STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Cen	1166 E. 28th Avenue Eugene, OR 97403

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 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 observation, interview, and record review it was determined the facility failed to ensure residents were assessed to self-administer medications for 2 of 2 sampled residents (#s 13 and 47) reviewed for pain and dialysis (process to remove fluids and waste from the blood when kidney function fails). This placed residents at risk for an ineffective medication regimen. Findings include: 1. Resident 13 was admitted to the facility in 2022 with a diagnosis of kidney disease. A 2/16/24 Progress Note by Staff 16 (RD) revealed she spoke to the RD at the dialysis center for Resident 13. The note indicated Staff 16 would communicate with the resident's unit manager and see if the resident was appropriate to self-administer a phosphorous binder (medication to lower the mineral phosphate in the blood). Staff 16 also communicated with the unit manager on ensuring staff administered Resident 13's phosphorous binder with meals and not before or after meals. A 3/3/24 quarterly MDS revealed Resident 13 was cognitively intact. On 3/21/24 at 2:35 PM Resident 13 stated she/he was capable and wanted like to self-administer her/his phosphorous binder, but staff did not speak to her/him about the process. Resident 13 stated staff usually brought in the binder after meals and not with meals. On 3/21/24 at 2:38 PM Staff 16 stated she spoke to the RD at the dialysis center for Resident 13 on a regular basis. Approximately one month prior, Staff 16 stated she spoke to Staff 15 (LPN Unit Manager) to see if staff would assess Resident 13 for self-administration of the phosphorous binder. On 3/21/24 at 2:50 PM Staff 15 stated she did not assess Resident 13 for self-administration of her/his medication. 2. Resident 47 was admitted to the facility in 2023 with a diagnosis of diabetes. A 12/19/23 quarterly MDS revealed Resident 47 was cognitively intact. On 3/18/24 at 1:18 PM one tube of medicated cream for external use was observed on Resident 47's bedside table. Resident 47 stated she/he applied the cream PRN. Review of Resident 47's clinical record revealed no self-administration assessment for the cream. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 11:26 AM Staff 47 (LPN) stated a resident was to be assessed prior to a resident being able to self-administer medications. Staff 47 stated the resident also had to have an order for the self-administration, a care plan, and the medication needed stored in a secure manner. Staff 47 stated the resident did not have an assessment in her/his clinical record.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41455 Based on observation, interview, and record review it was determined the facility failed to address resident choice for 5 of 22 sampled residents (#s 2, 18, 30, 35, and 38) reviewed for dining. This placed residents at risk for lack of choice and meal satisfaction. Findings include: On 3/18/24 at 10:45 AM and 11:51 AM posted daily menus were observed in the facility on the first and second floors and no weekly menus were found. On 3/18/24 at 11:41 AM Resident 35 stated she/he normally ate in her/his room and she/he no longer had choices available regarding her/his meal selections because the option was taken away. On 3/18/24 at 12:23 PM Resident 30 stated both snack and meal choices were changed, were inadequate, and she/he planned to discuss these concerns with Staff 1 (Administrator). On 3/18/24 at 12:48 PM Resident 2 stated the facility implemented a new system and the daily choice to receive one of two meal options was no longer available. Resident 2 stated she/he was aware the kitchen required a three hour notice for menu changes but the only available menu was posted in the hall and difficult to access for residents who did not get out of bed. On 3/18/24 at 1:27 PM Resident 38 indicated she/he was new to the facility, had no choices related to her/his daily meal options, and wanted an alternative to the hot dog that was provided for dinner. On 3/19/24 at 9:21 AM Resident 18 stated staff no longer discussed the daily menu with her/him, menu choices were no longer available and she/he never knew what was on the menu until it arrived. On 3/19/24 at 1:39 PM Staff 46 (LPN) was unaware of what menu for residents was accurate since not every resident room had menu information. Staff 46 stated residents constantly voiced concerns that menu choices were removed and they were not involved. On 3/21/24 at 2:35 PM Staff 31 (Dietary Manager) and Staff 16 (RD) acknowledged there were no printed menus for residents and the lack of access to menus made it difficult for residents to understand their menu choices. On 3/22/24 at 10:55 AM Staff 1 and Staff 39 (Northern Regional Director of Operations) stated there was no menu information in new admissions packets and acknowledged resident menus were to be printed, distributed and placed in every resident room.

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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. 41455 Based on interview and record review it was determined the facility failed to respond timely to resident concerns related to dining for 1 of 1 Resident Council reviewed for dining. This placed residents at risk for unresolved dining issues. Finding include: The 11/2023 Council Minutes indicated: -Residents had concerns that the always available menus were not current in residents' rooms on the first floor. The facility responded that the menus would be updated. -Residents asked what day the weekly menu would be available each week. The facility responded on Wednesday for the next week. The 1/2024 Council Minutes indicated no old business was reviewed. The 2/2024 Council Minutes indicated residents with dietary concerns were to attend the Dining Committee and no old business was reviewed. The 3/13/24 Council Minutes indicated residents requested weekly menus so residents could make menu choices. The facility responded they could send out a week at a glance menu to residents. On 3/21/24 at 2:35 PM Staff 31 (Dietary Manager) and Staff 16 (RD) acknowledged printed menus for residents were not available due to other priorities in dining. On 3/22/24 at 10:55 AM Staff 1 (Administrator) and Staff 37 (Regional Director of Social Services and Activities) acknowledged residents' concerns raised in Resident Council and Dining Committee meetings should be addressed during the next meetings the following month respectively.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 49676 Based on interview it was determined the facility failed to have a system in place to deliver mail on Saturdays for 1 of 1 facility reviewed for Resident Council. This placed residents at risk for lack of timely written communications. Findings include: On 3/19/24 at 3:05 PM during a Resident Council meeting Resident 23 stated for a long time residents did not receive mail on Saturdays. On 3/21/24 at 12:04 PM, Staff 40 (Activity Director) stated when the facility had an activity assistant mail was delivered on Saturdays. The facility currently did not have anyone in that position. For approximately the last month mail was not delivered on Saturdays.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49676 Based on observation and interview it was determined the facility failed to ensure past survey results were readily available for 1 of 1 facility reviewed for survey results. This placed residents and visitors at risk for not being informed of the facility's survey results. Findings include: On 3/19/24 at 3:05 PM during the resident council interview residents stated they did not know where the past survey results were kept and they thought it was at the nurses' station. On 3/21/24 at 10:23 AM the past survey results were observed in a clear wall mounted bin that was labeled Requests, concerns, and suggestions. In the front of the survey binder, obscuring it from view, was information regarding following rules for visits, grievance forms, and other unrelated facility forms. On 3/21/24 at 10:25 AM Staff 1 (Administrator) confirmed the above noted location was where the facility normally kept the survey results.

