STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385168	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Lebanon	350 S. 8th Lebanon, OR 97355

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34703 Based on interview and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 1 resident (#46) reviewed for abuse. This placed residents at risk for abuse. Findings include Resident 46 admitted to the facility in 2024 with diagnoses including PTSD (post traumatic stress disorder) and anxiety disorder. The 4/5/24 Admission MDS indicated Resident 46 had a BIMS of 15 which indicated she/he was cognitively intact. The 4/1/24 care plan indicated Resident 46 was on behavior monitoring related to a history of PTSD, depression, and anxiety. Resident 46's triggers for PTSD included: -overwhelmed -feeling loss of control -upset with situation On 6/13/24 a public complaint was received which indicated Resident 46 was being harassed and intimidated by Resident 29. The facility was not doing enough to keep her/him safe and it was an ongoing issue. Witness 8 (Complainant) stated on 6/2/24 Resident 29 came into the dining room and was disruptive. Resident 46 politely asked her/him to to not be disruptive while they were having their meal. Resident 29 became angry and began yelling and cursing, and ever since then Resident 29 continued to come in the dining room on her/his electric scooter, ride around Resident 46 and stare at her/him. Resident 46 told Witness 8 she/he felt harassed and caused her/him anxiety. Witness 8 stated Resident 46 used to come out of her/his room to read and socialize but now spent time in her/his room. Witness 8 stated the residents lived on separate halls and there was no reason Resident 29 needed to come down the 400 hall where Resident 46 resided. Witness 8 stated Resident 29 came to Resident 46's room, stood in the door way and stared at her/him. Witness 8 stated she was concerned for Resident 46's safety and was worried the situation would escalate. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple observations from 7/16/24 through 7/19/24 on day and evening shifts revealed Resident 29 on the 400 hall by Resident 46's room staring at her/him. Staff intervened and Resident 29 began cursing. On 7/16/24 at 11:05 AM Resident 29 stated Resident 46 was mean and yelled at her/him in the dining room and when she/he was in the 400 hall. Resident 29 sated Resident 46 started the argument not her/him. On 7/17/24 at 3: 09 PM Resident 46 stated Resident 29 came into the dining room on 6/2/24 and started yelling at staff and banged on the tables. Resident 46 stated she/he politely asked Resident 29 to not be disruptive while residents ate their meal. Resident 46 stated Resident 29 became angry, left the dining, room, but came back and started cursing at her/him. Resident 46 stated after the incident Resident 29 continued to come down the 400 hall, stand in her/his doorway and stare at her/him. Resident 46 stated she/he felt scared, intimidated, and uncomfortable. Resident 46 stated she/he spoke with management but nothing was done. On 7/18/24 at 3:01 PM Staff 32 (LPN-RCM) stated Resident 29 was targeting and making Resident 46 uncomfortable by coming down the 400 hall and staring at her/him. Staff 32 stated there are multiple doors Resident 29 can exit from but chose the 400 hall door. Staff 32 stated management indicated if Resident 29 talked to Resident 46 staff can intervene otherwise there was noting staff could do because Resident 29 had a right to be wherever she/he wanted. Staff 32 stated Resident 46 had become more anxious, PTSD was intensified, and stated she/he felt targeted by Resident 29. Staff 32 stated management was aware of the incident but nothing was done to protect Resident 46. On 7/18/24 at 3:15 PM Staff 46 (CNA) stated Resident 29 intimidated Resident 46 all day. Resident 29 came down Resident 46's hall and stalked her/him. Staff 46 stated management told staff when Resident 29 came down the 400 hall to encourage her/him to go somewhere else, but Staff 46 indicated this caused Resident 29 to yell at staff. Staff 46 stated Resident 46 was more anxious and now stayed in her/his room due to Resident 29's behavior. Staff 46 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 12:34 PM Staff 16 (CMA) stated Resident 29 never came down the 400 hall until the 6/2/24 incident. Staff 16 stated management told staff there was nothing they could do because Resident 29 had the right to go wherever she/he wanted to go. Staff 16 stated staff saw Resident 29 outside Resident 46's window staring at her/him. Staff 16 stated Resident 46 stated she/he felt scared, anxious, not protected, and her/his rights were violated. Staff 16 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 2:22 PM Staff 1 (Administrator) stated Resident 46 indicated she/he felt intimidated by Resident 29, and Resident 29 glared and made faces at her/him. Staff 1 stated staff were instructed to redirect Resident 29 but this angered Resident 29. Staff 1 stated staff were to continue redirecting Resident 29.

