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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385182	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creswell Post Acute	735 South 2nd Street Creswell, OR 97426

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26991 Based on interview and record review it was determined a resident was not spoken to in a dignified manner for 1 of 3 sampled residents (#47) reviewed for dignity. This placed residents at risk for lack of self-worth. Findings include: Resident 47 admitted to the facility in 7/2024 with a diagnosis of post-surgical procedure paraplegia. On 8/14/24 Witness 9 (Anonymous) reported to the State agency Staff 7 (CNA) would not change Resident 47's sheets and it caused Resident 47 to feel afraid and Resident 47 felt she/he had to argue to receive care. A 7/31/24 admission MDS revealed Resident 47 was cognitively intact. On 8/26/24 at 3:30 PM Resident 47 stated her/his sheets were wet from sweat and requested Staff 7 (CNA) to change the sheets. Staff 7 insisted the sheets were not wet. Resident 47 stated it was frustrating to have to always argue with staff to have care provided. Eventually the sheets were changed. On 8/28/24 at 10:31 AM Staff 2 (DNS) stated if a resident requested her/his sheets to be changed, staff should honor the request. Staff 2 stated Resident 47 reported she/he requested her/his sheets to be changed, staff left, and Resident 47 felt it took too long for staff to return. On 8/29/24 at 10:26 AM Staff 7 (CNA) stated on one occasion Resident 47 stated her/his sheets were wet from sweat and wanted the sheets changed. Staff 7 stated she checked the sheets and told resident the sheets were not wet and did not need to be changed. However, she left the room, found another CNA, returned to the resident's room, and they changed her/his sheets.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 47001 Based on interview and record review it was determined the facility failed to obtain consent for an influenza vaccination for 1 of 5 sampled residents (#16) reviewed for immunizations. This placed residents and responsible parties at risk for lack of informed consent. Findings include: Resident 16 admitted to the facility in 10/2023 with diagnoses including diabetes. An 8/25/24 Quarterly MDS indicated Resident 16 was cognitively intact. An 8/29/24 review of Resident 16's immunization record revealed she/he received the influenza vaccine in the facility on 12/13/23. An 8/29/24 review of Resident 16's medical record revealed no evidence of a signed consent for the influenza vaccine received in the facility on 12/13/23. On 8/29/24 at 3:35 PM Staff 2 (DNS) stated she was unable to locate a signed consent for Resident 16's influenza vaccine received in the facility on 12/13/23. Staff 2 stated consent needed to be obtained prior to a resident receiving vaccines.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 26991 Based on interview and record review it was determined the facility failed to notify a resident's emergency contact of a hospitalization and a resident's physician for a change of condition for 2 of 6 sampled residents (#s 18 and 47) reviewed for hospitalization and pressure ulcers. This placed residents at risk for lack of family involvement and delayed treatment. Findings include: 1. Resident 18 admitted to the facility in 2010 with a diagnosis of delayed stomach and bowel emptying. An undated Admission Record revealed Witness 5 (Family Member), Witness 6 (Family Member), and Witness 7 (Family Member) were Resident 18's emergency contacts. An 10/26/23 Progress Note revealed Resident 18 was transported to the hospital for abdominal pain, nausea, vomiting, and uncontrolled diarrhea. There was no indication any of Resident 18's emergency contacts were notified. A 7/15/24 quarterly MDS indicated Resident 18 was cognitively intact. On 8/26/24 at 4:15 PM Resident 18 stated the facility did not call her/his emergency contacts when she/he was hospitalized . On 8/28/24 at 3:20 PM Staff 3 (RNCM) verified Resident 18's family was not notified of the 10/26/23 hospitalization . 2. Resident 47 admitted to the facility in 7/2024 with a diagnosis of paralysis after spinal surgery. Progress notes revealed the following: - 8/24/24 Resident 47 reported earlier in the day when she/he was assisted to turn there was a pop to her/his back. The nurse assessed the area to have a small lump above the surgical incision. The note indicated family stated they would communicate with the spinal surgeon on 8/26/24. There was no note to indicate staff notified the resident's physician. -8/25/24 Resident 47's pain was controlled with scheduled and PRN pain medications. -8/26/24 Staff 2 (DNS) and Staff 3 (RNCM) assessed the spine and did not see a lump to back. On 8/28/24 at 10:05 AM Staff 2 and Staff 3 acknowledged the physician was not notified at the time staff identified a lump.