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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 residents' representatives regarding changes in status or condition for 3 of 9 sampled residents (#s 19, 41, and 220) reviewed for notification failure and medications. This placed residents and responsible parties at risk for delayed notification. Findings include: 1. Resident 41 was admitted to the facility in 2022 with a diagnosis including respiratory failure. A 9/14/23 at 4:10 PM Nursing Note indicated Witness 3 (Family Member-emergency contact) called to check status of Resident 41 and no one informed her Resident 41 had COVID-19. A 9/14/23 at 6:24 PM Nursing Note indicated Staff 14 (Former DNS) called Witness 3 regarding communication complaints. Staff 14 apologized for poor communication and provided an update on Resident 41's status. On 3/21/24 at 12:13 PM Staff 13 (Social Services) stated the nurse was to notify the family member when a resident obtained COVID-19. Staff 13 stated she only sent out general notifications of COVID-19 in the building. On 3/19/24 at 8:59 AM Witness 3 stated she was not notified Resident 41 tested positive for COVID-19 on 9/11/23, but she was notified on 9/14/23 after she called to check on Resident 41's status. In an interview on 3/22/24 at 10:31 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) stated it was the resident's preference if a family was notified if the resident was their own representative. No documentation was found in Resident 41's clinical record to indicate she/he did not want Witness 3 to be notified of a change in condition. 2. Resident 220 was admitted to the facility in 2023 with diagnosis including brain damage. A 5/16/23 Investigation Report revealed on the evening of 5/16/23 Resident 220 had two episodes of wandering on facility property. A 5/18/23 Nursing Note revealed Staff 14 (Former DNS) spoke to Resident 220 and Witness 1 (Family Member) regarding Resident 220 exit seeking on 5/16/23. Witness 1 was upset that she was not notified Resident 220 left the facility unattended. Staff 14 apologized and assured education would be provided to staff. On 3/19/24 at 7:59 AM Witness 1 (Family Member) confirmed she was not notified of Resident 220's elopement and she spoke to Staff 14 about her concerns. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/24 at 8:34 AM Staff 14 confirmed the nurse did not notify Witness 1 of Resident 220's elopement. In an interview on 3/22/24 at 10:19 AM with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations), Staff 1 stated it was recommended to attempt to reach a resident's representative the day an elopement occurred. Refer to F689 36494 3. Resident 19 was admitted to the facility in 1/2020 with diagnoses including diabetes. A review of Resident 19's Physician Orders dated 10/2/22 revealed blood sugar levels were to be checked before meals and at bedtime. Staff were to call the provider for results above 300. A review of Resident 19's 2/2024 and 3/2024 Diabetic Administration Records revealed the following: -2/2024 there were 29 instances when Resident 19's blood sugar level exceeded 300. -3/2024 there were six instances when Resident 19's blood sugar level exceeded 300. A review of Resident 19's medical record revealed there was no indication the physician was notified of the resident's high blood sugars. On 3/20/24 at 6:36 PM Staff 34 (Agency LPN) stated she checked the resident's blood sugar levels and the results exceeded 300 at times. Staff 34 stated staff were expected to notify the physician when the resident's blood sugar level was outside the physician parameters. On 3/21/24 at 2:22 PM Staff 15 (LPN Unit Manager) and Staff 26 (Staff Development Coordinator RN) stated staff were expected to follow physician order parameters for monitoring blood sugar levels, including notifying the physician if Resident 19's blood sugar level exceeded 300 and documenting the notification in the resident's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 36494 Based on observation and interview it was determined the facility failed to ensure rooms were homelike and in good repair for 2 of 10 sampled residents (#s 2 and 7) reviewed for environment. This placed residents at risk for lack of a homelike environment and disrepair. Findings include: Random observations from 3/18/24 through 3/21/24 revealed the following: -The footboard of Resident 7's bed was damaged. It was mended with electrical tape encircling its entire vertical width. Additionally, the fractured segment was angled away from the mattress, failing to align seamlessly with the bed. -A wall in Resident 2's room had multiple large gouges that exposed the underlying drywall, along with numerous black vertical streaks extending approximately four feet in width and four feet in length. On 3/18/24 at 12:57 PM Resident 2 stated the black marks and exposed drywall were present for approximately six to seven months back to when she/he moved rooms. On 3/21/24 at 11:43 AM Staff 42 (Maintenance Director) stated he was aware Resident 7's footboard was broken for roughly two weeks, but did not order a replacement for the damaged piece. Staff 42 entered Resident 2's room with the surveyor. Staff 42 was unaware of the gouges and marks on the resident's wall.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 26991 Based on interview and record review it was determined the facility failed to ensure a resident's missing items were addressed timely for 1 of 2 sampled residents (#22) reviewed for personal property. This placed residents at risk for loss of meaningful items. Findings include: Resident 22 admitted to the facility in 2024 with a diagnosis of heart disease. On 3/18/24 at 12:38 PM Witness 8 (Family Member) stated approximately one month prior, in 2/2024, he reported to the laundry staff Resident 22's favorite shirt was missing and approximately two weeks ago the resident's new blanket went missing. Witness 8 indicated the staff stated they would look for the items but after he reported the missing items no resolution was provided. On 3/19/24 at 13:35 PM Staff 38 (Regional Director of Clinical) stated there were no missing item forms filled out for Resident 22. On 3/20/24 at 9:32 AM Staff 3 (Laundry Manager) stated a hand-written note was provided to the laundry staff indicating the resident lost a blanket. Staff looked for the item, but did not yet find it. The item did not have the resident's name on it. A grievance form was not filled out and Staff 3 was no longer able to locate the note. On 3/20/24 at 10:10 AM Staff 39 (Northern Regional Director of Operations) stated if a resident reported a missing item it should be documented on a form and staff should provide a response to the resident or responsible party within seven days.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 35855 Based on observation, interview, and record review it was determined the facility failed to monitor and assess the continued use of a physical restraint for 1 of 4 sampled residents (#4) reviewed for accidents. This placed residents at risk for potential abuse or neglect. Findings include: Resident 4 was admitted to the facility in 2022 with diagnoses including muscle wasting and atrophy (shrinkage of muscles or nerve tissues). An 8/14/23 revised care plan indicated Resident 4 was an elopement risk due to dementia and wandering behavior. Interventions included distract Resident 4 from wandering and ensure a Wander Guard placed to the right wrist was working by testing the device every Thursday. A 3/2024 Documentation Survey Report indicated to verify placement of the Wander Guard on the right wrist every shift for elopement prevention. From 3/1/24 through 3/5/24 out of 15 opportunities there was no documentation the device was verified for placement four times. No documentation was found to indicate the device placement was verified from 3/13/24 through 3/22/24. A 3/2024 TAR instructed staff to test the Wander Guard weekly on Thursdays. The order was discontinued on 3/11/24. A 3/15/24 Hospice Facility Visit Note indicated Resident 4 appeared fragile and was at risk for a rapid decline. On 3/18/24 at 2:46 PM Resident 4 was in bed with a Wander Guard placed on her/his right wrist. A 3/20/24 Nursing Note indicated Resident 4 no longer attempted to elope and requested orders to discontinue the Wander Guard. On 3/21/24 at 11:35 AM Staff 15 (LPN Unit Manager) stated Resident 4 was not a wander risk. On 3/22/24 at 6:47 AM Resident 4 was in the downstairs dining room with the Wander Guard in place to right wrist. The alarm to front door triggered and a staff member stated it was Resident 4's Wander Guard causing the alarm to go off as he attempted to take Resident 4 out of the facility for an appointment.

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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 an elopement event to the State Survey Agency within 24 hours of the incident for 1 of 4 sampled residents (#220) reviewed for accidents. This placed residents at risk for accidents. Findings include: Resident 220 was admitted to the facility in 2023 with diagnosis including brain damage. A 5/16/23 Investigation Report revealed on the evening of 5/16/23 Resident 220 had two episodes of wandering on facility property. A FRI form dated 5/18/23 indicated on 5/16/23 Resident 220 walked outside to the facility smoking area without informing staff of her/his intended whereabouts. The FRI was received at the State agency via email on 5/19/23 at 12:24 AM. In an interview on 3/22/24 at 10:20 AM with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations), Staff 1 confirmed the incident was not reported to the State Agency in a timely manner.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 26991 Based on interview and record review it was determined the facility failed conduct a Significant Change MDS assessment within the required timeframe for 1 of 1 sampled resident (#22) reviewed for hospice. This placed residents at risk for unassessed needs. Findings include: Resident 22 was admitted to the facility 2024 with a diagnosis including heart disease. A 2/3/24 signed hospice narrative revealed the resident was approved and certified for hospice services by the physician on 2/3/24. Review of Resident 22's clinical record revealed a significant change MDS was not completed within 14 days after the resident was admitted to hospice. On 3/20/24 at 12:54 PM Staff 11 (MDS Coordinator) acknowledged she did not do the significant change MDS after the resident was admitted to hospice. Refer to F849.

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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. 26991 Based on interview and record review it was determined the facility failed to ensure a care plan was revised for 3 of 3 sampled residents (#s 13, 22, and 47) reviewed for dialysis, hospice and pain. This placed residents at risk for increased injury and pain. Findings include: 1. Resident 13 admitted to the facility in 2022 with a diagnosis including kidney failure. A Progress note dated 1/12/24 revealed Resident 13's dialysis (process to remove fluids and wastes from the blood when the kidneys stop functioning) start times were to change on 1/29/24. On Mondays, Wednesdays, and Fridays Resident 13 was to be at the dialysis center at 7:40 AM and dialysis was to start at 8:00 AM. A Care Plan revised on 9/12/23 revealed Resident 13 had dialysis on Monday, Wednesday, and Friday and she/he was picked up between 8:00 AM and 8:10 AM. A 3/3/24 quarterly MDS revealed Resident 13 was cognitively intact. On 3/18/24 at 2:52 PM Resident 13 stated on dialysis days she/he needed to leave the facility by 7:00 AM. On 3/21/24 at 2:50 PM Staff 15 (LPN Unit Manager) acknowledged the care plan was not updated when the dialysis times changed. Refer to F698 2. Resident 22 admitted to the facility in 2024 with a diagnosis including heart disease. A 2/3/24 signed hospice narrative revealed the resident was approved and certified for hospice services by the physician on 2/3/24. Resident 22's care plan last updated on 2/12/24 revealed the following: -Resident 22 was independent to eat. -Hospice would address the resident's advance directive status. -There was no revision of the care plan related to admission to hospice including the name of the agency. -The discharge plan was to be determined. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 2/22/24 Care Plan Conference form revealed hospice attended the conference. It was determined hospice was to review the resident's advance directive status with the resident and staff were to assist the resident with meals and transfers and not family. The form also indicated the resident was to remain at the facility for care. A 2/22/24 hospice note indicated staff were to notify hospice if Resident 22 had pain, anxiety, or agitation. Staff were also to call hospice if the resident fell . The resident's care plan was not updated to reflect hospice notification, staff only to assist the resident with cares, and the resident's plan to continue to reside in the facility. On 3/19/24 at 12:38 PM Staff 43 (CNA) stated Resident 22 had a private aide and family who assisted the resident to eat. On 3/20/24 at 9:26 AM Staff 13 (Social Services) stated she did not communicate with hospice in order to update the care plan related to advance directive information. On 3/20/24 at 1:05 PM Staff 11 (MDS Coordinator) stated if she did not attend the care conference staff were to notify her of changes which were needed to update the care plan. Staff 11 stated she was not aware of the care conference recommended changes. Refer to F849. 3. Resident 47 admitted to the facility in 2023 with diagnoses including diabetes. A 12/19/23 quarterly MDS revealed Resident 47 was cognitively intact. Progress notes revealed the following: -12/24/23 Resident 47 reported increased pain due to hemorrhoids. -1/5/24 refused cream for hemorrhoid pain due to burning. -1/31/24 Resident 47 reported rectal pain, the resident was assessed, and cream applied. -2/1/24 a new order for hemorrhoids was obtained. -2/2/24 an unscheduled provider visit occurred due to Resident 47's report of increased pain from hemorrhoids. On 3/18/24 at 1:18 PM Resident 47 stated she/he had pain for months related to hemorrhoids. Resident 47's current care plan was not revised to include pain related to hemorrhoids. On 3/20/24 at 1:05 PM Staff 11 (MDS Coordinator) stated if she was not made aware of changes she could not update the care plans. Staff 11 acknowledged Resident 47 had pain related to hemorrhoids since 12/2023 and the care plan was not updated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Cen	1166 E. 28th Avenue Eugene, OR 97403