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NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Lebanon		STREET ADDRESS, CITY, STATE, ZIP CODE 350 S. 8th Lebanon, OR 97355	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34703 Based on observation, interview, and record review it was determined the facility failed to investigate allegations of abuse for 1 of 1 sampled resident (#46) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 46 admitted to the facility in 2024 with diagnoses including PTSD (post traumatic stress disorder) and anxiety disorder. The 4/5/24 Admission MDS indicated Resident 46 had a BIMS of 15 which indicated she/he was cognitively intact. The 4/1/24 care plan indicated Resident 46 was on behavior monitoring related to a history of PTSD, depression, and anxiety. Resident 46's triggers for PTSD included: -overwhelmed -feeling loss of control -upset with situation On 6/13/24 a public complaint was received which indicated Resident 46 was being harassed and intimidated by Resident 29. The facility was not doing enough to keep her/him safe and it was an ongoing issue. Witness 8 (Complainant) stated on 6/2/24 Resident 29 came into the dining room and was disruptive. Resident 46 politely asked her/him to to not be disruptive while they were having their meal. Resident 29 became angry and began yelling and cursing, and ever since then Resident 29 continued to come in the dining room on her/his electric scooter, ride around Resident 46 and stare at her/him. Resident 46 told Witness 8 she/he felt harassed and caused her/him anxiety. Witness 8 stated Resident 46 used to come out of her/his room to read and socialize but now spent time in her/his room. Witness 8 stated the residents lived on separate halls and there was no reason Resident 29 needed to come down the 400 hall where Resident 46 resided. Witness 8 stated Resident 29 came to Resident 46's room, stood in the door way and stared at her/him. Witness 8 stated she was concerned for Resident 46's safety and was worried the situation would escalate. Multiple observations from 7/16/24 through 7/19/24 on day and evening shifts revealed Resident 29 on the 400 hall by Resident 46's room staring at her/him. Staff intervened and Resident 29 began cursing. On 7/16/24 at 11:05 AM Resident 29 stated Resident 46 was mean and yelled at her/him in the dining room and when she/he was in the 400 hall. Resident 29 sated Resident 46 started the argument not her/him. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3: 09 PM Resident 46 stated Resident 29 came into the dining room on 6/2/24 and started yelling at staff and banged on the tables. Resident 46 stated she/he politely asked Resident 29 to not be disruptive while residents ate their meal. Resident 46 stated Resident 29 became angry, left the dining, room, but came back and started cursing at her/him. Resident 46 stated after the incident Resident 29 continued to come down the 400 hall, stand in her/his doorway and stare at her/him. Resident 46 stated she/he felt scared, intimidated, and uncomfortable. Resident 46 stated she/he spoke with management but nothing was done. On 7/18/24 at 3:01 PM Staff 32 (LPN-RCM) stated Resident 29 was targeting and making Resident 46 uncomfortable by coming down the 400 hall and staring at her/him. Staff 32 stated there are multiple doors Resident 29 can exit from but chose the 400 hall door. Staff 32 stated management indicated if Resident 29 talked to Resident 46 staff can intervene otherwise there was noting staff could do because Resident 29 had a right to be wherever she/he wanted. Staff 32 stated Resident 46 had become more anxious, PTSD was intensified, and stated she/he felt targeted by Resident 29. Staff 32 stated management was aware of the incident but nothing was done to protect Resident 46. On 7/18/24 at 3:15 PM Staff 46 (CNA) stated Resident 29 intimidated Resident 46 all day. Resident 29 came down Resident 46's hall and stalked her/him. Staff 46 stated management told staff when Resident 29 came down the 400 hall to encourage her/him to go somewhere else, but Staff 46 indicated this caused Resident 29 to yell at staff. Staff 46 stated Resident 46 was more anxious and now stayed in her/his room due to Resident 29's behavior. Staff 46 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 12:34 PM Staff 16 (CMA) stated Resident 29 never came down the 400 hall until the 6/2/24 incident. Staff 16 stated management told staff there was nothing they could do because Resident 29 had the right to go wherever she/he wanted to go. Staff 16 stated staff saw Resident 29 outside Resident 46's window staring at her/him. Staff 16 stated Resident 46 stated she/he felt scared, anxious, not protected, and her/his rights were violated. Staff 16 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 2:22 PM Staff 1 (Administrator) stated Resident 46 indicated she/he felt intimidated by Resident 29, and Resident 29 glared and made faces at her/him. Staff 1 stated staff were instructed to redirect Resident 29 but this angered Resident 29. Staff 1 stated staff were to continue redirecting Resident 29. Staff 1 stated he was not made aware of the 6/2/24 incident until 6/5/24 and the police were not called until 6/5/24. Staff 1 acknowledged the investigation should have started on 6/2/24 the date of the incident.

