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	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Lebanon	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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on interview and record review it was determined the facility failed to ensure residents were informed of their rights both orally and in writing on an ongoing basis for 1 of 1 facility reviewed for Resident Council. This placed residents at risk for not being informed of their rights. Findings include:A review of the Resident Council Meeting Minutes from 6/28/25, 7/25/25, and 8/27/25 revealed resident rights were not reviewed during any of the meetings.On 9/4/25 at 2:08 PM, Staff 27 (Activity Director) stated he did not review resident rights during Resident Council meetings.On 9/5/25 at 10:51 AM, members of the Resident Council confirmed resident rights were not reviewed during the meetings.On 9/8/25 at 11:38 AM, Staff 1 (Administrator) stated the expected resident rights to be reviewed with residents during Resident Council meetings.

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification, including reserved bed hold payment, at the time of transfer to the hospital and notify the Ombudsman for 4 of 4 sampled residents (#s 10, 11, 67, and 69) reviewed for hospitalization and discharge. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include:A review of the facility's Transfer or Discharge, Emergency Acute Care and Bed-Holds and Return policy dated 10/2022 revealed the following: -When a resident is transferred to an acute care facility a notice of transfer is provided to the resident and resident representative. -A Copy of the transfer was also sent to the LTC Ombudsman. -All resident/representatives were provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence. 1.Resident 10 was admitted to the facility in 6/2025 with diagnoses including heart failure and kidney disease. A review of Resident 10's clinical record revealed she/he was transferred to the hospital on 8/16/25. No evidence was found in the clinical record to indicate written notice of the facility's bed-hold policy was provided to the resident or her/his representative. No documentation was found indicating the LTC Ombudsman was notified of the transfer. On 9/8/25 at 12:01 PM, Staff 1 (Administrator) stated a written bed-hold notification was not provided to Resident 10 or her/his representative at the time of transfer to the hospital. Staff 1 stated the LTC Ombudsman was not notified of the transfer. 2.Resident 67 was admitted to the facility in 7/2025 with diagnoses including weakness and stroke. A review of Resident 67's clinical record revealed she/he was discharged home on 8/1/25. No documentation was found in the clinical record indicating the LTC Ombudsman was notified of the discharge. On 9/8/25 at 12:01 PM, Staff 1 (Administrator) stated his expectation was the LTC Ombudsman should have been notified of Resident 67's discharge home. 3.Resident 69 was admitted to the facility in 7/2025 with diagnoses including alcohol abuse. A review of Resident 69's clinical record revealed she/he was discharged home on 8/14/25. No documentation was found in the clinical record indicating the LTC Ombudsman was notified of the discharge. On 9/8/25 at 12:01 PM, Staff 1 (Administrator) stated his expectation was the LTC Ombudsman should have been notified of Resident 69's discharge home. 4. Resident 11 was admitted to facility in 8/2023 with diagnoses including chronic kidney disease. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident's clinical record revealed she/he was hospitalized on [DATE], 7/29/25, 8/13/25 and 8/18/25. No evidence was found in the clinical record to indicate written notice of transfer or the facility's bed-hold policy was provided to the resident or her/his representative. On 9/5/25 at 2:50 PM, Staff 14 (Social Services Director) stated she did not have or send copies of notice of transfers to the Ombudsman. On 9/8/25 at 12:40 PM, Staff 1 (Administrator) stated Resident 11 did not receive a notice of transfer or have a signed acknowledgement of the bed-hold policy for her/his hospitalizations.