STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385171	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of McMinnville	1309 NE 27th Street McMinnville, OR 97128

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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. 34702 Based on observation, interview and record review it was determined the facility failed to ensure a resident received assistance with fingernail care for 1 of 4 sampled residents (#46) reviewed for ADL care. This placed residents at risk for unmet care needs. Findings include: Resident 46 admitted to the facility in 2024 with diagnoses including stroke and left sided hemiparesis (paralysis to one side of the body). The 8/7/24 care plan indicated Resident 46 had left sided weakness and required assistance with ADL care. The 10/2024 TAR indicated Resident 46 received nail care on 10/31/24. On 11/4/24 at 12:43 PM Resident 46 was observed to have long fingernails. Resident 46 stated she/he requested to have her/his nails trimmed but staff did not provide nail care. On 11/6/24 at 2:10 PM Staff 7 (CNA) stated nail care was completed or offered for all residents on shower days. Staff 7 acknowledged Resident 46 was dependent on staff for nail care and her/his fingernails were long. On 11/6/24 at 2:15 PM Staff 2 (DNS) observed Resident 46's fingernails and acknowledged her/his fingernails were long and nail care was not completed.

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 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. 34702 Based on interview and record review it was determined the facility failed to provide a restorative program to prevent decline in range of motion for 1 of 1 sampled resident (#46) reviewed for RA. This placed residents at risk for physical decline. Findings include: Resident 46 admitted to the facility in 2024 with diagnoses including stroke and left sided hemiparesis (paralysis to one side of the body). The 8/7/24 care plan indicated Resident 46 had left sided weakness, impaired mobility and required assistance with ADL care. The 9/23/24 Physical and Occupational Therapy Discharge Summaries indicated Resident 46 made consistent progress throughout the plan of treatment and responded positively to techniques to stimulate functional performance and enhance safety to prevent further decline. Notes further indicated she/he had upper extremity hemiparesis which did not improve. The restorative program was, not indicated at this time. On 11/4/24 at 12:43 PM Resident 46 was observed to have her/his hand to be closed into a fist and stated she/he did not receive range of motion exercises for her/his hand and wanted to participate in an RA program. On 11/5/24 at 10:58 AM Staff 6 (PT) stated Resident 46 was discharged from therapy on 9/19/24. Staff 6 stated the resident was a good candidate for RA services after she/he discharged from therapy due her/his left sided stroke and difficulty using her/his left hand due to it tensing up. Staff 6 stated she was unable to make a referral to RA as the facility did not offer an RA program. On 11/5/24 at 10:51 AM and 11/7/24 at 1:33 PM Staff 2 (DNS) stated the facility did not have an RA program and was unsure of the last time RA was offered to residents. Staff 2 acknowledged Resident 46 had left sided weakness and would have benefited from an RA program.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34324 Based on interview and record review it was determined the facility failed to provide appropriate treatment for a resident receiving dialysis including monitoring of the dialysis site and communication with the dialysis provider for 1 of 1 sampled resident (#30) reviewed for dialysis. Findings include: Resident 30 admitted to the facility in 2022 with diagnoses including renal dialysis. a. The facility's Hemodialysis Offsite Policy, revised in 2023, indicated staff were to initiate the Pre/Post Dialysis Communication Form that was to be sent to the dialysis clinic with the resident. The policy further indicated upon return from dialysis the Pre/Post Dialysis Communication Form was to be completed. The 11/20/23 care plan indicated Resident 30 received dialysis three days a week on Tuesdays, Thursdays, and Saturdays. Review of the Pre/Post Dialysis Communication Form from 7/2024 through 10/2024 revealed the following: - 7/2024 five instances when the dialysis forms were not completed. - 