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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. **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 revise care plan interventions for 3 of 13 sampled residents (#s 10, 17 and 24) reviewed for ADLS, medications, positioning and mobility. This placed residents at risk for unmet needs. Findings include: 1. Resident 10 admitted to the facility in 5/2024 with diagnoses including a broken arm. The Admission MDS dated [DATE] revealed Resident 10 had a BIMS score of 10, which indicated the resident was moderately impaired cognitively. Resident 10 was at risk for contracture to the left fingers. A review of a TAR for 7/2024 instructed staff to soak and wash her/his hand in warm water every shift and apply a hand brace every day and evening shift for the hand contracture with a start date of 6/11/24. Review of Resident 10's current care plan revealed no documentation related to the hand contracture. On 7/19/24 at 7:54 AM Staff 16 (CMA) stated she was the one who started soaking Resident 10's hand as her/his hand was crusty and smelled bad. She requested the brace and she used to apply it, but now Staff 43 (Restorative Aide) applied the brace. On 7/19/24 at 8:07 AM Staff 43 stated everyone soaks Resident 10's hand and applied her/his brace. Staff 43 stated Resident 10's fingernail broke off into the palm of her/his hand due to the hand contracture. In an interview on 7/19/24 at 12:42 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed Resident 10's hand contracture should have been added to the care plan. 2. Resident 24 admitted to the facility in 1/2024 with diagnoses including aphasia (damage or injury to the language area of the brain) and stroke. A review of the care plan dated 1/23/24 indicated Resident 24 had deficits in ADL performance and nutritional issues due to dysphagia (difficulty in swallowing), poor intake and leaving 25 percent of food uneaten. Interventions included easy-to-chew textures, nutritional supplement four times a day. There was no documentation specifying whether Resident 24 required supervision or assistance with eating. On 7/18/24 at 10:54 AM, Staff 14 (CNA) stated Resident 24 did not require assistance with eating she/he just needed some cues to eat at times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 8:35 AM Resident 24 was observed eating breakfast in her/his room. Staff 43 (Restorative Aide) stated Resident 24 did not require assistance with eating and she/he usually ate breakfast in her/his room. In an interview on 7/19/24 at 12:12 PM, Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) acknowledged that supervision and cueing for eating assistance should have been specified on Resident 24's care plan. 47001 3. Resident 17 admitted to the facility in 9/2019 with diagnoses including alcohol dependency and narcissistic personality disorder (a mental health condition in which people have an unreasonably high sense of their own importance). A review of Resident 17's care plan revealed a behavior care plan related to a history of behaviors and a diagnosis of narcissistic personality disorder. On 7/19/24 at 10:16 AM Staff 2 (DNS) stated any alcohol consumption by Resident 17 would result in worsening behaviors. A 7/19/24 care plan review revealed no evidence Resident 17 was care planned for alcohol dependency or worsening behaviors with alcohol consumption. On 7/19/24 at 1:02 PM Staff 32 (LPN RCM) stated alcohol consumption by Resident 17 made her/his behaviors worse. Staff 32 confirmed Resident 17 was not care planned for alcohol dependency or for worsening behaviors with alcohol consumption. On 7/19/24 at 1:12 PM Staff 2 confirmed Resident 17 was not care planned for alcohol dependency or worsening behaviors with alcohol consumption.

