| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385164 | A. Building<br>B. Wing | 03/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aidan Senior Living at Reedsport | 600 Ranch Road<br>Reedsport, OR 97467 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>35855<br><br>Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 5 residents (#s 18 and 19) reviewed for medications. This placed residents at risk for delayed treatment and unmet needs. Findings include:<br><br>1. Resident 18 was admitted to the facility in 3/2024 with diagnoses including dementia and insomnia.<br><br>A 3/2025 MAR instructed staff to instill two drops of Ciprofloxacin (an antibiotic used to treat bacterial infections) in both eyes every two hours for conjunctivitis (also known as pink eye, a bacterial or viral infection, or allergic reaction) for two days, starting on 3/21/25. The MAR referred the reader to Administration Notes on 3/21/25 at 12:30 AM, 2:29 AM, 4:30 AM, and 3/22/25 at 6:30 AM.<br><br>Administration Notes revealed the following for Resident 18 and Ciprofloxacin:<br><br>-3/21/25 at 1:52 AM: Resident was asleep, refused.<br><br>-3/21/25 at 3:30 AM: Resident was asleep.<br><br>-3/21/25 at 4:17 AM: Resident was asleep.<br><br>-3/22/25 at 6:46 AM: Resident was asleep.<br><br>On 3/28/25 at 8:17 AM, Staff 10 (LPN) stated she was instructed not to wake Resident 18 to instill her/his eye drops as she/he became agitated. Staff 10 did not think the physician was notified.<br><br>On 3/28/25 at 11:50 AM, Staff 1 (Administrator), Staff 7 (DNS), and Staff 49 (Regional Nurse Consultant) confirmed staff should have contacted the physician regarding instructions for when Resident 18 was asleep and did not receive her/his eye drop.<br><br>2. Resident 19 was admitted to the facility in 7/2024 with diagnoses including dementia and depression.<br><br>A review of the signed physician orders dated 1/31/25 instructed staff to administer Rexuliti (used to treat schizophrenia, and as an add-on treatment for major depressive disorder) in the morning for depressive disorder, with a start date of 1/2/25.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 3/2025 MAR instructed staff to administer Rexuliti in the morning for depressive disorder, with a start date of 1/2/25. On 3/6/25, 3/7/25, 3/8/25, and 3/9/25 the MAR referred the reader to Administration Notes.<br><br>Administration Notes revealed the following for Rexuliti:<br><br>-3/6/25 was not administered as the medication needed to be ordered from the pharmacy.<br><br>-3/7/25 waiting for delivery of the medication.<br><br>-3/8/25 medication was not in stock; the nurse was notified.<br><br>-3/9/25 medication was not in stock, ordered from the pharmacy.<br><br>On 3/28/25 at 8:06 AM Staff 8 (LPN) stated Resident 19's Rexuliti did not arrive at the facility from the pharmacy. Staff 8 stated she did not remember if she called the pharmacy on 3/6/24 when she documented Rexuliti needed to be ordered from the pharmacy.<br><br>On 3/28/25 at 11:44 AM Staff 1 (Administrator), Staff 7 (DNS), and Staff 49 (Regional Nurse Consultant) stated if a medication was not available, the expectation would be for staff to notify the physician to obtain instructions. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>35855<br><br>Based on interview and record review it was determined the facility failed to ensure a resident's environment remained free from accident hazards for 1 of 1 sampled resident (#19) reviewed for falls. This placed residents at risk for accidents. Findings include:<br><br>Resident 19 was admitted to the facility in 7/2024 with diagnoses including dementia and disc degeneration (condition when the discs between the vertebrae in the spine wear down).<br><br>A 7/26/24 admission MDS revealed Resident 19 sustained a fall in the last two to six months.<br><br>A Care Plan Report revealed on 7/29/24 Resident 19 required the assistance of one person for toileting. Resident 19 had a history of falls and impaired safety awareness. Interventions included to review information on past falls and attempt to determine the cause of the falls. Record possible root causes and alter and remove any potential causes.<br><br>A 9/29/24 Unwitnessed Fall investigation revealed on 9/29/24 at 11:27 AM Resident 19 sustained a fall in the bathroom. The CNA reported Resident 19's call light was activated and the CNA found Resident 19 on the floor in the bathroom. The investigation determined it was an isolated incident, and the care plan was not revised.<br><br>A 11/11/24 Unwitnessed Fall investigation revealed on 11/11/24 at 4:28 PM Resident 19 was found on the floor in her/his bathroom by the CNA. The CNA reported she took Resident 19 to the bathroom, assisted her/him onto the toilet, and gave her/him the call light. The CNA heard the toilet flush and entered the bathroom and found Resident 19 on the floor. It was determined Resident 19's care plan needed to reflect she/he should not be left unattended while in the bathroom.<br><br>A Care Plan Report revealed on 12/5/24 Resident 19 required assistance of one staff member for toileting and was not to be left unattended while on the toilet.<br><br>A 12/31/24 Unwitnessed Fall investigation revealed on 12/31/24 at 6:30 AM Resident 19 was found on the floor in the bathroom. Staff 30 assisted Resident 19 on to the toilet in the bathroom and pulled the curtain for privacy. Staff 37 (CNA) and Staff 30 (CNA) were in the resident's room at the time of the fall. Staff 30 and 37 heard Resident 19 fall in the bathroom and responded.<br><br>On 3/24/25 at 12:24 PM Witness 1 (Family Member) stated Resident 19 sustained three falls. Witness 1 stated staff would assist Resident 19 to the toilet and leave her/him unattended.<br><br>On 3/27/25 at 9:24 AM Staff 37 stated on 12/31/24 she was working with Resident 19's roommate when Resident 19 fell . Staff 37 stated when a care plan instructed staff not to leave a resident unattended she understood unattended as staff should not leave a resident where they could not be seen.<br><br>On 3/28/25 at 7:51 AM Staff 30 stated she was straightening Resident 19's bed when Resident 19 fell in the bathroom on 12/31/24. Staff 30 stated she should not have left Resident 19 alone in the bathroom because Resident 19 was care planned not to be left unattended.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/28/25 at 11:44 AM Staff 1 (Administrator), Staff 7 (DNS), and Staff 49 (Regional Nurse Consultant) stated the expectation was for staff to follow Resident 19's care plan. |