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F697

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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 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. **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 dependent residents received required assistance with ADLs for 3 of 9 sampled residents (#s 4, 35, and 41) reviewed for ADLs and accidents. This placed resident at risk for unmet needs. Findings include: 1. Resident 4 was admitted to the facility in 2022 with diagnoses including muscle wasting and atrophy (shrinkage of muscles or nerve tissues.) A 2/23/23 care plan indicated Resident 4 required extensive assist of one staff with bathing. A 3/2024 Documentation Survey Report (DSR) revealed no documentation Resident 4 received any type of bathing from 3/1/24 through 3/6/24. Resident 41 was admitted to the hospital on 3/6/24 and readmitted to the facility on [DATE]. The DSR revealed no documentation Resident 4 received any type of bathing from 3/13/24 through 3/20/24. On 3/20/24 at 11:27 AM Staff 12 (CNA) stated she did not always have time to complete all assigned cares for residents and at times had to prioritize taking residents' vitals over completing showers. In an interview on 3/22/24 at 10:33 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) stated Staff 2 was new and was currently going through all of the facility systems. Staff 2 stated continued education was needed. 2. Resident 41 was admitted in 2022 with diagnosis which included stroke. A 7/9/23 Annual MDS indicated Resident 41's BIMS was a 15 which indicated she/he was cognitively intact. Resident 41 required one-person staff assistance with bathing. An 10/18/23 care plan indicated Resident 41 required partial to moderate assistance for bathing and preferred her/his bathing days on Monday and Thursday. On 3/18/24 at 1:15 PM Resident 41 was observed with oily hair and white flakes on her/his shirt. Resident 41 stated it was over a week since she/he was bathed. A review of the 3/2023 Documentation Survey Report revealed Resident 41's last bathing occurred on 3/11/24. No documentation was found in Resident 41's clinical record she/he was offered bathing from 3/12/24 through 3/21/24 (nine days). On 3/20/24 at 11:27 AM Staff 12 (CNA) stated she did not always have time to complete all assigned cares for residents and at times had to prioritize taking residents' vitals over completing showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/22/24 at 10:33 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) stated Staff 2 was new and was currently going through all of the facility systems. Staff 2 stated continued education was needed. 26991 3. Resident 35 was admitted to the facility in 2021 with diagnoses including stroke. A care plan revised 1/2024 revealed Resident 35 required extensive assistance of two staff for bathing and dressing and needed supervision/touching assistance with personal hygiene. a. On 3/19/24 at 1:34 PM Witness 9 (Friend) stated Resident 35's nails were often long and dirty and staff did not assist the resident. Witness 9 stated two weeks prior he cut the resident's nails. On 3/19/24 at 2:46 PM with Staff 44 (LPN) Resident 35 was observed to have long fingernails with brown debris underneath the free edges. Staff 44 acknowledged the resident's nails were long, dirty, and needed to be trimmed. Staff 44 stated the resident's nails had to be trimmed by a nurse because the resident was on blood thinning medication. Staff 44 also stated the nurses did not have Resident 35's nail care on the TAR but the CNAs were to notify the nurses when the resident's nails were long. b. Review of Resident 35's 9/2023 showers revealed the resident had nine opportunities for showers. Resident 35 received a shower or bath on 9/9/23, 9/16/23, and 9/19/23. It was documented the resident refused a shower on 9/26/23. Progress notes did not have documentation related to Resident 35's 9/26/23 shower refusal. Review of Resident 35's 3/2024 showers revealed Resident 35 had six opportunities for showers and received a shower or bath on 3/5/24 and 3/9/24. Resident 35 was documented to refuse a shower on 3/12/24. Progress Notes did not have documentation related to Resident 35's 3/12/24 shower refusal. On 3/21/24 at 3:14 PM Staff 15 (LPN Unit Manager) stated if a resident refused a shower the nurse was to communicate with the resident and document in the progress notes. The CNAs were to attempt multiple times, and offer a bed bath or a shower the next day. A request was made of Staff 15 to provide documentation the resident was provided more than three showers in 9/2023 and more than two showers in 3/2024. No additional information was provided.