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to comprehensively assess 1 of 3 resident (#11) reviewed for positioning and hospitalization. This placed resident at risk for unassessed needs. Findings include:Resident 11 was admitted to facility in 8/2023 with diagnoses including chronic kidney disease.On 9/2/25 at 2:19 PM, Resident 11 stated she/he was not certain of what her/his care needs consisted of, as she/he had recently experienced multiple hospitalizations.A review of Resident 11's clinical record revealed her/his Annual MDS completion deadline date was 8/2/25 and was incomplete as of 9/7/25. A review of Resident's clinical record revealed she/he was hospitalized on [DATE], 7/29/25, 8/13/25 and 8/18/25 and her/his most recent entry back to facility was on 8/22/25. No evidence was found in the clinical record to indicate a significant change assessment, or an admissions assessment was completed as of 9/7/25.On 9/8/25 at 8:58 AM, Staff 15 (Regional Reimbursement Analyst) acknowledged a comprehensive assessment had not been completed timely for Resident 11. He stated although Resident 11 had multiple hospitalizations, the expectation was for a comprehensive assessment to be completed timely.On 9/8/25 at 12:40 PM, Staff 1 (Administrator) acknowledged Resident 11's MDS assessment was not completed timely. He stated the expectation was for MDS Assessments to be completed timely and accurately for each resident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, it was determined the facility failed to coordinate the appropriate services to address communication needs for 1 of 1 sampled resident (#6) reviewed for communication. This placed residents at risk for ineffective communication and unmet needs. Findings include: Resident 6 was admitted to the facility in 4/2025 with diagnoses including persistent vegetative state (awake with no environmental awareness) and traumatic brain injury.The 4/24/25 admission MDS indicated Resident 6's ability to understand others was not assessed.A 5/26/25 physician order indicated PT, OT, SLP per family request. A 7/21/25 facility Care Conference Information form indicated Witness 2 (Family Member) requested Staff 6 (Resident Care Manager-LPN) coordinate referrals for OT. PT, SLP and a neurologist (brain disorder specialist).A 7/23/25 revised care plan indicated Resident 6 was not able to make her/his needs known and used non-verbal techniques to supplement her/his communication.On 9/2/25 at 12:59 PM, Witness 2 stated Resident 6 previously communicated using flash cards and wanted her/him assessed for improved communication technology.On 9/4/25 at 9:08 AM, Resident 6 was observed lying in bed and grunting while the television was on.On 9/4/25 at 2:08 PM, Staff 27 (Activities Director) stated he observed Resident 6's eyes respond and noted increased grunting when she/he was engaged in an activity of interest. On 9/5/25 at 4:00 PM, Staff 23 (CNA) stated Resident 6 made her/his needs known by swatting Staff 23's hand when undesired care was attempted.On 9/8/25 at 9:44 AM, Staff 6 acknowledged Resident 6 communicated using her/his eyes, but Staff 6 was unsure how an SLP could assist. Staff 6 stated a referral to a neurologist was ordered within the last few days and did not know if SLP had been contacted following the care conference.On 9/8/25 at 11:20 AM, Staff 3 (Regional Director of Quality Assurance) stated staff were expected to initiate referrals for communication services and specialists as soon as the request was made. Staff 3 acknowledged communication services for Resident 6 were delayed.

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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. Based on interview and record review it was determined the facility failed to provide bathing and shower care for 1 of 3 sampled residents (#16) reviewed for ADLs. This placed residents at risk for poor hygiene. Findings include: Resident 16 was admitted to facility on 7/5/25 with diagnoses including chronic obstructive pulmonary disease and metabolic encephalopathy (temporary or permanent brain dysfunction caused by a problem with the body's metabolism).Resident 16's 7/5/25 Care Plan indicated she/he required two staff to assist with bathing.Resident 7/13/25 admission MDS indicated the resident was dependent on assistance with bathing/showering.Resident 16's 7/2025 Bath/Shower task logs indicated the resident received showers on 7/8/25, 7/15/25 and 7/22/25. There was no documentation for 7/11/25, 7/18/25, and 7/29/25, which were Resident 16's scheduled shower days, as those entries were left blank.A review of Resident 16's Progress Notes from 7/5/25 through 7/30/25 revealed no evidence the resident was offered additional a showering opportunity when a shower was refused or not provided. On 09/04/2025 7:35 AM Staff 8 (CNA) stated there were times when staff would get too busy to chart tasks performed on residents. She stated after performing a shower task on residents, she would chart the shower task as completed.On 9/8/25 at 10:14 AM, Staff 6 (Resident Care Manager - LPN) stated if the Bath/Shower task logs were blank, it would indicate the task was not given. She stated residents were typically given baths/showers two times per week, and the expectation was for staff to complete resident showers and documenting they were done. At 11:53 AM, Staff 6 provided documentation stating on 7/11/25, Resident 16's bath/shower was not completed due to being short-staffed.