8/2024 10 instances when the dialysis forms were not completed. - 9/2024 10 instances when the dialysis forms were not completed. - 10/2024 10 instances when the dialysis forms were not completed. On 11/7/24 at 12:11 PM Staff 4 (LPN) stated Resident 30 took the dialysis book (which contained the communication form) with her/him to each appointment. Staff 4 stated the communication form was used to communicate with dialysis with any updates or changes to Resident 30's care. Staff 4 stated nursing staff were supposed to complete the Pre/Post Dialysis Communication Form before and after the resident's dialysis appointments. Staff 4 acknowledged nursing staff did not always complete the dialysis communication forms. On 11/8/24 at 10:34 AM Staff 2 (DNS) stated the Pre/Post Dialysis Communication Forms were to be completed by nursing staff at each dialysis appointment and acknowledged the forms were not completed for the identified dates. b. The 9/24/24 care plan indicated Resident 30 had a right chest wall dialysis access site. An intervention included for the site to be checked daily. Review of Resident 30's medical record revealed no evidence Resident 30's access site was checked daily. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 10:00 AM Resident 30 stated staff did not assess her/his dialysis site after she/he returned from dialysis. On 11/8/24 at 10:34 AM Staff 2 (DNS) stated nursing staff were to check Resident 30's chest and it was to be documented on the TAR. Staff 2 acknowledged there was no evidence Residents 30's chest wall dialysis site was being checked on the TAR or in the resident's medical record.

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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. 34702 Based on interview and record review it was determined the facility failed to ensure pharmacist recommendations were considered for 2 of 5 sampled residents (#s 14 and 28) reviewed for unnecessary medications. This placed residents at risk for unnecessary medication. Findings include: 1. Resident 14 admitted to the facility in 2021 with diagnoses including delusional disorder. Resident 14's 9/26/24 pharmacy recommendation indicated the following: -The resident received haloperidol (antipsychotic medication) 2.5 mg in the morning and 5 mg at bedtime for psychosis related to metabolic encephalopathy (brain dysfunction) and hallucinations. -Nursing assessments indicated no episodes of delusions or hallucinations in the last three months. -Please attempt a gradual dose reduction of haloperidol to 5 mg at bedtime. - The pharmacy recommendation was signed by the physician on 9/26/24 and indicated the recommendations were accepted and to be implemented as written. The pharmacy recommendation was not noted by Staff 2 (DNS) until 10/8/24 (13 days later). On 11/7/24 at 1:23 PM Staff 2 stated the facility received the recommendation but did not have a system in place to ensure pharmacy recommendations were addressed. Staff 2 acknowledged Resident 14's pharmacy recommendations were not addressed timely. 2. Resident 28 admitted to the facility in 2022 with diagnoses including atrial fibrillation. On 11/8/24 a request was made from Staff 2 (DNS) for the 10/2024 pharmacy recommendations for Resident 28 as they were not located in the clinical record. Resident 28's 10/16/24 pharmacy recommendation indicated the following: -During the review of the resident's Eliquis (anticoagulant medication) tablet 5 mg twice daily directions include to resume on 4/27/24 after Paxlovid (antiviral medication) was complete. -Please remove the following from the order: resume on 4/27/24 after Paxlovid was complete. On 11/8/24 at 11:27 AM Staff 2 acknowledged the 10/16/24 pharmacy recommendation was not addressed as of 11/8/24. Staff 2 stated she did not recall receiving the pharmacy recommendation and had to go online on 11/8/24 to find the recommendation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34702 Based on observation, interview and record review it was determined the facility failed to ensure the facility maintained a medication error rate of less than 5%. There were six errors in 26 opportunities resulting in a 23% medication error rate. This placed residents at risk for adverse side effects from medications. Findings include: 1. Resident 152 admitted to the facility in 2024 with diagnoses including heart failure, gastroesophageal