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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. 35855 Based on interview and record review it was determined the facility failed to provide care and treatment as care planned, follow physician orders for blood sugar parameters, and provide bowel care for 3 of 9 residents (#s 4, 35 and 41) reviewed for accidents, and medications. This placed residents at risk for delayed treatment, constipation, and risk for adverse side effects. Findings include: 1. Resident 4 was admitted to the facility in 2022 with diagnoses including muscle wasting and atrophy (shrinkage of muscles or nerve tissues). A 7/10/23 revised care plan indicated Resident 4 had an ADL self-care performance deficit due to weakness and she/he used a soft pad call light to call for assistance. On 3/19/24 at 8:25 AM and 3/21/24 at 7:55 AM Resident 4 was in bed with a regular call light button next to him/her in bed. On 3/20/24 at 10:35 AM Staff 11 (MDS Coordinator) stated she did not know why Resident 4's call light was a regular call light and not a soft pad call light. Staff 11 stated she/he was care planned for a soft pad call light. On 3/20/24 at 11:27 AM Staff 12 (Agency CNA) stated Resident 4 would benefit from having a soft pad call light. 2. Resident 41 was admitted to the facility in 2022 with diagnosis which included dysphagia (a condition with difficulty in swallowing food or liquid). A 9/2023 comprehensive care plan indicated Special Instructions; medications whole in applesauce or pudding one at a time. A 9/10/23 Nursing Note indicated Resident 41 had a significant coughing episode when administered her/his medications without pudding. On 3/20/24 at 10:20 AM Staff 11 (MDS Coordinator) stated she was in the room when the nurse administered Resident 41's medication without applesauce or pudding and she/he started coughing. In an interview on 3/22/24 at 10:31 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) stated it was the expectation of staff to review the care plan for any special instructions. 26991 3. Resident 35 was admitted to the facility in 2021 with diagnosis of a stroke. A 9/2023 bowel record revealed Resident 35 did not have a bowel movement from 9/2/23 through 9/9/23 and from 9/20/23 through 9/28/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/2023 MAR and TAR revealed Resident 35 was administered a suppository for constipation on 9/6/23 but the results were unknown. No additional bowel care was provided. Progress notes revealed the following: -9/6/23 Resident 35 reported constipation and the nurse was notified. There was no assessment of the resident's abdomen. -9/9/23 the resident did not have a bowel movement for 21 shifts. The resident's abdomen was firm with bowel tones. The resident denied pain. The note indicated a request was made to the physician for an enema. -9/20/23 Resident 35 had a bloody bowel movement and the physician was notified. -9/21/23 and 9/22/23 the resident did not have a bloody bowel movement or abdominal pain. -9/29/23 Resident 35 did not have a bowel movement since 9/20/23. The resident had sluggish bowel tones (decreased bowel motility), denied pain and refused a suppository. On 3/20/24 at 11:59 AM Staff 15 (LPN Unit Manager) acknowledged the resident had multiple days without a bowel movement. A request was made of Staff 15 to provide documentation if bowel care was provided or the resident had additional bowel movements. No additional information was provided. On 3/20/24 at 8:46 PM Staff 45 (LPN) stated if a resident did not have a bowel movement for six shifts bowel care was to be initiated. The bowel care started with oral medications, then progressed to a suppository, then the last step was to administer an enema. If the resident did not have a bowel movement for nine shifts the physician was to be notified.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41455 Based on observation, interview, and record review it was determined the facility failed to provide splints to reduce contractures (a permanent tightening of muscles, and tendons) for 1 of 1 sampled resident (#18) reviewed for position and mobility. This placed residents at risk for compromised mobility and pain. Findings include: Resident 18 was admitted to the facility in 2019 with diagnoses including contractures of the left and right elbows. An 8/1/23 revised care plan indicated Resident 18 was to receive elbow braces to her/his right and left elbows during the day for six hours. A 2/28/24 quarterly MDS revealed no splint or brace was provided to Resident 18 during a seven-day review period. The Kardex (care plan for CNAs) reviewed on 3/20/24 had no reference to Resident 18's elbow braces. On 3/19/24 at 9:44 AM Resident 18 was observed in her/his bed with no braces applied to her/his right and left elbows. Resident 18 stated her/his elbow braces were offered inconsistently and last applied three days prior. Resident 18 stated staff did not know how to correctly apply her/his elbow braces and she/he felt less painful when her/his elbows braces were in place. On 3/20/24 at 8:06 AM Staff 29 (CNA) stated she worked with Resident 18 routinely over the last two months and was not aware of the resident's need for elbow braces until 3/19/24. On 3/21/24 at 12:27 PM Staff 28 (LPN-Unit Manager) acknowledged Resident 18's left and right elbow braces were not consistently placed and needed to be in the Kardex so CNAs were aware.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review it was determined the facility failed to provide care and treatment to prevent accidents for 4 of 10 sampled residents (#s 4, 22, 35, and 220) reviewed for accidents, hospice, ADLs and medications. This placed residents at risk for injury. Findings include: 1. Resident 4 was admitted to the facility in 2022 with diagnoses including dysphagia (a condition with difficulty in swallowing food or liquid). The most recent comprehensive care plan for Resident 4 revealed the following: -Interventions for nutrition: supervision and set up assistance for eating, needs to be UP in wheelchair for all meals, cue to take small sips between bites, mug with handle, lid and straw as needed. -Swallowing problem with coughing or choking during meals, order for thickened liquids. Interventions: small bites and sips, use teaspoon for eating, Do not use straws. Eat in upright position, eat slowly, chew each bite thoroughly, Supervision/frequent checks with meals. Resident 4 ate in the dining room. A 3/11/24 hospital Speech Language Pathology Brief Note indicated Resident 4 choked and coughed with her/his lunch. Resident 4's diet was changed to puree. A 3/2024 Documentation Survey Report indicated to monitor Resident 4 and document any signs of aspiration including fever, coughing when eating or drinking, difficulty eating, gagging, drooling, regurgitating food or drink, abnormal breath sounds, and impaired voice. Documentation was completed from 3/1/24 through 3/5/24. Documentation was not restarted after Resident 4 readmitted to the facility on [DATE]. On 3/19/24 the following was observed: -8:20 AM a staff member brought in Resident 4's breakfast tray, then left the room and continued to deliver trays. -8:25 AM Resident 4 was in her/his room eating with a teaspoon. Resident 4 had one cup with a handle and one cup with no handle with a plastic lid still on the cup. No staff were observed in Resident 4's room. Resident 4 could not be seen from the hallway. -8:40 AM Resident 4 attempted to remove a plastic lid off the cup with no handle with a spoon. Staff 12 (Agency CNA) was requested to go into Resident 4's room and assist (20 minutes with no supervision). On 3/20/24 at 11:27 AM Staff 12 (Agency CNA) stated she was told the care plan was not updated and she did not check Resident 4's care plan to see if she/he needed to be supervised during meals. Staff 12 stated she trusted the verbal report from staff and should have checked the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/24 at 11:35 AM Staff 15 (LPN Unit Manager) confirmed after Resident 4 readmitted with unclear physician orders. The orders should be clarified with the physician. Staff 15 stated Resident 4 was discussed the morning of 3/21/24 for speech and language therapy. 2. Resident 220 was admitted to the facility in 2023 with diagnoses including brain damage. A 5/16/23 admission MDS revealed Resident 220's BIMS was seven indicating severe cognitive impairment. A 5/16/23 Investigation Report revealed on the evening of 5/16/23. The first incident was witnessed by staff and the second was unwitnessed. At approximately 7:40 PM Resident 220 reported to Staff 10 (LPN) she/he wanted to go outside and walk. Staff 10 indicated to Resident 220 she/he could not go out alone but could sit out on the back patio for fresh air. Staff 6 (Agency CNA) was out on the back patio eating her lunch and witnessed Resident 220 walk toward the west side of the building. Staff 9 (OT) was in the therapy office and witnessed Resident 220 unchaining the chain to the wheelchair ramp and walk through. Resident 220 was brought back into the building. Approximately 30 minutes later Staff 10 checked on Resident 220, and she/he had her/his eyes closed in her/his recliner in her/his room. At around 9:15 PM the on-duty LPN on the second floor called down and reported Resident 220 was found in the upstairs smoking area. Resident 220 was sitting in the outside smoking area. Conclusion of the investigation was Resident 220 eloped from the facility but remained on the facility grounds. The facility gathered estimates on a more secure gate for the back patio which would prevent resident elopement in the future. A 5/18/23 Nursing Note indicated Resident 220 asked if she/he could take a walk outside after 7:30 PM. Staff 10 indicated there was a patio where Resident 220 could sit down, but could not allow her/him to walk in front of the facility. Two to five minutes later therapy staff came out of the therapy gym and stated Resident 220 had unlatched the chain which led to the back of the facility. Staff 10 led Resident 220 back to the patio and explained to the resident it was unsafe. Resident 220 was placed in her/his recliner in her/his room and was checked later and was found to be sleeping in her/his chair. 5/18/24 and 5/19/23 witness statements revealed the following occurred on 5/16/23: -Staff 17 (Admissions Coordinator) indicated on 5/16/23 at approximately 5:30 PM Resident 220 attempted to leave the building but did not leave because the door alarms sounded. Resident 220 returned to her/his room (this was not included in the investigation). -Staff 6 indicated between 7:05 PM and 7:35 PM she saw Resident 220 come outside unattended and walk past the therapy office. Later in the evening he asked for a key to get out of the back door of the first floor (this was not included in the investigation). -Staff 7 (CNA) stated between 9:00 PM and 9:15 PM she took the trash outside and saw Resident 220 sitting in a chair. Resident 220 asked to come inside the facility with Staff 7. -Security video tape revealed Resident 220 walked down to the smoking area from the sidewalk at 9:02 PM (this was not included in the investigation). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/21/24 at 8:15 AM revealed a sliding glass door adjacent to the downstairs dining room opened to a patio area with chairs and tables. Facing the back of the facility a concrete wheelchair ramp was observed to go up the hill on the right. A chain to the wheelchair ramps off the patio area was unlatched. The wheelchair ramp went in two directions. One continued up a hill to the left and ended at small dirt path which continued up the hill to a curb and pavement. The other wheelchair ramp went from the back of the building and turned to the side of the building and ended with an approximate two to three-foot drop into shrubbery. On 3/21/24 at 7:34 AM Staff 7 (CNA) stated the main garbage dumpster was off the second floor level and when she went to take the garbage out the evening of 5/16/23 Resident 220 was sitting in the smoking section. Resident 220 stated to her that she/he needed to sit as she/he had walked all the way around the building. On 3/21/24 at 9:34 AM Staff 17 confirmed the witness statement and stated it was correct. In an interview on 3/22/24 at 10:16 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) stated it was expected of staff to have a resident at risk for elopement within line of sight or have a wander guard device placed on the resident. Staff 1 stated the facility requested a bid for a gate off the back patio and they were currently waiting for a couple more contractors to provide bids. 26991 3. Resident 22 was admitted to the facility in 2024 with a diagnosis of heart failure. A 1/8/24 admission MDS and associated CAAs revealed Resident 22 was at risk for falls. Resident 22 had falls prior to admission to the facility, had decreased mobility, impaired memory, and visual deficits. Resident 22 was assessed to be incontinent and staff were to check on the resident at least every two hours. A care plan would be developed to prevent falls. A care plan initiated 1/2/24 revealed staff were to keep commonly used items within reach such as water, call light and the resident's phone. Staff were also to ensure the resident wore appropriate footwear (non-skid footwear or shoes) before transfers. a. A 1/27/24 Unwitnessed fall report revealed on 1/27/24 at 2:55 AM Resident 22 was found on the floor. The resident reported she/he was going to the bathroom. The investigation indicated the call light was activated prior to her/his fall. The investigation revealed the last time staff visualized the resident the resident was in bed with her/his eyes shut. The investigation failed to indicate when the resident was last visualized or how long the call light was activated. New interventions to be implemented were non-skid socks. On 3/20/24 at 11:56 AM Staff 26 (Staff Development Coordinator) acknowledged the investigation did not indicate how long the call light was on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/24 at 1:05 PM Staff 11 (MDS Coordinator) stated the investigation indicated new interventions included non-skid socks, but that was not a new intervention. Non-skid socks was an intervention implemented on 1/6/24, prior to the fall. No additional interventions were developed to prevent falls. b. A 2/17/24 Unwitnessed fall report revealed on 2/17/24 Resident 22 fell at 12:25 AM. The investigation revealed Resident 22 reached for her/his snack, which was not within reach, and fell . Resident 22 did not sustain an injury. On 3/20/24 at 11:55 AM Staff 15 (LPN Unit Manager) acknowledged the care plan was not followed when Resident 22 fell . 4. Resident 35 was admitted to the facility in 2021 with a diagnosis of a stroke. Review of an undated list of residents who smoked, provided by the facility on 3/18/24, did not include Resident 35. A 1/31/24 Smoking Screen indicated Resident 35 smoked two to five times a day. The resident had dexterity problems, had a history if hiding smoking materials, and a history of being noncompliant with the facility smoking policy. The resident was assessed to be able to light her/his own cigarette and was to be an unsupervised smoker. On 3/18/24 at 7:58 AM and 3/19/24 at 9:34 AM Resident 35 stated she/he smoked about three times a week, was an independent smoker and was not supervised. Resident 35 stated she/he kept her/his smoking materials in a locked box. On 3/21/24 at 9:24 AM Resident 35 was observed outside smoking with three other residents. The ground of the designated smoking area was cement and there were three designated receptacles for residents to dispose of the cigarettes. Locked boxes were observed to the right of the smoking area for residents' smoking materials. Resident 35 was not observed to have tremors or burn holes in her/his clothing. Resident 35 threw her/his cigarette in the drain grate in the ground. The drain was observed to have liquid in it. The resident did not use the designated receptacles to dispose her/his cigarettes. On 3/20/24 at 11:37 AM Staff 15 (LPN Unit Manager) stated Resident 35 occasionally smoked and usually went out with a community friend or a facility friend who lived a few rooms from the resident. Staff 15 reviewed the resident's 1/2024 smoking assessment and stated she did not perform the assessment. Staff 15 stated based on the resident's health status, which deteriorated, and the 1/2024 Smoking Assessment, the resident should be a supervised smoker due to her/his risk factors. On 3/21/24 at 2:20 PM Staff 1 (Administrator) and Staff 39 (Northern Regional Director of Operations) stated Resident 35's 1/31/24 Smoking Screen did not reflect a resident who should be independent and a new screening assessment was to be completed.