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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. Based on observation, interview and record review it was determined the facility failed to follow physician orders for 1 of 4 sampled residents (# 49) reviewed for infection control. This placed residents at risk for wound infections. Findings include:Resident 49 was admitted to the facility in 8/2025 with diagnoses including a leg fracture.An 8/8/25 Orthopedic Physician Order directed staff to remove Resident 49's dressing one week after 8/8/25. Staff were instructed to gently cleanse the incision using warm water and soap, pat dry, apply a nonadhesive pad or gauze dressing secured with tape, and change the dressing every one to two days until the follow-up appointment. Staff were to contact Trauma/Orthopedics if signs or symptoms of redness, drainage, onset of pain, chills, fever, sweats, or infection were observed.The 8/25 TAR did not contain the Orthopedic Physician's order for wound care. There was no evidence the wound care was completed.On 8/25/25, a Progress Note indicated Resident 49's middle incision on her/his left thigh was red, swollen, and warm to the touch. Resident 49 reported a burning sensation and tenderness.On 9/2/25 at 10:01 AM, Resident 49 stated staff did not remove her/his wound dressing for nearly two weeks after she/he was admitted to the facility, and her/his incision became infected and painful. Resident 49 stated she/he reported the pain to staff multiple times but staff did not check the incision until the incision was infected.On 9/8/25 at 9:29 AM, Staff 29 (LPN) stated when residents were admitted , Staff 30 (Medical Records) placed the orders in the resident's electronic record. Staff 6 stated two nurses verified the orders were correct and placed them on the MAR and TAR. Staff 6 verified the Orthopedic Physician's order was not on the TAR, dressing changes were not initiated, and Resident 49 developed an incision infection.On 9/8/25 at 9:45 AM, Staff 30 stated upon a new admission she reviewed the orders and uploaded the orders into the electronic record. Staff 30 stated two nurses reviewed the orders, confirmed they were correct, and placed them on the MAR and TAR. Staff 30 verified the Orthopedic Physician's order was not on the TAR and acknowledged the order was missed.On 9/8/25 at 12:28 PM, Staff 6 (Resident Care Manager-LPN) stated upon admission, the resident's new orders were placed in the electronic record by Staff 30 and reviewed by two nurses to verify accuracy. Staff 6 verified the Orthopedic Physician's order was not on the 8/2025 TAR. Staff 6 acknowledged dressing changes were not initiated for Resident 49 and she/he developed an incision infection.On 9/8/25 at 12:38 PM, Staff 3 (Regional Director of Quality Assurance) stated the process for new admissions was for Staff 30 to upload the new orders into the electronic record. Staff 3 stated two nurses were to verify the orders were uploaded correctly and placed on the MAR and TAR. Staff 3 verified the Orthopedic Physician's order was not on the 8/2025 TAR and acknowledged Resident 49 developed an incision infection.