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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 6 sampled residents (#s 16, 24, and 40) reviewed for ADLs. This placed resident at risk for unmet needs. Findings include: 1. Resident 16 admitted to the facility in 2/2017 with diagnoses including a fractured pelvis. The quarterly MDS dated [DATE] revealed Resident 16 had a BIMS score of 15 indicating the resident was cognitively intact. The resident required substantial to maximal assistance with transfers related to toileting. A review of Resident 16's care plan revised 7/5/21 revealed Resident 16 had bladder incontinence. Interventions included to notify staff of toileting needs. Resident 16 was occasionally incontinent before reaching the bathroom and required one-person assistance for toilet transfers. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were busy with dinner one night the week of 5/20/24. Resident 16 activated her/his call light for toileting assistance, but staff did not respond for 45 minutes. A review of a 5/2024 Documentation Survey Report revealed the week of 5/20/24 to 5/27/24, on the evening shift, Resident 16 was continent twice, was both continent and incontinent seven times, and incontinent once. Witness 1 (Staff) was interviewed on 7/17/24 at 9:31 AM and confirmed the complaint that Resident 16 did not receive timely toileting assistance the week of 5/2024, and was upset she/he had an incontinent episode. During an interview on 7/17/24 at 9:58 AM Resident 16 confirmed that in 5/2024, during dinner time, she/he waited 45 minutes after activating her/his call light for toileting assistance. Resident 16 indicated she/he could not wait and had an incontinent episode. During an interview on 7/18/24 at 12:00 PM Staff 13 (CNA) stated when toileting assistance was documented as both continent and incontinent during a shift it indicated a resident was continent one time and incontinent another time on the same shift. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the expectation for a call light to be answered was 15 to 20 minutes. 2. Resident 24 admitted to the facility in 1/2024 with diagnoses including stroke and dementia. The quarterly MDS dated [DATE] revealed Resident 24 was rarely or never understood and experienced short-term and long-term memory issues. Resident 24 was dependent on staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan dated 1/23/24 indicated Resident 24 had deficits in ADL performance and required two-person physical assistance for bathing. A review of the 4/2024 and 5/2024 Documentation Survey Reports indicated Resident 24 refused showers eight times and received nine showers. On 5/17/24 there was no documentation that Resident 24 received a shower. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were unable to complete showers for all residents. Resident 24 missed showers and developed body odor due to lack of bathing. A review of a 6/2024 Documentation Survey Report indicated Resident 24 refused showers four instances and received four showers. On 7/17/24 at 10:59 AM Staff 18 (CNA) stated not all tasks for residents, including showers, could always be completed due to time constraints. On 7/17/24 at 11:53 AM, Witness 1 (Staff) stated when showers could not be completed she/he documented that the resident refused, as there was no option to document that the shower was not completed. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated staff were expected to not document if a shower was not completed and for the next shift to complete the shower if a shower was not completed. 41455 3. Resident 40 admitted to the facility in 2022 with diagnoses including dementia and depression. The 5/2024 Documentation Survey Report indicated Resident 40 received two showers during the month on 5/24/24 and 5/28/24 and refused showers on 5/2/24, 5/3/24, 5/21/24 and 5/31/24. A 6/6/24 revised care plan indicated Resident 40 needed physical assistance for personal hygiene and bathing. The CNA Tasks: Bathe/Shower on 7/15/24 revealed Resident 40 received four showers in the past 30 days on 6/21/24, 7/5/24, 7/9/24 and 7/15/24, and refused showers on 6/18/24, 6/25/24 and 7/2/24. On 7/16/24 at 9:24 AM Resident 40 was observed to have dry flakes on her/his head and hair which appeared to stick together. On 7/17/24 at 10:07 AM Staff 27 (LPN) stated showers for Resident 40 were not completed two times each week as assigned to CNAs due to lack of available staff. On 7/18/24 at 12:32 PM Staff 30 (CNA) stated Resident 40 rarely refused showers when she/he was properly approached. Staff 30 acknowledged staffing was a challenge in order to accomplish evening showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 6:09 PM Staff 28 (LPN-Unit Manager) acknowledged improved training for CNAs was necessary in order for Resident 40 to accept her/his needed showers.