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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. 36494 Based on observation, interview, and record review it was determined the facility failed to provide catheter care for 1 of 3 sampled residents (#6) reviewed for catheter care. This placed residents at risk for increased infections. Findings include: Resident 6 admitted to the facility in 7/2022 with diagnoses including quadriplegia (paralysis of all four limbs) and dysfunction of the bladder. Review of Resident 6's care plan revised on 12/23/23 revealed the resident had a history of UTIs related to a chronic indwelling catheter. A suprapubic (situated above the pubis) catheter was placed on 11/1/23 due to a dysfunction of the bladder. Resident 6 had an 18 FR [French Foley], 8 cc [cubic centimeter] balloon. A 1/3/24 urology clinic note revealed Resident 6 had her/his suprapubic tube replaced with an 18 French Foley catheter and placed 8cc in the balloon. There was no concern with the suprapubic replacement. Resident 6 was to have a follow-up appointment in one week to exchange the suprapubic tube. A review of Resident 6's medical record from 1/4/24 through 3/17/24 revealed no follow-up urology appointment was made. On 3/18/24 in an Alert Note from Staff 26 (Staff Development Coordinator RN) the Nurse Practitioner asked when Resident 6's last suprapubic catheter change was completed. Staff 26 was unable to locate the information and placed a call to the urology clinic. On 3/20/24 at 10:15 AM Resident 6 was observed on a gurney at the nurses' station. Staff 46 (LPN) stated the resident was scheduled for a urology appointment to have her/his suprapubic catheter changed. A 3/20/24 Nursing Note by Staff 46 at 10:57 AM revealed Resident 6 returned from the urology appointment because it had been canceled and the suprapubic catheter changes can be done at facility, no need for [Resident 6] to go in. A 3/20/24 Order Administration note by Staff 46 at 6:58 PM revealed per urology clinic to change the suprapubic tube with 18 french Foley with 8 ml in balloon. Obtain ua [urinalysis] after changed tube and send to lab. Unable to change as appropriate size catheter not in stock. [Staff 2 (DNS)] aware and will work with supply to obtain. A 3/21/24 Alert Note revealed staff were awaiting supplies to be delivered to change Resident 6's suprapubic catheter and management was aware. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Cen	1166 E. 28th Avenue Eugene, OR 97403

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/24 at 2:09 PM Staff 15 (Unit Manager LPN) and Staff 26 (Staff Development Coordinator RN) acknowledged Resident 6 was not scheduled for a follow-up urology appointment after her/his 1/3/24 appointment, indicating the follow-up was overlooked. Staff 26 stated Resident 6 returned from the 3/20/24 appointment because the urology clinic informed the facility they could change the suprapubic catheter, but the facility lacked the correct supplies to perform the care and was waiting for the supplies.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

35855

Based on observation, interview, and record review the facility failed to maintain healthy parameters of nutritional status for 1 of 3 sampled residents (#4) reviewed for nutrition. This placed residents at risk for weight loss. Findings include:

Resident 4 admitted to the facility in 2022 with diagnosis including dysphagia (a condition with difficulty in swallowing food or liquid).

The most recent comprehensive care plan for Resident 4 revealed the following:

-Interventions for nutrition: supervision and set up assistance for eating, needs to be UP in wheelchair for all meals, cue to take small sips between bites, mug with handle, lid and straw as needed.

-Swallowing problem with coughing or choking during meals, order for thickened liquids. Interventions: small bites and sips, use teaspoon for eating, Do not use straws. Eat in upright position, eat slowly, chew each bite thoroughly, Supervision/frequent checks with meals.

-Nutritional problem physician order for unavoidable weigh loss was requested on 1/16/24 because of high supplementation and meal fortification. The RD was to evaluate and make diet change recommendations; the resident ate in the dining room. Provide nutritional supplements, offer fluids at bedside.

A 3/2024 MAR instructed staff to provide Resident 4 with Ensure Enlive (nutritional supplement) three times a day. From 3/1/24 through 3/6/24 the nutritional supplement was documented as refused one time. Ensure Enlive was discontinued on 3/11/24. The MAR also instructed staff to provide TwoCal (nutritional supplement) three times a day with meals. From 3/1/24 through 3/6/24 it was documented Resident 4 refused the nutritional supplement one time. TwoCal was discontinued on 3/11/24.

A 3/14/24 Nutritional Evaluation indicated Resident 4 weighed 116 pounds and her/his ideal body weight was 166 pounds. Resident 4 needed an altered texture diet and liquids with no adaptive equipment, she/he received a nutritional supplement three times a day, and supplement intakes were not applicable. Resident 4 was at nutrition risk because of the altered textured diet, low body mass index, limited food choices, dementia, and dysphagia. Goals were to maintain or improve nutritional status to increase acceptance of meals. Interventions included continuation of supplements, monitor intake and monitor weight.

On 3/19/24 the following was observed:

-8:20 AM a staff member brought in Resident 4's breakfast tray into her/his room and then left the room to continue delivering meal trays.

-8:25 AM Resident 4 was in her/his room eating with a teaspoon, Resident 4 ate in her/his room and had one cup with a handle and another cup with no handle with a plastic lid on the cup with no handle. No straws were observed. No staff were observed in Resident 4's room. Resident 4 could not be seen from the hallway.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8:40 AM Resident 4 attempted to remove the plastic lid with her/his spoon. Staff 12 (Agency CNA) was requested to go into Resident 4's room and assist (20 minutes with no supervision). On 3/20/24 at 10:35 AM Staff 11 (MDS Coordinator) stated, regarding the care plan, she somehow missed where in one area Resident 4 was care planned to use straws and another area indicated she/he did not use straws. On 3/20/24 at 11:27 AM Staff 12 stated she was told the care plan was not updated and she did not check Resident 4's care plan to see if she/he needed to be supervised or not during meals. Staff 12 stated she trusted the staff verbal report and should have checked the care plan. On 3/21/24 at 11:22 AM Staff 16 (RD) stated Resident 4 recently started hospice and she did not want to order nutritional supplements unless Resident 4 enjoyed the nutritional supplements. On 3/21/24 at 11:35 AM Staff 15 (LPN Unit Manager) stated there was a standing order if a resident did not eat 50 percent of their meal the resident was offered a health shake. Resident 4 did not drink liquid unless it was from a straw. Staff 15 confirmed after Resident 4 was readmitted , all the physician orders were unclear and needed clarified with the physician. Staff 15 stated Resident 4 refused nutritional supplements. No documention related to Resident 4's refusals of nutritional supplements was provided.