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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. Based on observation, interview and record review it was determined the facility failed to implement care plan interventions related to smoking safety for 1 of 2 sampled residents (#37) reviewed for accidents. This placed residents at risk for increased smoking hazards and avoidable accidents. Findings include: The facility provided the following schedule for smoking:3:00 AM9:30 AM1:30 PM4:00 PM7:45 PM11:00 PMResident 37 was admitted to the facility in 9/2019 with diagnoses including inhalant dependence with inhalant-induced dementia (a condition where an individual has developed a physical or psychological reliance on substances which are inhaled to induce psychoactive effects).Resident 37's 8/8/25 Annual MDS assessment indicated she/he was cognitively intact.Resident 37's comprehensive Care Plan related to smoking safety last revised 8/26/25 indicated although she/he was assessed to be independent with smoking, she/he was to smoke in the smoking areas and to follow the smoking schedule. The care plan also indicated Resident 37's clothing and hands were to be checked for burns and for the facility to store her/his tobacco and fire materials in a lock box at the nurse's station.On 9/2/25 at 1:59 PM, Resident 37 stated she/he did not smoke where the others gathered in the designated courtyard of the facility. Resident 37 was observed entering a code into a keypad, exiting out the North exit door, and using a vape box.The following observations were made on 9/3/25:At 6:59 AM, Resident 37 was observed vaping/smoking outside of the North exit door.At 7:08 AM, Resident 37 was observed placing a box of cigarettes, lighter, and vape box on the counter of the nurse's station before entering her/his room. At 7:16 AM, Resident 37 came out of her/his room, picked up the box of cigarettes, lighter, and vape box off the counter of the nurse's station and exited through the North exit door.The following observations were made on 9/4/25:At 7:20 AM, Resident 37 was observed entering the facility from the North exit door, placed a box of cigarettes, lighter, and vape box on the nurse's station counter and entered her/his room.At 7:29 AM, Resident 37 was observed exiting her/his room, picked up the box of cigarettes, lighter, and vape box and exited through the North exit door.At 7:38 AM, Resident 37 was observed placing a box of cigarettes, lighter, and vape box on the nurse's station counter.At 7:47 AM, Resident 37 took a vape box and exited through the North door. The box of cigarettes and lighter were still on the counter.On 9/4/25 at 2:59 PM, Staff 9 (CNA) stated Resident 37 was able to smoke without supervision, but the smoking items were to be kept in a lock box. Staff 9 stated the items were given to Resident 37 when she/he asked. Staff 9 stated Resident 37 could smoke whenever she/he wanted to and did not need to go during designated times with the other residents who smoked in the designated courtyard. She stated Resident 37 could go through the North exit door independently.On 9/4/25 at 3:06 PM Staff 2 (DNS) stated the only designated smoking area on the premises was the courtyard, not where Resident 37 was going outside of the North exit doors. She stated Resident 37 had a lockbox kept in a cupboard for staff to keep the smoking materials. She stated her expectations were for staff to immediately take the smoking materials and lock the items in the lock box. Staff 2 stated she expected for staff to check Resident 37 for burns, but was not sure of the frequency.

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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. Based on interview and record review, it was determined the facility failed to ensure annual performance reviews for CNA staff were completed for 2 of 5 sampled CNA staff (#s 24 and 25) reviewed for staffing. This placed residents at risk due to lack of competent staff. Findings include:A review of personnel profile records revealed the following.-Staff 24 (hired on 5/14/20): The last performance review was dated 6/12/24.-Staff 25 (hired on 8/1/18): The last performance review was dated 8/15/24.On 9/8/25 at 11:36 AM, Staff 1 (Administrator) stated he expected the timely completion of annual staff evaluations.