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 41455 Based on observation, interview, and record review it was determined the facility failed to replace hearing aids in a timely manner for 1 of 3 sampled residents (#40) reviewed for sensory needs. This placed residents at risk for a decline in hearing and impaired communication. Findings include: Resident 40 admitted to the facility in 2022 with diagnoses including dementia and depression. A 5/17/24 Quarterly MDS indicated Resident 40's hearing was adequate and she/he was assessed for the use of hearing aids or a hearing appliance. A 6/6/24 revised care plan indicated Resident 40 was to wear hearing aids in both ears in order to address her/his mild hearing deficit. On 7/16/24 at 9:24 AM Resident 40 was observed seated at a dining room table with no hearing aid in either ear. Staff 29 (CNA) stated Resident 40 did not use her/his hearing aids because they were broken for the last three to four months, and the resident was on a list to have her/his hearing aids repaired. On 7/17/24 at 10:07 AM Staff 27 (LPN) stated Resident 40 had no hearing aids since the resident moved to a new hall on 4/19/24. On 7/17/24 at 3:35 PM Staff 31 (Social Service Director) stated she believed Resident 40 chose not to wear hearing aids and acknowledged she was not aware her/his hearing aids were missing or broken.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34703 Based on observation, interview, and record review it was determined the facility failed to ensure a resident's environment remained free from accident hazards for 1 of 1 sampled resident (#66) reviewed for accidents, and respond to changes in condition in a timely manner for 1 of 1 sampled resident (#65) reviewed for change of condition. This placed residents at risk for injury and untimely care needs. Findings include: 1. Resident 65 admitted to the facility in 2024 with diagnoses including leg fracture. A progress note dated 12/15/23 at 5:33 PM indicated Resident 65 had a recent fall and her/his right lower extremity was swollen, bruised, and and painful. A STAT (immediate) x-ray was ordered to rule out injury. A progress note dated 12/16/23 at 2:41 AM indicated the x-ray revealed Resident 65 had a right ankle fracture. A progress note dated 12/18/23 at 9:40 AM indicated Staff 41 (LPN) sent a message to the physician that Resident 65 had a fractured ankle. The physician replied the x-ray was noted on 12/16/23. Staff 41 indicated Staff 42 (LPN) sent a message to the physician but did not call the on-call physician regarding Resident 65's fracture. Resident 65 was sent to the emergency roiagnom on [DATE] two days after the right ankle fracture was verified. On 7/19/24 at 1:34 PM Staff 42 stated she did not call the on-call physician she only sent a message through the hospital messaging system. Staff 42 acknowledged she should have called the on-call physician to get Resident 65 the care she/he needed. On 7/19/24 at 2:39 PM Staff 1 (Administrator) stated he did not know why the resident was not sent to the emergency roiagnom on [DATE] when the fracture was verified. Staff 1 stated his expectation is for nurses to call the on-call physician for after hour emergencies and notify the physician in a message through the hospital messaging system. 49677 2. Resident 66 admitted to the facility in 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), generalized muscle weakness, and Transient Ischemic Attack (slight stroke). An Incident Report dated 11/11/23 indicated Resident 66 required two staff to assist with all mechanical lift transfers. The Incident Report revealed Resident 66 fell out of the lift sling while a CNA was transferring the resident. The incident report also indicated the care plan was not followed as indicated for two staff at all times for in and out of bed transfers. Review of hospital notes dated 11/13/23 indicated Resident 66 did not have any acute traumatic abnormalities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/18/24 at 7:20 AM Staff 1 (Administrator) stated he was aware of Staff 43 (RA) not following the care plan that indicated the resident was to be transferred by two people. Staff 1 indicated that Staff 43 communicated to Staff 1 that she knew she wasn't following the care plan and she should have waited for an additional staff member to assist in the Hoyer transfer. In an interview on 7/18/24 at 7:46 AM Staff 43 (RA) stated she attempted to transfer Resident 66 by herself. As the mechanical lift was elevated, she heard the sling rip, the resident slid out of the sling backwards hitting her head on the floor. Resident 66 was painful and crying and was sent to the hospital. Staff 43 stated she was aware of the care plan indicated the resident was to be transferred by two people, however she was rushed and thought she could transfer the resident alone.

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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. 41455 Based on interview and record review it was determined the facility failed to provide adequate catheter care for 1 of 2 sampled residents (#14) reviewed urinary catheter. This placed residents at risk for urinary infections. Findings include: Resident 14 admitted to the facility in 2023 with diagnoses including chronic kidney disease and displacement of a nephrostomy catheter (tube that diverts urine from kidney). A 6/14/23 Discharge Summary indicated Resident 14 had a nephrostomy tube placed. An 10/13/23 through 3/13/24 physician order indicated to cover Resident 14's nephrostomy tube site and change the bandage daily. The 4/2024 TAR indicated to ensure catheter straps were attached to the lower left extremely for the nephrostomy bag. Treatments were discontinued on 4/30/24. A 5/9/24 