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure pain interventions were implemented to ensure a resident's pain was managed for 1 of 1 sampled resident (#47) reviewed for pain. This placed residents at risk for decreased activity. Findings include: Resident 47 admitted to the facility in 2023 with diagnoses including diabetes. A 12/19/23 quarterly MDS revealed Resident 47 was cognitively intact. Progress notes revealed the following: -12/24/23 Resident 47 reported increased pain due to hemorrhoids. -1/5/24 refused cream for hemorrhoid pain due to burning. -1/31/24 Resident 47 reported rectal pain, she/he was assessed, and cream was applied. -2/1/24 a new order regarding hemorrhoids was obtained. -2/2/24 an acute provider visit occurred due to the resident's report of increased pain from hemorrhoids. -3/1/24 NP progress note revealed the resident continued with hemorrhoid pain and the plan was for a roho cushion. Resident 47's care plan last revised on 2/29/24 was not revised to include pain related to hemorrhoids. On 3/20/24 at 1:05 PM Staff 11 (MDS Coordinator) stated if she was not made aware of changes, she could not update the care plans. Staff 11 acknowledged Resident 47 had pain related to hemorrhoids since 12/2023 and the care plan was not updated. A 3/2024 MAR revealed the resident was to be administered a pad with witch hazel (herbal treatment) PRN for hemorrhoidal pain. There was no documentation to indicate the medication was administered or refused. The start date was 3/15/24. On 3/18/24 at 1:18 PM and 3/20/24 at 2:59 PM Resident 47 stated she/he had hemorrhoid pain for about two months. The facility was to provide witch hazel and a special cushion for her/his wheelchair but did not. Resident 47 stated she/he could not sit up for meals or go to activities due to pain. Resident 47 stated no one communicated with her/him if the witch hazel was prescribed. On 3/20/24 at 2:19 PM Staff 28 (LPN Unit Manager) stated the previous week she spoke to Resident 47's NP and the NP prescribed pads with witch hazel for the resident's hemorrhoids. Staff 28 stated she did not speak to the resident about the order. The facility did not have the pads with just witch hazel and only carried the pads with 50 percent witch hazel which caused the resident pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 3:03 PM and 3:05 PM Staff 47 (LPN) stated the only medicated pads in the central stores had alcohol in them. She requested the facility obtain the pads without alcohol, then provided them to the resident and the pads were effective for the resident. On 3/21/24 at 11:22 AM Staff 27 (Director of Therapy Services) stated he was not aware the NP ordered the specialized cushion on 3/1/24. Staff 27 stated on 3/20/24, once therapy was notified, the cushion was provided to the resident.

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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. 35855 Based on interview, and record review it was determined the facility failed to have adequate staff available to meet the needs of residents in a timely manner for 1 of 14 sampled residents (#10) and 1 of 2 floors (2nd floor) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. Resident 10 admitted in 2020 with diagnoses including difficulty in walking and a stroke. A 11/1/23 care plan indicated Resident 10 required supervision and touching assistance with transferring on and off the bedside commode and was dependent on staff for toileting hygiene, and adjusting of clothing before and after toileting. A 2/12/24 annual MDS indicated Resident 10 was continent of bowel and bladder and was cognitively intact with a BIMs of 15. On 3/19/24 at 6:40 AM Resident 10 stated call light wait times were over 15 minutes and about once a month over 30 minutes. Resident 10 stated she/he had incontinent episodes multiple times because she/he had to wait for assistance. A 3/2024 Documentation Survey Report indicated Resident 10 was incontinent on the evening shift of 3/13/24 and on night shift of 3/14/24. On 3/20/24 at 11:27 AM Staff 12 (CNA) stated approximately two shifts a week she was assigned 12 to 13 residents. Staff 12 stated at times she had to prioritize collecting vital signs over resident care. Residents complained of long call light wait times of 20 to 30 minutes. Staff 12 experienced starting her shift with residents soaked in urine or soiled with feces. On 3/22/24 at 10:10 AM in an interview with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) it was stated the facility continued to actively hiring staff. 2. The 11/2023 resident Council Minutes indicated staff went into residents' rooms when a call light was activated, turned it off and left without asking how they could assist the resident. Call light wait times were as long as an hour on day shift. Staff assisted residents to the restroom and then went on break or lunch leaving a resident in the restroom. The following interviews occurred on 3/18/24: -11:40 AM Resident 35 stated call light wait times were up to 30 minutes. -11:48 AM Resident 19 stated the facility was short-staffed. Call light wait times were up to 30 minutes during shift change. Resident 19 felt she/he was not cared for during rounds for incontinent checks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:26 PM Resident 30 stated call light wait times were 30 minutes and longer all three shifts. -12:39 PM Witness 8 (Family Member) stated short-staffing occurred all three shifts. Witness 8 came to visit in the mornings, and he would find Resident 22 incontinent and soiled. Witness 8 activated the call light and the wait was 30 minutes. -12:54 PM Resident 2 stated the facility was short-staffed and the wait for assistance with toileting was 20 to 25 minutes. -1:03 PM Resident 43 stated because the facility was short-staffed, she/he was not getting her/his showers. At times Resident 43 refused and staff did not try and reschedule them. Call light wait times were 30 minutes and she/he had to wait for water or assistance getting dressed. -1:25 PM Resident 47 stated she/he had to wait for an hour and a half the morning of 3/18/24 for the call light to be answered. -1:51 PM Resident 18 stated she/he had to wait for over an hour for call light response multiple times and the facility did not have enough staff. Resident 18 stated on the night of 3/17/24 there were only two CNAs for the second floor with approximately 40 residents. -2:47 PM Resident 13 stated there were issues with staff shortages approximately ten percent of the time which was usually weekends. -3:31 PM Resident 23 stated the facility was understaffed. Resident 23 waited over an hour for staff to answer call lights. The following interviews occurred on 3/20/24: -9:44 AM Staff 28 (Unit Manager-LPN) stated there were concerns with short staff and the facility was behind in completing wound care. -10:42 AM Staff 21 (CNA) stated the facility was consistently short of CNA staff on day and evening shift. Staff 21 stated it was difficult to find another staff member to assist when two-person assistance was required. -11:27 AM Staff 12 (CNA) stated approximately two shifts a week she was assigned 12 to 13 residents. Staff 12 stated at times she had to prioritize collecting vital signs over care of residents. Residents complained of long call light wait times of 20 to 30 minutes. Staff 12 experienced coming on shift to find residents soaked in urine or soiled in feces. -3:51 PM Staff 25 (Former CNA) stated in 11/2023 residents were not receiving their showers because the facility was short-staffed. At times Staff 25 placed someone on a bedside commode and the resident was on the commode for 30 minutes or longer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6:36 PM Staff 34 (Agency-LPN) stated from 4/2023 to 12/2023 she worked upstairs, and she could not complete all assigned care for residents. CNA staffing was short and staff were not coming to work as assigned. Residents complained of long call light wait times as long as 45 minutes. At times CNAs went on their break and a resident was left on a bedside commode for 20 minutes or longer. CNA staff did not communicate with each other. The following interviews occurred 3/21/24: -8:44 AM Staff 36 (LPN) stated on 3/20/24 there was only one nurse to complete medication pass, process two resident admissions, complete wound care, an IV treatment, and process any discharges. The facility continued to admit residents even when short-staffed. -11:45 AM Resident 14 stated on 3/18/24 she/he waited one hour for assistance and experienced an incontinent episode in bed. Resident 14 stated with the lack of staff she/he had to clean herself/himself and it was difficult. On 3/22/24 at 10:10 AM in an interview with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) it was stated the facility continued actively hiring staff.

