

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were given the right to participate in the development of their person-centered care plan for 1 of 1 sampled resident (#2) reviewed for care planning. This placed residents at risk for not being involved in the care planning process. Findings include:</p> <p>Resident 2 was admitted to the facility in 4/2023 with diagnoses including major depression and repeated falls.</p> <p>A review of Resident 2's health record revealed Resident 2 had not had a care conference completed since 11/9/23.</p> <p>A review of Resident 2's care plan revealed on 2/7/24, 3/5/24, 3/6/24 and 5/10/24, Resident 2's care plan was updated.</p> <p>On 6/23/24 at 12:36 PM, 6/24/24 at 11:55 AM, and 6/26/24 at 9:09 AM, Resident 2 stated with dissatisfaction, her/his most recent care conference was sometime last year. Resident 2 stated it was important for her/him to be involved in her/his care planning process and other residents participated regularly in care conferences so she/he did not understand why she/he had not had a care conference since last year.</p> <p>On 6/25/24 at 9:14 AM, Staff 8 (SSD) stated, due to changes in staff, it was difficult to get a team together in order to conduct care conferences. Staff 8 confirmed Resident 2 did not have a care conference since 11/9/23 and she expected residents to be offered care conferences at least quarterly. Staff 8 stated Resident 2 always participated in her/his care conferences and one should have been scheduled since 11/9/23.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to accurately assess residents for falls for 1 of 1 sampled resident (#6) reviewed for falls. This placed residents at risk for inaccurate assessments and unmet care needs. Findings include:</p> <p>Resident 6 was admitted to the facility in 10/2023 with diagnoses including dementia.</p> <p>The 3/28/24 Quarterly MDS indicated Resident 6 had one fall with major injury since her/his prior MDS assessment on 1/3/24.</p> <p>On 6/24/24 at 2:57 PM Staff 2 (DNS) stated Resident 6 had no falls since her/his prior MDS assessment on 1/3/24 and the resident's 3/28/24 Quarterly MDS, fall section, was inaccurate.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50926</p> <p>Based on interview and record review it was determined that facility failed to develop and provide a summary of the baseline care plan for 3 of 8 sampled residents (#s 25, 26 and 180) reviewed for pain, nutrition and ADLs. This placed residents at risk for being uninformed of their plan of care. Findings include:</p> <ol style="list-style-type: none"> Resident 25 was admitted to the facility in 5/2024, with diagnoses including dementia without behavioral disturbances. <p>Review of the Resident 25's health record indicated no evidence the facility provided a written summary of the baseline care plan to the resident or their representative.</p> <p>During an interview with Staff 2 (DNS) on 6/27/24 at 4:23 PM, she stated she did not know if a summary of the baseline care plan was provided to the resident.</p> <ol style="list-style-type: none"> Resident 180 was admitted to the facility in 6/2024, with diagnoses including compression fracture (occurs when one or more bones in the spine weaken and crumple). <p>Review of Resident 180's health record indicated that a baseline care plan was not developed within 48 hours of admission and did not include resident centered pain interventions. There was no evidence the baseline care plan was provided to the resident.</p> <p>Interview with Staff 2 (DNS) on 6/27/24 at 4:23 PM, she stated the baseline care plan should be completed with 48 hours and did not know if a summary of the baseline care plan was provided to with the resident.</p> <p>50927</p> <ol style="list-style-type: none"> Resident 26 was admitted to the facility on [DATE], with diagnoses including depression. <p>Review of the medical record revealed Resident 26 was not provided with a written summary of her/his baseline care plan.</p> <p>On 6/25/24 at 1:54 PM, Staff 3 (Divisional Director of Clinical Operations) verified there was no documentation to indicate the baseline care plan was discussed with Resident 26 or a written summary was offered. Staff 3 further indicated there was no system in place to provide a baseline care plan to residents and their representatives.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to assist in vision care needs for 1 of 1 sampled resident (#2) reviewed for vision. This placed residents at risk for impaired vision. Finding include:</p> <p>Resident 2 was admitted to the facility in 4/2023 with diagnoses including major depression and repeated falls.