared to be in severe pain, so the day shift nurse immediately asked another nurse (Staff 4 - RN) to examine Resident 13. Staff 4 examined the resident's injuries, stated the resident looked as if she/he had fallen and should be sent out. Witness 2 stated Staff 2 (DNS) and Staff 3 (RNCM) were notified, examined Resident 13 but decided not to send her/him to the hospital. Witness 2 stated the resident was given ice packs for the swelling and scheduled pain medication. Witness 2 later learned Resident 13's blood test/lab results indicated Resident 13's hemoglobin and hematocrit counts were at critically low levels, requiring hospitalization and blood transfusions. On 8/6/25 at 11:45 AM, Staff 11 (CNA) stated she provided care for Resident 13 several times. She stated the resident was totally dependent for everything and had been care planned as a two person Hoyer transfer for about two weeks. Prior to that, staff used a sit to stand lift for the resident. Staff 11 stated she had worked the day shift on 7/24/25 and assisted Resident 13 to get up and dressed for breakfast. She recalled she and another CNA used the Hoyer because the resident appeared weak and in pain. She stated the resident did not have any injuries that morning and was certain because she had changed the resident's shirt.On 8/6/25 at 12:31 PM, Staff 4 (RN) stated he came to work for day shift on 7/25/25. He stated another nurse asked him to examine Resident 13's left breast area and stated the resident's left breast area was swollen to three times the size of the right breast, was engorged and hard to palpate. He noticed a lump on the size of the breast that was firm to the touch and stated the resident had bruising on the left side of her/his abdomen. Staff 4 stated he was told the resident was transferred with the sit to stand, screamed while being transferred and the incident was reported to the evening shift nurse. Staff 4 stated at that point, Staff 1, Staff 2 and Staff 3 took it from there. On 8/6/25 at 3:06 PM, Staff 13 (CNA) stated on 7/24/25 she assisted Staff 14 with transferring Resident 13 using the sit to stand a little before 5:00 PM. She recalled the resident was placed in the sit to stand, the straps were on, the resident's feet were positioned correctly and the resident grabbed the bar. Staff 13 and Staff 14 stood Resident 13 up and the resident stated shit loudly, which was unusual for the resident. Staff 13 stated she noticed the resident was already tired when they transferred her but did not notice anything else. On 8/6/25 at 4:17 PM Staff 5 (LPN) confirmed she worked the evening shift on 7/24/25. She stated she wasn't made aware of the resident's injury until the CNAs told her the resident was transferred into her/his chair and to bed when they noticed the significant bruising. Staff 5 stated the CNAs stated the resident stated ouch when she/he was getting ready