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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 15 out of 123 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: Review of the Direct Care Staff Daily Reports from 5/1/23 through 5/31/23, 6/1/23 through 6/31/23, 8/1/23 through 8/31/23 and 2/17/24 through 3/17/24 revealed the facility did not have RN coverage on all three shifts on the following days: 5/18/23, 5/24/23, 5/30/23, 5/31/23, 6/6/23, 8/1/23, 8/2/23, 8/9/23, 8/15/23 2/18/24, 2/27/24, 3/3/24, 3/5/24, 3/10/24, and 3/12/24. On 3/22/24 at 10:10 AM in an interview with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) it was stated the facility continued actively hiring staff.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 35855 Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 5 of 5 sampled CNA staff (#s 18, 19, 20, 21, and 22) reviewed for staffing. This placed residents at risk for lack of competent staff. Findings include: On 3/21/24 at 9:50 AM Staff 1 (Administrator) provided the most recent performance reviews for Staff 18 (CNA), Staff 19 (CNA), Staff 20 (CNA), Staff 21 (CNA), and Staff 22 (CNA). - Staff 18 was hired on 12/14/13 and the facility was unable to provide a performance review. - Staff 19 was hired on 1/9/19 and the facility was unable to provide a performance review. - Staff 20 was hired on 10/7/21 and the facility was unable to provide a performance review. - Staff 21 was hired on 12/18/15 and the facility was unable to provide a performance review. - Staff 22 was hired on 12/14/21 and the facility was unable to provide a performance review. On 3/21/24 at 10:43 AM Staff 1 (Administrator) confirmed there were no performance reviews for Staff 18, Staff 19, Staff 20, Staff 21, and Staff 22.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34667 Based on interview and record review it was determined the facility failed to address pharmacy recommendations for 1 of 5 sampled residents (#43) reviewed for medications. This placed residents at risk for medication complications. Findings include: Resident 43 was admitted to the facility in 2023 with diagnoses including arthritis and anxiety. A pharmacy review dated 12/25/23 recommended labs be obtained to evaluate several medications the resident received. There was no evidence in the clinical record the labs were obtained. On 3/21/24 at 2:54 PM Staff 26 (Staff Development Coordinator) confirmed the labs were not obtained timely.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 34667 Based on interview and record review it was determined the facility failed to obtain routine labs to monitor medication effectiveness for 1 of 5 sampled residents (#43) reviewed for medications. This placed residents at risk for ineffective medication management and unnecessary medications. Findings include: A pharmacy review dated 12/25/23 identified the need for routine labs to evaluate Resident 43's medications used to treat high cholesterol, diabetes, vitamin D, B12 deficiencies, sodium, and potassium levels. A pharmacy review dated 2/27/24 noted the labs were ordered by the physician on 2/19/24 and requested the facility obtain a copy of the results to be included into Resident 43's clinical record. There was no evidence in Resident 43's clinical record the labs were obtained until 3/1/24. On 3/21/24 at 2:54 PM Staff 26 (Staff Development Coordinator) confirmed the labs were not obtained as recommended until 3/1/24.

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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. 36494 Based on interview and record review it was determined the facility failed to adequately monitor psychotropic medications for 1 of 5 sampled residents (#19) reviewed for medications. This placed residents at risk for lack of effective medication management. Findings include: Resident 19 was admitted to the facility in 1/2020 with diagnoses including bipolar disorder with depression, personality disorder and agoraphobia (fear of entering crowded places) with panic disorder. A review of Resident 19's Physician Orders dated 2/2024 revealed the following medications: -Duloxetine (for depression) 120 mg, two tablets for mood disorder with depression. -Rexuliti (an antipsychotic) 1 mg at bedtime for bipolar disorder. A review of Resident 19's 2/2024 and 3/2024 MARs revealed facility staff were to monitor for adverse reactions to the antidepressant and antipsychotic medications each shift. Review of the monitoring documentation revealed the following: -2/2024: out of 87 opportunities facility staff did not monitor Resident 19 for adverse reactions to her/his antidepressant or antipsychotic medication on 32 occasions. -3/2024: out of 57 opportunities facility staff did not monitor Resident 19 for adverse reactions to her/his antidepressant or antipsychotic medication on 25 occasions. On 3/20/24 at 9:43 AM Staff 47 (LPN) and at 6:36 PM Staff 34 (Agency LPN) stated they were required to monitor for adverse reactions to Resident 19's antidepressant and antipsychotic medication use, but they did not consistently document appropriately in the resident's medical record. On 3/21/24 at 2:22 PM Staff 15 (LPN Unit Manager) and Staff 26 (Staff Development Coordinator RN) stated staff were expected to monitor and document adverse reactions every shift related to Resident 19's use of her/his antidepressant and antipsychotic medications.

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NAME OF PROVIDER OR SUPPLIER South Hills Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 1166 E. 28th Avenue Eugene, OR 97403	

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 26991 Based on interview and record review it was determined the facility failed to ensure a resident colonoscopy (scope passed through the rectum to visualize the large intestine and part of the small intestine) was rescheduled for 1 of 3 sampled residents (#35) reviewed for nutrition. This placed residents at risk for delayed treatment. Findings include: Resident 35 admitted to the facility in 2021 with a diagnosis of a stroke. A provider Progress Note dated 2/7/24 revealed Resident 35 had abnormal weight loss. A colonoscopy was scheduled for 2/15/24. After the colonoscopy additional tests would be completed to assist in diagnosing possible causes of the resident's weight loss. The resident verbalized the desire to complete the colonoscopy. Resident 35's clinical record did not indicate if the 2/15/24 colonoscopy was completed. In interview on 3/20/24 at 11:48 AM with Staff 26 (Staff Development Coordinator) and Staff 15 (LPN Unit Manager) Staff 26 stated the resident was to have the colonoscopy on 2/15/24. The preparation for the test came from the pharmacy on 2/14/24 and the resident refused to consume all the medication. The physician was notified, and the test was to be rescheduled. Staff 15 stated the notification to the resident's physician and the canceled test was not documented in the resident's clinical record. Staff 15 was not certain if a follow-up was made. On 3/20/24 at 11:59 AM Staff 48 (Medical Records) stated at this time a colonoscopy was not rescheduled for Resident 35.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 41455 Based on interview and record review it was determined the facility failed to obtain dental services for 1 of 1 sampled resident (#18) reviewed for dental. This placed residents at risk for dental pain and difficulty eating. Findings include: Resident 18 was admitted to the facility with diagnoses including malnutrition and quadriplegia (a form of paralysis that affects all four limbs). The 2/28/24 quarterly MDS indicated Resident 18 did not have dentures. A 3/1/24 revised care plan indicated Resident 18 had her/his teeth extracted in 5/2023 and arrangements for dental care and transportation should be coordinated. On 3/19/24 at 9:34 AM Resident 18 stated she/he continued to ask for dentures and there remained no update regarding her/his request. On 3/20/24 at 9:44 AM Staff 23 (Social Worker) stated she worked to get a denture appointment for Resident 18 and waited for Staff 2 (DNS) to speak with Resident 18 about the risks and benefit of sitting in a dental chair for an extended period of time. On 3/21/24 at 9:21 AM Staff 2 stated she was first approached in 2/2024 about Resident 18's request for dentures and acknowledged the follow-up related to her/his request was lacking.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 41455 Based on observation, interview, and record review it was determined the facility failed to ensure snack requests were honored and provided for 1 of 5 sampled residents (#2) and 1 of 1 Resident Council reviewed for dining. This placed residents at risk for lack of response to dietary requests and snack preferences. Findings include: 1. Resident 2 was admitted to the facility in 2023 with diagnoses including kidney disease and diabetes. Resident 2 resided on the second floor. The 1/30/24 through 2/1/24 Snack List indicated the residents' snack refrigerator on the second floor did not have string cheese or yogurts in stock at the time the snack inventory was taken. No additional Snack List inventory sheets during the last three months were provided. A 2/8/24 revised care plan indicated to provide Resident 2 additional protein intake for wound healing. A 2/20/24 Dietary Profile indicated Resident 2 requested yogurt and sandwiches as snacks. On 3/20/24 at 8:00 AM the second floor resident snack refrigerator was observed with no yogurt. On 3/21/24 at 2:00 PM Staff 30 (Cook) stated she often stocked the residents' snack refrigerators in the evenings and lacked an adequate supply of dairy items 50 percent of the time. On 3/21/24 at 2:35 PM Staff 31 (Dietary Manager) indicated Resident 2, who requested yogurt and sandwiches as a snack, should have been provided both items. Staff 31 acknowledged the residents' snack refrigerators were not stocked with ample yogurt and cheese stick snacks to meet the requests of residents. 2. The 1/30/24 through 2/1/24 Snack List indicated the residents' snack refrigerator on the second floor did not have string cheese or yogurts in stock at the time the snack inventory was taken. No additional Snack List inventory sheets during the last three months were provided. The 3/13/24 Dining Committee minutes indicated residents voiced concerns related to the lack of an adequate amount of string cheese. Additionally Staff 31 (Dietary Manager) acknowledged the kitchen ran out of milk one day during the week and she was not informed of the issue. On 3/19/24 at 3:05 PM during a Resident Council meeting, residents in attendance indicated they did not receive snacks at bedtime when requested and items like milk, string cheese and sandwiches were insufficient. Residents believed with a grocery store in the vicinity, they should not need to go without those items. On 3/20/24 at 8:00 AM the second floor resident snack refrigerator was observed with no yogurt. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/24 at 2:00 PM Staff 30 (Cook) stated she often stocked the residents' snack refrigerators in the evenings and lacked an adequate supply of dairy items 50 percent of the time. On 3/21/24 at 2:35 PM Staff 31 (Dietary Manager) indicated she did not use available documentation in order to monitor what resident snacks were in high demand. Staff 31 acknowledged the residents' snack refrigerators were not stocked with ample snacks to meet the requests of residents.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 41455 Based on observation and interview it was determined the facility failed to ensure waste was properly contained in the garbage storage area for 1 of 1 garbage area reviewed for kitchen sanitation. This placed residents at risk for exposure to pathogens related to pests. Findings include: On 3/21/24 at 12:36 PM the outside garbage area was observed with a garbage container lid open and on the ground of the surrounding area was observed broken doors, unused resident commodes, dirty disposable gloves, miscellaneous wood pieces, and outdoor debris accumulated in the corner of the building. On 3/21/24 at 12:40 PM Staff 42 (Maintenance Director) acknowledged the garbage area was dirty, not organized, and Staff 42 lacked the time since 2/2024 to clean it. On 3/21/24 at 12:44 PM Staff 41 (CNA) stated she came outside routinely and the garbage area frequently had debris around it including dirty disposable gloves on the ground. On 3/22/24 at 9:11 AM the outside garbage area was observed with Staff 31 (Dietary Manager). The lid on the garbage container was open and multiple dirty gloves were on the ground nearby. Staff 31 stated she was unaware of any requirement to monitor the garbage area but acknowledged it should be kept clean.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 26991 Based on interview and record review it was determined the facility failed to coordinate care with hospice for 1 of 1 sampled resident (#22) reviewed for hospice. This placed residents at risk for unmet needs. Findings include: Resident 22 was admitted to the facility in 2024 with a diagnosis of heart disease. A 2/3/24 signed hospice narrative revealed the resident was approved and certified for hospice services by the physician on 2/3/24. Resident 22's clinical record did not have a significant change MDS completed with an assessment of the resident's end of life care needs with coordination from hospice, resident, family, and facility. Resident 22's care plan last updated on 2/12/24 revealed the following: -Resident 22 was independent to eat. -Hospice would address the resident's advance directive status. -There was no revision of the care plan related to admission to hospice including the name of the agency. -The discharge plan was to be determined. A 2/22/24 Care Plan Conference form revealed hospice attended the conference. It was determined hospice was to review the resident's advance directive status with the resident and staff were to assist the resident with meals and transfers and not family. The form also indicated the resident was to remain at the facility for care. A 2/22/24 hospice note indicated staff were to notify hospice if Resident 22 had pain, anxiety, or agitation. Staff were also to call hospice if the resident fell . The resident's care plan was not updated to reflect hospice notification, staff only to assist the resident with cares, and the resident's plan to continue to reside in the facility. On 3/18/24 at 12:56 PM Witness 8 (Family) stated the coordination of care was not good. Witness 8 indicated the family was told they could not assist the resident to eat, but staff did not assist the resident. On 3/19/24 at 12:38 PM Staff 43 (CNA) stated Resident 22 had a private aide and family who usually assisted the resident. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 9:26 AM Staff 13 (Social Services) stated she did not communicate with hospice in order to update the care plan related to advance directive information. On 3/20/24 at 1:05 PM at Staff 11 (MDS Coordinator) stated if she did not attend the care conference, staff were to notify her of changes which were needed to update the care plan. Staff 11 stated she was not aware of the care conference changes and recommendations.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35855 Based on interview and record review it was determined the facility failed to submit mandatory staffing information based on the payroll data journal and other verifiable and auditable data as required. This placed residents at risk for inaccurate staffing information. Findings include: Review of the Payroll Based Journal Staffing Data for fiscal year, quarter two, 2023 (4/1/23 through 6/30/24) indicated the facility failed to submit required data for the quarter. On 3/22/24 at 10:10 AM in an interview with Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) it was stated the corporate office handled submitting data and they were unaware it was not submitted.