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 36494 Based on interview and record review it was determined the facility failed to respect the resident rights to deliver postal service mail unopened for 1 of 3 (#12) sampled resident reviewed for privacy. This placed residents at risk for lack of privacy and confidentiality. Findings include: Resident 12 admitted to the facility in 5/2023 with a diagnosis of diabetes. A 6/11/24 admission MDS revealed Resident 12 was cognitively intact. On 8/27/24 at 9:05 AM, Resident 12 stated she/he was upset because a staff member opened her/his mail a box, which was addressed to her/him. The resident stated the box had supplements and acknowledged she/he needed a doctor's approval before taking the supplements. However, staff did not honor her/his privacy or personal property. On 8/28/24 at 12:03 PM Staff 5 (CMA) stated on 6/3/24 she opened a package addressed to Resident 12's. After shaking the box, she heard a bottle which sounded like it contained supplements or medication. Staff 5 stated she should have let the resident open the box in front of her and acknowledged she violated Resident 12's rights. On 8/28/24 at 12:31 PM Staff 14 (Activity Director) stated she delivered the mail or received assistance to delivar the mail. Staff 14 stated Staff 5 accidentally opened Resident 12's package and immediately addressed the error with Resident 12. Staff 14 stated anything addressed to a resident should be delivered unopened. Staff 14 stated if staff thought there were medications in a box, they should be present and ask if it would be okay for the resident to open her/his mail in front of the staff member. On 8/29/24 at 1:39 PM Staff 3 (RNCM) stated she was unaware a staff member opened Resident 12's mail. Staff 3 stated if mail or a package sounded like it contained supplements or medications, staff could be present when the resident opened her/his mail. Staff 3 stated staff should never open any resident's mail because it was a violation of privacy.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 26991 Based on interview and record review it was determined the facility failed to initiate a grievance process for 1 of 2 sampled residents (#16) reviewed for personal property. This placed residents at risk for unaddressed concerns. Findings include: 47001 1. Resident 16 admitted to the facility in 10/2023 with diagnoses including diabetes. An 8/25/24 Quarterly MDS indicated Resident 16 was cognitively intact. On 8/27/24 at 8:32 AM Resident 16 stated her/his cell phone was stolen a couple of months ago and she/he spent $300 to replace it. Resident 16 stated the facility did not reimburse her/him. On 8/28/24 at 11:39 AM Staff 4 (Social Services) stated she was informed by Resident 16 she/he bought a new phone because she/he lost her/his old phone. Staff 4 stated Resident 16 never filled out a grievance form and she did not complete a grievance form for Resident 16. Staff 4 stated this was a grievance and should have had a grievance form filled out and investigated.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure a resident received a bed hold policy for 1 of 2 sampled residents (#47) reviewed for hospitalization . This placed residents at risk for not being informed of their rights to return to the facility. Findings include: Resident 18 admitted to the facility in 2018 with a diagnosis of delayed emptying of the stomach and intestines. Progress Notes from 10/2023 through 8/2024 revealed Resident 18 was hospitalized on [DATE], 11/8/23, and 2/10/24. The notes did not indicate Resident 18 or her/his emergency contacts were provided a bed hold policy. On 8/29/24 at 9:23 AM Staff 4 (Social Services) stated if she was in the facility when a resident was discharged to the hospital, she ensured the resident or representative was provided a bed-hold policy. If it was after hours or on the weekend, nursing staff were to provide the policy. Staff 4 stated Resident 18 was not provided bed-hold policies at the time of the resident's hospitalization s.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to develop a baseline care plan for 1 of 2 sampled residents (#47) reviewed for constipation. This placed residents at risk for unmet care needs. Findings include: Resident 18 admitted to the facility on [DATE] with a diagnosis of paralysis after spinal surgery. A baseline care plan was initiated on 7/26/24 and did not include Resident 47 was to be log-rolled (ensuring the spine did not twist). The care plan was updated on 8/5/24 to include log rolling and spinal precautions, and no leg movement. An untitled therapy document form revealed on 8/5/24 therapy indicated a care plan change was made. The change indicated two staff were to assist Resident 47 for all bed mobility for log rolls, use spinal precautions, and to ensure no leg movement. A 7/31/24 Admission MDS revealed Resident 