</p> <p>A 12/6/23 Physician Order indicated Resident 6 was referred for an eye examination due to visual changes and double vision.</p> <p>The 5/1/24 Quarterly MDS indicated Resident 2 had no impaired cognitive functioning and the resident wore glasses.</p> <p>A review of Resident 2's health record revealed no evidence an eye examination was discussed with the resident, scheduled or completed.</p> <p>Observations from 6/23/24 through 6/27/24 between the hours of 8:00 AM and 4:30 PM revealed Resident 2 was not wearing glasses.</p> <p>On 6/23/24 at 12:40 PM, Resident 2 stated she/he was supposed to wear glasses and asked for glasses several months ago but nobody followed up.</p> <p>On 6/27/24 at 10:50 AM, Staff 2 (DNS) confirmed there was no evidence in Resident 2's health record that an eye examination was discussed with Resident 2 or completed.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to maintain and prevent a potential decrease in mobility for 1 of 2 sampled residents (#5) reviewed for rehabilitation services. This placed residents at risk for loss of mobility. Findings include:</p> <p>Resident 5 was admitted to the facility in 12/2022 with age-related debility (weakness).</p> <p>Resident 5's 6/14/24 PT Discharge Summary indicated the resident was discharged from PT services on 6/14/24.</p> <p>Resident 5's current Walk Daily Program task indicated Resident 5 was to be walked by CNA staff from her/his room to the nursing station and back using a front wheeled walker every day before lunch.</p> <p>A review of Resident 5's health record revealed no evidence the resident was walked by staff from her/his room to the nursing station and back on any days since Resident 5 was discharged from PT services.</p> <p>Observations from 6/23/24 through 6/27/24 between the hours of 8:00 AM and 11:15 PM revealed no observations of Resident 5 being walked by staff.</p> <p>On 6/23/24 at 1:28 PM, Resident 5 stated she/he was discharged from PT services earlier this month and was supposed to walk everyday with staff. Resident 5 stated she/he had not walked for at least the past two weeks. Resident 5 stated it was very important for her/him to keep up with her/his walking or she/he would lose her/his walking abilities and become weak.</p> <p>On 6/25/24 at 10:00 AM, Staff 11 (PTA) stated Resident 5 was discharged from PT services on 6/14/24 and was supposed to be walked by staff everyday. Staff 11 stated Resident 5 had not been walked since her/his discharge from PT services.</p> <p>On 6/25/24 at 11:00 AM and 6/26/24 at 8:52 AM, Staff 12 (CNA) and Staff 7 (CNA) stated no CNAs walked Resident 5. Staff 7 stated she saw Resident 5's Walk Daily Program on the resident's Kardex (a care plan that gives a brief overview of the resident's care needs) but she did not have time to walk Resident 5 given the number of residents assigned to her.</p> <p>On 6/26/24 at 1:19 PM, Staff 2 (DNS) stated CNAs were expected to complete Resident 5's Walk Daily Program and acknowledged Resident 5's Walk Daily Program was not being completed.</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>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure records were accurate for 2 of 5 sampled residents (#s 6 and 10) reviewed for unnecessary medications. This placed residents at risk for inaccurate treatment. Findings include:</p> <p>1. Resident 6 was admitted to the facility in 10/2023 with diagnoses including hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone).</p> <p>Resident 6's 10/3/23 Physician Order indicated the resident was to receive levothyroxine (medication to treat hypothyroidism) one time a day to be given alone before breakfast.</p> <p>Resident 6's 5/2024 MAR revealed no documentation the resident's levothyroxine was administered on 5/6 and 5/30.</p> <p>On 6/26/24 at 1:53 PM, Staff 2 (DNS) stated the same nurse worked on 5/6/24 and 5/30/24 and the nurse administered Resident 6's levothyroxine on both days but did not document that he administered the medication because he was distracted during change of shift.</p> <p>2. Resident 10 was admitted to the facility in 8/2021 with diagnoses including stomach ulcer.</p> <p>Resident 10's 12/28/22 Physician Order indicated the resident was to receive Protonix (a medication to treat stomach ulcers) one time a day, 30 minutes before meals.</p> <p>Resident 10's 5/2024 MAR revealed no documentation the resident's Protonix was administered on 5/6 and 5/30.</p> <p>On 6/27/24 at 11:00 AM, Staff 2 (DNS) stated the same nurse worked on 5/6/24 and 5/30/24 and the nurse administered Resident 10's Protonix on both days but did not document that he administered the medication because he was distracted during change of shift.</p>		