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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 follow infection control standards for 1 of 4 sampled residents (#4) and 1 of 2 floors (1st floor) reviewed for accidents and infection control. This placed residents at risk for cross contamination. Findings include: 1. Resident 4 was admitted to the facility in 2022 with diagnoses including prostate cancer. An 8/14/23 care plan indicated Resident 4 had a catheter due to a history of prostate cancer and urinary retention. On 3/19/24 at 8:25 AM Resident 4 was observed with her/his catheter bag attached to small garbage can next to the bed. On 3/20/24 at 8:58 AM and 9:33 AM Resident 4 was observed in the dining room with her/his catheter bag attached to her/his wheelchair with approximately one fourth of the catheter bag in contact with the floor and falling out of the privacy bag. On 3/20/24 at 11:27 AM Staff 12 (Agency CNA) stated she attached Resident 4's catheter bag to the garbage can as the bed was in a low position and she did not know where else to attach the bag. On 3/22/24 at 10:28 AM in an interview Staff 1 (Administrator), Staff 2 (DNS), Staff 37 (Regional Director of Social Services and Activities), Staff 38 (Regional Director of Clinical) and Staff 39 (Northern Regional Director of Operations) were notified of Resident 4's catheter bag being secured to a garbage can and the catheter bag on the floor. 41455 2. On 3/21/24 at 9:15 AM Staff 32 (CNA) walked towards room [ROOM NUMBER] and carried dirty linens in her hands instead of being placed in a disposable bag. On 3/21/24 at 10:13 AM Staff 32 was observed leaving room [ROOM NUMBER] carrying dirty linens in her hands without a disposable bag, and then placed them in a dirty linen container in the shower room. Staff 32 stated the facility did not maintain a supply of disposable bags necessary to carry out tasks for resident care and maintain infection control standards since 12/2023. On 3/21/24 at 10:36 AM a dispenser filled with disposable bags was observed installed on the wall in the bathroom of room [ROOM NUMBER] with Staff 33 (Housekeeper). Staff 33 stated each resident bathroom was equipped with the dispenser and she had no knowledge the facility lacked disposable bags. On 3/21/24 at 12:27 PM Staff 28 (LPN-Unit Manager) confirmed she observed staff walk out of residents' rooms without placing the linens in disposable bags. Staff 28 did not address the infection control issue with CNA staff at that time, and was not aware of the dispensers with disposable bags that were installed in residents' bathrooms. Staff 28 acknowledged disposable bags and not bare hands should be used to transport dirty linens.

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F 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Implement a program that monitors antibiotic use.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26991

Based on interview and record review it was determined the facility failed to ensure an antibiotic was indicated for use for 1 of 3 sampled residents (#60) reviewed for beneficiary. This placed residents at risk for antibiotic resistant organisms. Findings include:

Resident 60 admitted to the facility in 2023 with a diagnosis of dementia with behaviors.

2/2024 through 3/2024 Vital Signs records revealed Resident 60's highest temperature was 99 F which was on 2/23/24.

Progress notes revealed the following:

-2/27/24 Resident 60's urinary catheter was removed on 2/26/24.

-2/28/24 a NP progress note indicated the resident wanted her/his urinary catheter replaced because she/he had urgency and frequency and could not sleep. Staff monitored the resident and the staff reported the resident did not have urinary retention (urine remains in the bladder after attempting to urinate). The resident's symptoms were possibly a response from the catheter removal or a UTI. The resident did not have a fever or bloody urine. The resident's recent blood test showed a slightly elevated white count of 15.1 (normal range 4-11/elevated range could indicate an infection, stress, allergies etc.). The note indicated the resident was to be started on an antibiotic pending the results of the UA and culture.

-2/28/24 Resident 60 was alert, oriented, urinated three times, and her/his bladder was not painful or distended.

-2/29/24 Resident 60 continued to urinate without issue and alert charting was discontinued.

-3/1/24 staff called the lab to verify if the resident's urine specimen was sent. Resident 60's antibiotic was to start 3/2/24.

-3/4/24 Resident 60 had 600 ml of urine after attempting to urinate and refused to be catheterized. Resident 60 denied pain and did not have bladder distention.

-3/4/24 Resident 60 was urinating without difficulty.

A Final Diagnostic lab form revealed Resident 60's urine sample was submitted on 2/29/24. The resident's urine sample was not able to be tested . The information was reported to the facility on [DATE].

A 3/2024 MAR revealed staff were to administer Cipro (antibiotic) for five days from 3/2/24 through 3/6/24. Resident 60 was administered all doses of the antibiotic.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation in the resident's record to indicate the facility notified the physician there was no urine tested and no culture to verify if the antibiotic was indicated. There was no rationale for the continued use of the antibiotic after the facility was notified the resident's urine sample was not tested . On 3/22/24 at 10:45 AM Staff 2 (DNS) was asked to provide documentation to indicate the resident met criteria to continue the use of the antibiotic or the rationale to continue the antibiotic despite no laboratory data. No additional information was provided.