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review it was determined the facility failed to timely address a new identified behavior for 1 of 2 sampled residents (#2) reviewed for mood and behavior. This placed residents at risk for lack of emotional and behavioral health needs. Findings include:Resident 2 was admitted to the facility in 7/2025 with diagnoses including anxiety and heart failure. The 2/2025 Facility Assessment revealed behavior health staffing was insufficient. The 7/23/25 admission MDS revealed Resident 2 had a BIMS score of 15 which revealed she/he was cognitively intact, was depressed two to six days during the previous two weeks and received no antidepressant medications. The 8/2025 Behavior Monitoring Record revealed Resident 2 exhibited inappropriate behaviors on nine of 31 days which included refusal of care, confabulation (fabrication of false memories), and verbal aggression. On eight out of nine days, behavior interventions did not alter the outcome. The 8/1/25 through 9/5/25 Progress Notes revealed Resident 2 exhibited no additional behaviors. An 8/12/25 physician order revealed Resident 2 started melatonin (a supplement used to regulate sleep) for insomnia and anxiety. The 8/24/25 revised care plan indicated staff were to addressed Resident 2's behaviors through interventions which included: redirection, assessment of her/his pain, one on one interactions, toileting, snacks, to leave the room and then return, and repositioning. Resident 2's triggers included pain, feeling the loss of independence, and being upset. On 9/3/25 at 9:26 AM, Resident 2 stated she/he banged her/his walker against the wall a few days earlier because staff did not respond to her/his needs. Resident 2 was observed wringing her/his hands while speaking and stated she/he wanted to ensure the correct person was blamed for her lack of care. On 9/4/25 at 1:18 PM, Staff 17 (CMA) stated Resident 2's behaviors were challenging to address. Staff 17 stated she witnessed Resident 2 bang her/his walker against the wall in her/his room over ten days ago. Staff 17 stated she said did not report the incident because she believed other staff were aware. On 9/4/25 at 7:10 PM, Staff 28 (LPN) stated Resident 2 accused Staff 28 of providing inadequate care, which was dismissed following an investigation. Staff 28 acknowledged Resident 2's mood and behaviors impacted her/his care. On 9/5/25 at 12:38 PM, Staff 14 (Social Services Director) stated she was aware of Resident 2's verbal aggression towards staff, refusal of care, and confabulation related to staff. Staff 14 stated she witnessed Resident 2 bang her/his walker against the wall a few days earlier, which Staff 14 identified as a change in behavior. Staff 14 was unaware of Resident 2's prior physically aggressive behavior and expected documentation of behavioral changes to ensure timely interventions. Staff 14 stated behavioral services should be considered due to change in Resident 2's behaviors. Staff 14 stated she needed to complete a new behavioral assessment for Resident 2 to obtain additional behavioral services. On 9/5/25 at 1:03 PM, Staff 2 (DNS) stated she was unaware of Resident 2's physical aggressive behavior and expected documentation of the incident to support the management team in addressing the behavioral change.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview it was determined the facility failed to ensure treatment carts were locked and secured appropriately for 2 of 2 treatment carts observed during random observations for medication and treatment cart storage. This placed residents at risk for unsafe access to stored medications. Findings include: 1. On 9/4/25 at 7:15 AM, the North Hall treatment cart was unlocked. Staff and residents were observed to be walking by the treatment cart.On 9/4/25 at 7:17 AM, Staff 17 (CMA) walked by the cart, walked back, and locked the cart. Staff 17 stated she was not in charge of the treatment cart, but noticed it was unlocked and locked it on behalf of Staff 19. She stated Staff 19 was with a resident. On 9/4/25 at 7:19 AM, Staff 19 (RN - Charge Nurse) stated she usually locked the treatment cart before walking away, but was unsure why she did not lock the treatment cart. The treatment cart contained insulin, needles, glucometers, and IV supplies.On 9/8/25 at 12:40 AM, Staff 1 (Administrator) and Staff 3 (Regional Director of QA) stated they expected treatment carts to be locked at all times when staff walked away from the cart.2. On 9/4/25 at 8:03 AM, the South Hall treatment cart was unlocked. There were no staff members observed to be near the treatment cart.On 9/4/25 at 8:05 AM, Staff 20 (LPN - Charge Nurse) stated she was supposed to lock the treatment cart before walking away from it. Inside of the cart were insulin, syringes and prep pads. Staff 20 stated the small vials of liquid were anticoagulant and antibiotic medications.On 9/8/25 at 12:40 AM, Staff 1 (Administrator) and Staff 3 (Regional Director of QA) stated they expected treatment carts to be locked at all times when staff walked away from the cart.