47 was cognitively intact. On 8/26/24 at 3:32 PM Resident 47 stated the staff did not follow therapy directions for turning. On 8/27/24 at 1:35 PM Staff 15 (Therapy Director) stated on 8/5/24 the care plan was updated and a communication form was created. On 8/28/24 at 11:46 AM Staff 16 (Occupational Therapist) stated Resident 47 reported staff did not implement spinal precautions and staff were educated on assisting Resident 47 to turn. On 8/29/24 at 9:00 AM Staff 17 (LPN) stated if a resident had special precautions, such as transfers, the information was located in the care plan and nursing tasks. On 8/29/24 at 9:02 AM Staff 18 (CNA) stated when a resident was admitted to the facility resident specific instructions were on the care plan. On 8/29/24 at 9:27 AM Staff 19 (CNA) stated if a resident was new to the facility the resident's immediate interventions were provided verbally by the nurse. Within 24 hours the information was on their care plan. On 8/29/24 at 11:08 AM Staff 4 (RNCM) acknowledged spinal precautions were not on the baseline care plan and were not added until 8/5/24.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001 Based on interview and record review it was determined the facility failed to ensure safe discharge planning services for 1 of 5 sampled residents (#16) reviewed for unnecessary medications. This placed resident at risk for unsafe discharge. Findings include: Resident 16 admitted to the facility in 11/2023 with diagnoses including third degree burns to her/his left chest, abdomen and thigh. A review of a 11/10/23 facility discharge summary revealed Resident 16 was discharged from the facility to home on 11/10/23 with orders for home health, and Resident 16 had orders for daily wound care to her/his burn wounds. A review of a 11/15/23 hospital history and physical revealed Resident 16 went to the emergence room due to her/his concerns of a wound infection, inability to care for self at home and home health did not come to Resident 16's home since discharge from the facility on 11/10/23. The burn wounds on Resident 16's left chest, left abdomen and left thigh were described as having increased pain and purulent exudates (commonly referred to as pus) coming out of the wound with redness and swelling around the wounds. A review of a 11/16/23 hospital progress not stated Resident 16's burn wounds on her/his left chest, left abdomen and left thigh were infected and Resident 16 was receiving intravenous antibiotics. A review of Resident 16's 11/17/23 admission orders revealed Resident 16 was readmitted to the facility on two different antibiotics for burn wound infections. An 8/25/24 Quarterly MDS indicated Resident 16 was cognitively intact. On 8/28/24 at 11:39 AM Staff 4 (Social Services) stated home health was ordered for Resident 16 upon discharge on 11/10/23, but home health did not have time to see Resident 16 prior to her/him being admitted to the hospital on 11/15/23. On 8/28/24 at 2:54 PM Staff 3 (RNCM) stated Resident 16 was discharged on [DATE] with orders for daily wound care to her/his burn wounds. Staff 3 stated, according to Resident 16, her/his roommate was supposed to assist her/him with wound care upon discharge on 11/10/23. Staff 3 stated there was no evidence of wound care training completed with Resident 16 or her/his roommate. On 8/29/24 at 1:56 PM Resident 16 stated the facility discharged her/him by mistake. Resident 16 stated she/he was unable to do her/his own wound care and she/he had no family or friends that could do wound care for her/him. Resident 16 stated the facility did not talk to her/him about wound care or train her/him on wound care.

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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. 47001 Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 3 sampled residents (#41) reviewed for ADLs. This placed resident at risk for unmet needs. Findings include: Resident 41 admitted to the facility in 1/2024 with diagnoses including diabetes. A 7/13/24 Quarterly MDS indicated Resident 41 had severe cognitive deficits. On 8/27/24 at 9:26 AM Resident 41 was observed to have dirty hair and dirty, jagged fingernails. An 8/28/24 review of shower/bathing documentation revealed the following: - On 7/26/24 shower/bathing activity did not occur due to resident refusal. - On 8/2/24 shower/bathing activity did not occur. - On 8/19/24 Resident 41 received a shower. There was no shower/bathing documentation between 8/3/24 and 8/18/24. An 8/29/24 medical record review revealed no evidence Resident 41 refused shower/bath or nail care on 7/30/24 or between 8/3/24 and 8/18/24. On 8/29/24 at 11:31 AM an observation of Resident 41's fingernails was made with Staff 18 (CNA). Staff 18 stated Resident 41's fingernails needed trimmed and cleaned. On 8/29/24 at 11:43 AM an observation of Resident 41's fingernails was made with Staff 3 (RNCM). Staff 3 stated Resident 41 needed her/his fingernails filed and cleaned. Staff 3 stated nail care should be completed with showers and as needed. On 8/29/24 at 4:01 PM Staff 3 stated Resident 41 should have received showers twice a week. Staff 3 was able to provide documentation which indicated Resident 41 refused her/his shower on 8/9/24. Staff 3 acknowledged Resident 41 should have received a shower/bath on 7/30/24, 8/2/24, 8/6/24, 8/13/24 and 8/16/24. Staff 3 confirmed there was no documentation Resident 41 refused bathing on 7/30/24, 8/2/24, 8/6/24, 8/13/24 and 8/16/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 26991 Based on observation, interview, and record review it was determined the facility failed to follow physician orders, provide bowel care, and administer medications timely for 9 of 12 sampled residents (#s 2, 4, 8, 13, 14, 41, 43, 47, 203) reviewed for change of condition, restraints, pain, bowel care, and medication pass. This placed residents at risk for ineffective interventions. Findings include: 1. Resident 2 admitted to the facility in 3/2010 with a diagnosis of cancer. A care plan initiated in 2020 revealed Resident 2's bed had bed rails to improve bed mobility. On 8/26/24 at 2:47 PM Witness 1 (Family Member) stated Resident 2 used mobility bars to assist with bed mobility, the facility removed the bars, and she was not informed the reason the mobility bars were removed. On 8/27/24 at 1:59 PM Resident 2 was observed in bed. The bed did not have bed rails. On 8/27/24 at 2:46 PM Staff 3 (RNCM) stated Resident 2's original bed was replaced with a new bed and the rails were not transferred to the new bed. 2. Resident 47 admitted to the facility in 7/2024 with a diagnosis of paralysis after spinal surgery. a. A care plan initiated on 7/25/24 revealed Resident 47 was at risk for constipation. Interventions included: -Staff were to monitor Resident 47 for constipation. Symptoms to monitor included nausea, vomiting, and abdominal distention. -Provide non-pharmacological interventions. -Provide medications to relieve constipation. Resident 47's 7/2024 and 8/2024 Documentation Survey Report revealed: -7/27/24 day shift Resident 47 had a bowel movement. -7/28/24 no bowel movement. -7/29/24 no bowel movement. -7/30/24 no bowel movement. -7/31/24 no bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/1/24 day shift Resident 47 had a small bowel movement. A 7/2024 MAR revealed on 7/30/24 Resident 47 received Milk of Magnesia (laxative) which was documented as effectiveness unknown. No additional laxatives were administered. An 8/2024 MAR revealed on 8/1/24 Resident 47 was administered Milk of Magnesia and sennoside (laxative) and the medication was effective. 7/2024 Progress Notes revealed no assessments of the resident's bowel status or abdomen. On 8/28/24 at 9:56 AM Staff 5(CMA) stated every morning she looked at the bowel report. If a resident did not have a bowel movement in two days, on the third day bowel care was provided. If a resident refused a medication the nurse was notified. On 8/28/24 at 10:11 AM Staff 2 (DNS) stated if a resident was constipated and a medication was not effective, additional interventions should be provided and documented in the progress notes. Staff 2 acknowledged there were no assessments in the progress notes and staff did not provide additional interventions prior to 8/1/24. b. Resident 47's 7/2024 and 8/2024 MARs revealed she/he was to be administered hydromorphone (narcotic pain medication) every four hours at 1200 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. Medications were administered one hour or later on the following dates and times: -7/25/24 12:00 dose -7/27/24 8:00 AM dose -8/3/24 4:00 PM dose -8/4/24 4:00 PM dose -8/8/24 12:00 AM dose -8/9/24 8:00 PM dose -8/13/24 4:00 AM dose -8/15/24 8:00 PM dose -8/17/24 12:00 AM dose -8/20/24 12:00 MA dose -8/25/24 4:00 PM dose (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 1:25 PM Staff 5 (CMA) stated it was difficult to pass the medications, especially in the morning, to 50 residents. Staff 5 also stated at times it was hard to administer Resident 47 her/his medications at the scheduled times and Resident 47 did not like to wait for her/his medications. On 8/28/24 at 10:25 AM Staff 2 (DNS) acknowledged there were multiple days when Resident 47's medications were administered more than one hour after the scheduled time. 47001 3. Resident 43 admitted to the facility in 2/2024 with diagnoses including alcohol use. A 6/1/24 Quarterly MDS indicated Resident 43 had moderate cognitive impairment. A review of a 7/30/24 progress note written at 2:26 PM revealed Resident 43 returned from an outing fatigued with a decreased level of responsiveness, was diaphoretic, had abnormal vitals signs and EMTs were called. A review of a 7/30/24 progress note written at 2:43 PM revealed Resident 43 returned to baseline