physician order indicated to change Resident 14's nephrostomy tube dressing, remove the old dressing, cleanse, dry and apply a new dressing. A 7/2/24 revised care plan indicated Resident 14 had a left nephrostomy related to end stage kidney disease, the goal was to have no infections, and interventions included to monitor for complications related to seizures. No other interventions related to Resident 14's nephrostomy were indicated. On 7/15/24 at 11:31 AM Resident 14 stated she/he had concerns about the placement and staff knowledge related to her/his nephrostomy bag. Resident 14 stated the bag burst or leaked because it was not checked or properly closed. On 7/17/24 at 9:32 AM Staff 29 (CNA) stated for a period of time it was not clear who was responsible for changing or addressing the needs of Resident 14's nephrostomy bag. Staff 29 stated the correct placement or strap to be used for Resident 14's nephrostomy bag was unclear and at times nephrostomy bag supplies were unavailable. On 7/17/24 at 10:07 AM Staff 27 (LPN) acknowledged there were previous challenges with Resident 14's nephrostomy supplies and CNAs began to monitor supplies within the last two weeks. Staff 27 stated the placement of Resident 14's nephrostomy bag was important for her/his comfort and not all CNAs knew how or where to position the nephrostomy bag. On 7/18/24 at 5:42 PM and 7/19/24 at 12:11 PM Staff 28 (LPN-Resident Care Manager) acknowledged a systematic method to maintain the preferred nephrostomy supplies for Resident 14 was needed, CNAs needed more training, and a detailed care plan related to Resident 14's nephrostomy bag care and placement was necessary. On 7/19/24 at 3:25 PM Staff 23 (Regional Nurse Consultant) acknowledged there were no orders for Resident 14's nephrostomy care from 3/13/24 through 5/9/24 as expected.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47001 Based on observation, interview, and record review it was determined the facility failed to obtain orders for oxygen for 2 or 2 sampled residents (#s 30 and 63) reviewed for respiratory care. This placed residents at risk for unmet respiratory needs. Findings include: 1. Resident 30 admitted to the facility in 4/2022 with diagnoses including chronic obstructive pulmonary disease (a lung disease which causes restricted airflow and breathing problems). A review of Resident 30's care plan revealed a 12/21/23 care plan for oxygen use as needed. A 7/18/24 review of Resident 30's medical record revealed no evidence of a current order for oxygen use. On 7/18/24 at 11:49 AM Staff 17 (CNA) stated Resident 30 used oxygen as needed almost daily. On 7/18/24 at 3:37 PM Staff 32 (LPN RCM) stated Resident 30 used oxygen as needed when she/he was short of breath. Staff 32 confirmed Resident 30 had no orders for oxygen use. 34703 2. Resident 63 admitted to the facility in 2024 with diagnoses including COPD (chronic obstructive pulmonary disease). A physician order dated 6/2/24 indicated Resident 63 received oxygen via nasal cannula (nasal tube allowing continuous oxygen delivery) at three liters a minute (LPM) as needed. A review of Resident 63's medical record revealed from 5/29/24 through 6/26/24 Resident 63 had oxygen on every day except for six days she/he was on room air. There was no documentation the resident was on three LPM of oxygen as ordered and no documentation of how often oxygen tubing was to be changed. On 7/17/24 at 10:49 AM Witness 7 (Caregiver) stated Resident 63 wore continuous oxygen on three LPM due to COPD. On 7/17/24 at 11:38 AM Staff 39 (CNA) stated she took care of the resident and she/he wore continuous oxygen or she/he became short of breath. On 7/17/24 at 11:11 AM Staff 26 (RN) and Staff 24 (CMA) stated Resident 63 wore continuous oxygen. On 7/18/24 Staff 28 (RCM-LPN) stated Resident 63 wore continuous oxygen. Staff 28 acknowledged the resident did not have an order for continuous oxygen, and no documentation could be found in the resident's medical record that oxygen tubing was changed.

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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. **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 provide sufficient staffing to meet the needs of residents for 1 of 8 sampled residents (#16) and 2 of 2 halls (North and 2nd South) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. A review of Council Minutes revealed the following: -4/29/24 Staff were overworked. Staff left a resident unattended during care resulting in the resident being stuck in the bathroom. Another resident was left in the shower for an extended period. Staff checked on one resident in a room but not their roommate. Call light response times were too long while residents were in the bathroom. -5/29/24 staff lacked the time to spend with residents and had poor attitudes. Call lights went unanswered for 20 minutes or more. Staff did not assist each other. If a staff member was not assigned to a resident, they did not answer their call light. On 7/15/24 the following interviews occurred: -8:46 AM, Resident 36 reported waiting 45 minutes for incontinent care three times during the week of 7/8/24. On 7/14/24 she/he waited 45 minutes to be assisted off the bedside commode and experienced pain as a result. -10:12 AM, Resident 42 reported staff did not respond