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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. Based on observation, interview and record review it was determined the facility failed to follow up on dental services for 1 of 2 sampled residents (#11) reviewed for dental care. This placed residents at risk for lack of dental services. Findings include:The facility's Dental Services policy dated 12/2016 included the following:Social services representatives will assist residents with appointments, transportation arrangements, and reimbursement of dental services. All dental services provided are recorded in the resident's medical record.The facility's Referrals to Social Service Director dated 11/2024 included the following:Any referrals for the following areas will be made to the social services department: dental.Social services is responsible for the follow up and communication with outside providers for any of the above referrals.The Social Services Director will document any referrals made to ancillary services, mental health services, or additional community services/supports and will also document the outcomes following these referrals.Resident 11 was admitted to facility in 8/2023 with diagnoses including chronic kidney disease. Resident 11's Care Plan related to dental revised on 7/11/25 revealed staff were to coordinate arrangements for dental care and transportation as needed.A review of Resident 11's clinical record revealed no evidence of dental services referred from 6/2025 through 9/2025.On 9/18/25 at 8:15 AM, Staff 14 (Social Services Director) provided documentation which showed a dental referral for Resident 11 was provided on 7/3/25, when the provider was at the facility. Staff 14 stated she was unsure of what occurred afterward and found no notes or documentation indicating a follow-up dental appointment was scheduled for Resident 11.

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	09/08/2025

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

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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. Based on observation and interview the facility failed to provide covered refuse containers for 3 of 4 exterior refuse containers observed. This placed residents at risk for pest infestations. Findings include: On 9/2/25 at 10:04 AM, an uncovered exterior refuse container was observed outside a North Hall exit. The container held food containers and other trash. On 9/4/25 at 10:03 AM, uncovered exterior refuse containers were observed outside a second North Hall exit and a rear exit. The containers held food debris and other trash. On 9/5/25 at 10:00 AM, Staff 4 (Maintenance Lead) observed the uncovered refuse containers and stated there were no lids available for the containers. On 9/8/25 at 12:38 PM, Staff 1 (Administrator) and Staff 3 (Regional Director of Quality Assurance) acknowledged exterior refuse containers needed to be covered and there were refuse containers without covers at 3 exterior doors.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review it was determined that facility failed to demonstrate active involvement of staff and residents to determine staffing needs for 1 of 1 facility assessment. This placed residents at risk for inadequate staffing to meet resident needs. Findings include:The 2025 Facility Assessment indicated the facility had areas of insufficiencies in staffing, training, services and personnel.On 9/4/25 at 4:59 PM, Staff 23 (CNA) stated staff were not asked to provide input regarding staffing needs based on the acuity (severity of condition) of residents. On 9/5/25 at 11:07 AM, members of the Resident Council stated concerns about staffing had been discussed during previous meetings, but no resolution had been reached. The Resident Council reported the facility utilized agency staff and felt the staff members required additional training. On 9/7/25 at 2:42 PM, Staff 7 (Resident Care Manager-LPN) stated staff were not fully trained which resulted in some staff resignations. Staff 7 stated there was no formal process to provide feedback to management related to staffing needs. On 9/8/25 at 1:08 PM, documentation was requested to demonstrate how staffing hours, as well as resident and staff feedback, were incorporated into the facility assessment. Staff 1 (Administrator) stated no such documentation was available