after the EMTs arrived to the facility and refused to go to the hospital. Resident 43 reported he consumed four beers while out of the facility on an outing. An 8/2/24 public complaint alleged the facility failed to ensure resident safety regarding alcohol consumption during an outing and the facility failed to notify the resident representative in a timely manner regarding the resident's change of condition. An 8/7/24 public complaint alleged the facility failed to ensure the resident's safety during a community outing. An 8/14/24 public compliant alleged the facility failed to ensure a safe environment for the resident while on an outing with staff. An investigation dated 8/16/24 revealed two staff members, Staff 26 (Staffing Coordinator) and Staff 25 (HR), took Resident 43 to the river to go rock hunting. Orders were received for Resident 43 to have 12 ounces of beer while on the outing. Upon arrival to the river, Staff 26 gave one 12-ounce can of beer that she/he spilled; Resident 43 drank half to three quarters of this beer before it was spilled. Staff 26 gave another 12-ounce beer to Resident 43. Staff 26 and Staff 25 were in the river rock hunting, and Resident 43 was on the riverbank with Staff 25's son. Staff 25's son obtained the rest of the beers from the vehicle per Resident 43's request. Staff 26 and Staff 25 stated they were unaware Resident 43 drank more beers than beers Staff 26 gave to her/him. Resident 43 stated he drank three and a half 12-ounce beers in total. Upon return to the facility Staff 26 and Staff 25 stated Resident 43's nurse was not notified of her/his consumption of more than the 12-ounces of beer allowed by the physician order. Resident 43 went back to her/his room, staff noticed her/his change of condition and called EMTs. Resident 43 was back to baseline when the EMTs arrived and she/he declined to go to the hospital. (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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 8/29/24 at 11:53 AM Staff 25 stated Resident 43 asked her a week before they went to the river to go rock hunting she/he wanted a beer. Orders for the beer were obtained by Staff 2 (DNS). Staff 25 stated when they arrived at the river Resident 43 was given a beer which spilled and Staff 26 gave her/him another one. Staff 25 stated she and Staff 26 went into the river to rock hunt and Resident 43 stayed on the riverbank. Staff 25 stated she and Staff 26 were supervising Resident 43, but she was unaware Resident 43 drank more than the beer Staff 26 gave her/him and she was unaware of her son getting the rest of the beers and bringing them down to the river. Staff 25 stated her son was unaware of how many beers Resident 43 could drink. Staff 25 stated they became aware how many beers were consumed when they were cleaning up and heading back to the facility. Staff 25 stated Resident 43 drank 2 to 3 beers but she was unsure. Staff 25 stated Staff 26 brought Resident 43 into the facility. Staff 25 stated she did not inform anyone how many beers Resident 43 drank.

On 8/28/24 at 12:07 PM Staff 26 stated she verified the order with Resident 43's provider prior to the outing at the river. Staff 26 stated the provider stated she gave orders for Resident 43 to have 12 ounces of beer. Staff 26 stated she and Staff 25 were supervising Resident 43 but she was unaware Resident 43 consumed more beers than what she provided to her/him. Staff 26 stated she was unaware how many beers Resident 43 consumed but thought she/he had two 12-ounce beers and maybe a sip of another can. Staff 26 stated she brought Resident 43 back into the facility after the outing and informed the nurse Resident 43 needed a change of clothes, a shower and a nap. Staff 26 stated she did not inform the nurse how many beers Resident 43 consumed.

On 8/29/24 at 12:16 PM Staff 2 stated she received orders for Resident 43 to consume 12 ounces of beer on the outing to the river, and both Staff 26 and Staff 25 were aware of the order. Staff 2 stated Staff 25's son gave Resident 43 more beers and Resident 43 consumed three and a half 12-ounce cans of beer. Staff 2 stated Staff 26 and Staff 25 did not inform anyone how many beers Resident 43 consumed upon return to the facility. Staff 2 confirmed Resident 43's physician orders were not followed. Resident 43 should have had no more than one 12-ounce can of beer and Staff 26 and Staff 25 should have informed Resident 43's nurse how many beers Resident 43 consumed so the nurse could inform the provider.

50897

4. Resident 14 admitted to the facility 2/2022 with diagnoses including chronic obstructive pulmonary disease.

A review of a nursing Progress Note dated 4/11/24 at 7:56 PM revealed Staff 10 (LPN) noted a discrepancy in the Medication Administration Record and the Narcotics Log and said she believed the resident was given oxycodone instead of methadone for pain that morning.