promptly to call lights and frequently apologized for being too busy. -10:30 AM, Resident 27 reported waiting up to an hour for assistance. -10:33 AM, Resident 55 expressed dissatisfaction with call light wait times across all shifts, particularly night shift. -11:03 AM, Resident 14 stated the week of 7/8/24 she/he waited for staff to answer her/his call light when needing to use the bathroom for over 20 minutes -12:29 PM Witness 5 (Family Member) stated Resident 3 was supposed to go to the dining room for meals to be supervised but she/he refused and there was not enough staff to supervise her/him in her/his room. On 7/17/24 at 9:31 AM Witness 1 (Staff) stated insufficient staffing led to new skin issues for a resident due to delayed incontinent care. Witness 1 sometimes could not complete resident showers because of time constraints. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 10:59 AM Staff 18 (CNA) stated the facility was consistently short-staffed. Staff 18 could not complete all her required tasks, including assisting with showers. After Staff 18's 30-minute lunch break the same call lights remained unanswered. Staff 18 witnessed residents with skin breakdown due to prolonged exposure to soaked incontinent briefs. Shift change was often disorganized, sometimes taking 30 to 40 minutes to determine staff assignments. Staff 18 stated staff did not receive breaks due to short staffing. On 7/17/24 at 12:03 PM Staff 38 (LPN) stated completing assigned tasks was a struggle as staff called off work two hours before the shift which resulted in CNA shortages. Staff 38 assisted CNAs during short-staffed periods but fell behind on her own work. The facility did not staff according to the residents' needs. Staff 38 stated short staffing occurred approximately three to four days a week. On 7/18/24 at 9:42 AM Staff 10 (CNA) stated the residents' needs exceeded the available staff capacity. Staff 10 sometimes struggled to complete her required daily tasks. The facility instructed CNA staff not to stay beyond their shifts to finish tasks. Some residents experienced skin issues due to delayed incontinent care by CNAs. Staff 10 reported when a fall-risk resident attempted to get up, she could not simultaneously monitor them and perform checks on other residents. On 7/18/24 at 10:54 AM Staff 14 (NA) stated understaffing was a significant issue at the facility. Staff continued to request additional staff. Staff experienced burnout because of ongoing understaffing. Staff 14 stated she faced challenges providing showers to residents due to short staffing. On 7/18/24 at 12:00 PM Staff 13 (CNA) reported ongoing concerns about short staffing in the facility. Residents become agitated waiting for their call lights to be answered. Short staffing occurred one or two days a week. Staff 13 stated many staff quit because of burnout. On 7/19/24 at 11:05 AM Staff 17 (CNA) stated sometimes she did not have enough time to complete resident showers. When she started her shift she found residents soaked in urine or bowel movements because the previous shift did not have time to complete incontinent care. Staff 17 stated she observed residents with skin redness because of sitting in urine or bowel movement. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed staffing issues. 2. Resident 16 admitted to the facility in 2/2017 with diagnosis including a fractured pelvis. The quarterly MDS dated [DATE] revealed Resident 16 had a BIMS score of 15 indicating the resident was cognitively intact. The resident required substantial to maximal assistance with transfers for toileting. Review of Resident 16's care plan revised 7/5/21 revealed Resident 16 had bladder incontinence. Interventions included to notify staff of toileting needs. Resident 16 was occasionally incontinent before reaching the bathroom and required one-person assistance for toilet transfers. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were busy with dinner one night the week of 5/20/24. Resident 16 activated her/his call light for toileting assistance, but staff did not respond for 45 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a 5/2024 Documentation Survey Report revealed the week of 5/20/24 to 5/27/24, on the evening shift, Resident 16 was continent twice, was both continent and incontinent seven times, and incontinent once. Witness 1 (Staff) was interviewed on 7/17/24 at 9:31 AM and confirmed the complaint that Resident 16 waited 45 minutes for toileting assistance one evening the week of 5/20/24. During an interview on 7/17/24 at 9:58 AM Resident 16 confirmed in 5/2024, during dinner time, she/he waited 45 minutes after activating her/his call light for toileting assistance. Resident 16 stated that about once a week she/he waited 20 minutes or more for the call light to be answered, with the afternoons being the worst. During an interview on 7/18/24 at 12:00 PM Staff 13 (CNA) reported call wait times sometimes were up to 30 minutes and residents became agitated. Staff 13 stated when toileting assistance was documented as both continent and incontinent during a shift it indicated a resident was continent one time and incontinent another time on the same shift. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the expectation for a call light to be answered was 15 to 20 minutes.