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to follow appropriate infection control practices during a COVID-19 outbreak for 2 of 2 halls reviewed for infection control. This placed residents at risk for exposure to the COVID-19 virus and other infectious disease. Findings include: The facility's COVID-19 Testing Program Guidelines dated 6/7/24 included the following: Facility testing programs for both the residents as well as the facility staff are implemented at the facility in addition to other infection prevention and control activities and interventions aimed at preventing the spread, detecting cases quickly and stopping transmission. These infection control activities including the testing programs are coordinated and overseen by the facility Infection Preventionist who is in contact with the local health department as needed. The facility's COVID-19 Identification and Management of Ill Residents policy dated 7/2020 included the following: Staff caring for residents with suspected or confirmed COVID-19 must strictly adhere to infection prevention and control practices. Residents with known or suspected COVID-19 are cared for using all recommended PPE, including an N95 or higher-level respirator (or facemask if respirators are not available), eye protection, gloves and gown. 1. The following observations were made while in the facility: On 9/3/25 at 7:06 AM, a bedside table was stationed inside of the facility next to the North exit door. There were used COVID rapid tests lined up on the bedside table. Staff 21 (Housekeeping Manager) stated all staff were required to take a COVID rapid test prior to the start of their shift. Staff and residents were observed going in and out of the North door where the bedside table was located. On 9/3/25 at 3:01 PM, Staff 31 (CNA) was observed entering room [ROOM NUMBER], which was identified to be on Droplet Precautions wearing an N95, gloves, and a gown. When she exited the room, she acknowledged forgetting to don a face shield. She stated she also forgot to doff the N95 respirator on her face before leaving the room. On 9/4/25 at 12:18 PM, Staff 11 (LPN – Infection Preventionist) acknowledged staff were testing at the North and South exit doors for COVID-19. Staff 11 stated staff were expected to take COVID tests inside of the medication rooms and a nurse was to administer the COVID-19 test. The used COVID-19 tests were to remain in the medication room. The nurse was to check the test after 15 minutes and throw it away. Staff 11 also stated she expected all staff to follow PPE guidelines provided on the signs posted by resident doors, which included doffing PPE before leaving the room. She acknowledged the Droplet Precautions were incorrect, as they had additional instructions posted on the back of the sign, which staff could not see. She stated the appropriate sign read, Special Droplet/Contact Precautions, as it did not have additional instructions on the back. On 9/8/25 at 12:40 PM, Staff 1 (Administrator) and Staff 3 (Regional Director of QA) stated they expected staff to follow appropriate PPE guidelines posted outside of resident doors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.An observation on 9/4/25 at 9:08 AM revealed used COVID-19 tests on top of the North Nurses Station. Staff 11 (LPN-Infection Preventionist) retrieved a paper towel, picked up the used tests, discarded them in the trash, then donned a glove to pick up the paperwork the tests had been placed on. Staff 11 stated the COVID-19 tests should not have been left in the open. Staff 11 stated testing was to be completed in the locked medication storage room to prevent the spread of COVID-19. The nurse was to read the test results within 15 minutes and discard the used tests. Staff 11 stated the night nurse had performed the COVID-19 tests and acknowledged the tests had remained on the North Nurses Station for an extended period and stated the tests should have been secured in the locked medication storage room. Staff 11 stated her expectation was for staff to place used Covid-19 tests in a closed locked room, not on top of the nurse's station counter to avoid the spreading of Covid-19. 3. Resident 26 was admitted to the facility in 6/2025 with a diagnosis of chronic obstructive pulmonary disease (chronic respiratory illness). Resident 26 resided in room [ROOM NUMBER]. A 9/2/25 revised care plan revealed Resident 26 had COVID-19 (respiratory illness) and was on Special Droplet Precautions. On 9/2/25 at 12:10 PM, a sign was observed outside the door of room [ROOM NUMBER] which indicated Resident 26 was on Special Droplet Precautions. Staff 26 (CNA) was observed to exit the room, disposed of her respirator facemask, and placed a new respirator facemask on as she exited the room. Staff 26 did not perform hand hygiene before donning her clean mask and acknowledged she neglected to perform hand hygiene as needed. On 9/4/25 at 12:20 PM, Staff 11 (IP) stated she expected staff to perform hand hygiene before donning a clean facemask.