reflux disease (GERD) and fibromyalgia. a. The 11/1/24 physician order indicated Resident 152 was to receive duloxetine (antidepressant medication) delayed release 60 mg once daily for chronic pain. On 11/6/24 at 9:01 AM Staff 5 (Agency RN) was observed to prepare morning medications for Resident 152. Staff 5 prepared duloxetine 30 mg in the medication cup and continued to the next medication. The State Surveyor stopped Staff 5 and asked her to review the order since the prepared medication did not match the order. Staff 5 acknowledged she prepared duloxetine 30 mg instead of the ordered duloxetine 60 mg. Staff 5 then prepared the correct dose of the medication. On 11/6/24 at 10:49 AM Staff 2 (DNS) acknowledged the identified findings and provided no additional information. b. The 11/1/24 physician order indicated Resident 152 was to receive Eliquis (anticoagulant medication) 2.5 mg twice daily for heart failure. On 11/6/24 at 9:01 AM Staff 5 (Agency RN) was observed to prepare morning medications for Resident 152. Staff 5 prepared Eliquis 5 mg in the medication cup and continued to the next medication. The State Surveyor stopped Staff 5 and asked her to review the order since the prepared medication did not match the order. Staff 5 acknowledged she prepared Eliquis 5 mg instead of the ordered 2.5 mg. Staff 5 then prepared the correct dose of the medication. On 11/6/24 at 10:49 AM Staff 2 (DNS) acknowledged the identified findings and provided no additional information. c. The 11/1/24 physician order indicated Resident 152 was to receive omeprazole 40 mg twice daily for GERD. The manufacturer recommendations indicated omeprazole was to be administered before meals. On 11/6/24 at 9:01 AM Staff 5 (Agency RN) was observed to prepare morning medications for Resident 152 including omeprazole 40 mg. On 11/6/24 at 9:01 AM Staff 5 acknowledged omeprazole was to be administered prior to breakfast but was administered after Resident 152 ate breakfast. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 10:49 AM Staff 2 (DNS) acknowledged the identified findings and provided no additional information. d. The 11/1/24 physician order indicated Resident 152 was to receive Tylenol 1000 mg three times daily for pain. On 11/6/24 at 9:01 AM Staff 5 was observed to prepare morning medications for Resident 152. The medications did not include Tylenol. On 11/6/24 at 9:28 AM Resident 152 was observed to ask Staff 5 for the Tylenol and stated it was scheduled. Staff 5 then prepared the Tylenol 1000 mg. On 11/6/24 at 9:31 AM Staff 5 stated the Tylenol was due at 8:00 AM but she did not see it because she pulled up medications that were due at 9:00 AM. Staff 5 administered the Tylenol to Resident 152 and acknowledged it was administered late. On 11/6/24 at 10:49 AM Staff 2 (DNS) acknowledged the identified findings and provided no additional information. e. The 11/1/24 physician order indicated Resident 152 was to receive loratadine 10 mg once daily for allergies. The physician order did not include cetirizine 10 mg. On 11/6/24 at 9:46 AM Staff 5 was observed to prepare cetirizine 10 mg for Resident 152. The State Surveyor stopped Staff 5 and asked her to review the order. Staff 5 reviewed the order and looked up cetirizine in the computer and acknowledged loratadine and cetirizine were two different drugs. Staff 5 stated she needed to check with the nurse as she could not find the loratadine in the medication cart or the medication room. On 11/6/24 at 10:49 AM Staff 2 (DNS) acknowledged the identified findings and provided no additional information. 2. Resident 10 admitted to the facility in 2024 with diagnoses including major depressive disorder. The 11/1/24 physician order indicated Resident 10 was to receive sertraline 50 mg two tabs once daily. On 11/7/24 at 8:07 AM Staff 3 (LPN) was observed to prepare morning medications for Resident 10. Staff 3 prepared sertraline 50 mg in a medication cup and continued to the next medication. The State Surveyor stopped Staff 3 and asked her to review the order since the prepared medication did not match the order. Staff 3 clarified the order with Staff 2 (DNS) and acknowledged she prepared sertraline 50 mg instead of the ordered 100 mg. Staff 3 then prepared the correct dose of the medication. On 11/7/24 at 1:26 PM Staff 2 (DNS) acknowledged the identified findings and provided no additional information.