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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 eight consecutive hours per day 7 days per week for 34 out of 126 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: Review of the Direct Care Staff Daily Report sheets from 1/1/24 through 1/28/24, 2/3/24 through 2/25/24, 3/10/24 through 3/24/24, 5/1/24 through 5/30/24, 6/14/24 through 6/30/24, 7/1/24 through 7/14/24 revealed the facility did not have RN coverage for eight consecutive hours on the following days: 1/20/24, 1/21/24, 1/28/24, 2/3/24, 2/4/24, 2/5/24, 2/7/24, 2/8/24, 2/10/24, 2/11/24, 2/13/24, 2/16/24, 2/17/24, 2/18/24, 2/19/24, 2/21/24, 2/23/24, 3/10/24, 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/16/24, 3/17/24, 3/18/24, 3/19/24, 3/20/24, 3/21/24, 3/22/24, 3/23/24, 3/24/24, 6/30/24 and 7/3/24. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated they thought RN coverage was better than what was documented and reported two RN's employment was terminated.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 of 5 sampled CNA staff (#9) reviewed for staffing. This placed residents at risk for a lack of competent staff. Findings include: A review of the facility's performance review records revealed the following: -Staff 9 (CNA) was hired on 3/23/21, the provided performance review was dated 4/30/22. In an interview on 7/19/24 at 12:02 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the missed review occurred during a staffing transition.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35855 Based on observation, interview, and record review, it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents and visitors at risk for incomplete and inaccurate staffing information. Findings include: On 7/15/24 at 9:41 AM the DCSDR (Direct Care Staff Daily Report) was observed posted on the wall. The DCSDR did not have any staff hours documented for LPNs or CNAs. On 7/16/24 at 7:38 AM and 8:25 AM the 7/15/24 DCSDR was still posted on the wall. On 7/17/24 at 7:57 AM the DCSDR was observed on posted on the wall with no LPN or CNAs documented on the form. On 7/17/24 at 11:53 AM Witness 1 (Staff) stated in the last few months the nurses were informed to just fill in the staff numbers without staff hours and the administration would complete the form the next day. On 7/18/24 at 7:51 AM and 9:11 AM the 7/18/24 DCSDR was observed posted on the wall with no LPN or CNA hours documented for all three shifts. On 7/18/24 at 8:40 AM a text message was received from Witness 1 which was a photo of the DCSDR for 6/1/24 which was posted behind glass showing day shift and evening shift with LPN's signatures. Day shift was missing hours worked for RN, LPN, and CNAs, Evening shift was missing resident census, number of CNA staff and hours worked for RN, LPN, and CNA staff. On 7/19/24 at 8:43 AM the 7/19/24 DCSDR was observed posted on the wall with no CNA or LPN hours documented. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated completing the DCSDR was an ongoing issue with staff not adding up the hours.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41455 Based on observation, interview, and record review it was determined the facility failed to ensure proper flavor and food temperatures were maintained for meals served for 1 of 5 sampled resident (#27) and 1 of 1 facility kitchen reviewed for dining services. This placed residents at risk for food that was not palatable, safe, or appetizing. Findings include: 1. The 7/18/24 posted lunch menu included breaded pork cutlet, au gratin potatoes, cauliflower and the alternative menu was sloppy joes, cheddar mash potatoes and broccoli. The desert was ice cream. On 7/18/24 at 1:20 PM two sample plates were received. The first plate included minced and moist textured sloppy joes, mashed potatoes and gravy and broccoli. The second sample plate included easy to chew textured au gratin potatoes and cauliflower. The au gratin potatoes had crunchy pieces of dried potatoes, the moist and minced broccoli was cold with pieces that were firm to chew, the ice cream was melted and the milk was served warm. On 7/18/24 at 1:27 PM Staff 5 (Certified Dietary Manager) acknowledged the au gratin potatoes were cold and underdone, the broccoli was cold with no flavor, the ice cream should not be melted and milk was too warm and served at 64 degree. Staff 5 acknowledged the meal temperatures, flavors and palatability were not appropriate. 34703 2. Resident 27 admitted to the facility in 2023 with diagnoses including malnutrition and diabetes. On 7/16/24 at 10:16 AM Resident 27 stated the flavor of the food was bland with no taste, the bananas were over-ripe, the meat was dry and tough, and the food was always cold. On 7/18/24 at 9:43 AM Resident 27 was observed in the dining room during breakfast which included eggs, sausage, muffin, and an over-ripe banana. Resident 27 stated breakfast was cold and had no flavor. On 7/18/24 at 1:12 PM Resident 27 was in the dining room for lunch which included sloppy joe, broccoli, and mashed potatoes. Resident 27 stated the food was cold and tasted bad. On 7/18/24 at 1:29 PM Staff 28 (RCM-LPN) observed Resident 27's meal and stated the meal did not appear appetizing or appealing.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35855 Based on interview and record review it was determined the facility failed to have a system in place to ensure CNA staff received 12 hours of in-service training annually for 5 of 5 randomly selected staff members (#s 6, 7, 8, 9, and 10) reviewed for evidence of in-service training. This placed residents at risk for lack of competent staff. Findings include: A review of the facility's staff training records revealed the following: - Staff 6 (CNA), hired 5/30/22, had 15 minutes of documented training from 5/30/23 through 5/30/24. - Staff 7 (CNA), hired 6/20/19, had one hour of documented training from 6/20/23 through 6/20/24. - Staff 8 (CNA), hired 5/14/20, had two hours of documented training from 5/14/23 through 5/14/24. -Staff 9 (CNA), hired 3/23/21, had 7.25 hours of documented training from 3/23/23 through 3/23/24 -Staff 10 (CNA) hired 6/16/21, had 15 minutes of documented training from 6/16/23 through 6/16/24. In an interview on 7/19/24 at 12:03 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated staff were not obtaining the sign-up sheets for the trainings to keep track of staff training hours.