A review of the Medication Error report completed by Staff 10 on 4/11/24 revealed Staff 12 administered oxycodone to Resident 14 during the morning medication pass instead of methadone. Staff 12 correctly completed the Narcotics Log for oxycodone but entered methadone in the Medication Administration Report.

On 8/29/24 at 1:04 PM Staff 11 (CMA) stated she noted the discrepancy in the Narcotics Log while administering methadone to Resident 14 during her afternoon medication pass on 4/11/24, and reported the discrepancy to Staff 10.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Creswell Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 735 South 2nd Street Creswell, OR 97426	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 1:17 PM Staff 12 (CMA) stated she did not recall administering the wrong medication to Resident 14 on 4/11/24. On 8/29/24 at 3:47 PM Staff 10 stated Staff 11 alerted her of the discrepancy in the Medication Administration Record the afternoon of 4/11/24, and informed her Resident 14 was likely administered oxycodone instead of methadone during morning medication pass. Staff 10 stated Resident 14 had no adverse side effects from receiving oxycodone. On 8/29/24 at 3:53 PM Staff 2 (DNS) stated she was aware of the medication error on 4/11/24 regarding Resident 14. Staff 2 stated she expected staff to ensure they followed physician orders and verify residents received the correct medications. 50930 5. Resident 4 admitted to the facility in 5/2023 with diagnoses including a brain tumor and epilepsy (a seizure disorder). A review of Resident 4's 8/28/24 Medication Admin Audit Report revealed the following: -Staff were to administer levothyroxine sodium (endocrine medication) at 7:00 AM, but the levothyroxine was not administered until 8:45 AM (one hour and 45 minutes late). -Staff were to administer apixaban (blood thinner) at 10:00 AM, but the apixaban was not administered until 11:42 AM (one hour 42 minutes late). -Staff were to administer lacosamide (anti-seizure medication) at 10:00 AM, but the lacosamide was not administered until 11:41 AM (one hour and 41 minutes late). -Staff were to administer baclofen (muscle spasm medication) at 10:00 AM, but the baclofen was not administered until 11:42 AM (one hour and 42 minutes late). -Staff were to administer levetiracetam (anti-seizure medication) at 10:00 AM, but the levetiracetam was not administered until 11:42 AM (one hour and 42 minutes late). -Staff were to administer pregabalin (nerve pain medication) at 10:00 AM, but the pregabalin was not administered until 11:41 AM (one hour and 41 minutes late). On 8/28/24 at 12:53 PM Staff 5 (CMA/CNA) verified there were multiple late medications for the 8/28/24 AM medication administration. She stated she was the only person responsible for passing all the resident medications and she struggled to administer medications on time due to high resident acuity. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated the facility had flex and scheduled medication administration times and the expectation was all medications were administered at those times. On 8/28/24 at 3:05 PM Staff 8 (RN) stated multiple residents complained regarding late medications on day shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident 8 admitted to the facility in 7/2024 with diagnoses including stroke and chronic obstructive pulmonary disease. A review of Resident 8's 8/28/24 Medication Admin Audit Report revealed the following: -Staff were to administer acetaminophen (pain medication) at 8:00 AM, but the acetaminophen was not administered until 11:17 AM (three hours and 17 minutes late). On 8/28/24 at 12:53 PM Staff 5 (CMA/CNA) verified there were multiple late medications for the 8/28/24 AM medication administration. She stated she was the only person responsible for passing all the resident medications and she struggled to administer medications on time due to high resident acuity. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated the facility had flex and scheduled medication administration times and the expectation was all medications were administered at those times. On 8/28/24 at 3:05 PM Staff 8 (RN) stated multiple residents complained regarding late medications on day shift. 7. Resident 13 admitted to the facility in 6/2024 with diagnoses including chronic obstructive pulmonary disease and arthritis. A review of Resident 13's 8/28/24 Medication Admin Audit Report revealed the following: -Staff were to administer metoprolol tartrate (blood pressure medication) at 8:00 AM, but the metoprolol tartrate was not administered until 11:19 AM (3 hours and 19 minutes late). -Staff were to administer Oxycodone HCL (opioid pain medication) at 8:00 AM, but the Oxycodone HCL was not administered. This medication was scheduled every four hours and the last dose was administered at 4:00 AM on 8/28/24. -Staff were to administer gabapentin (nerve pain medication) at 8:00 AM, but the gabapentin was not administered. This medication was scheduled for every eight hours. On 8/28/24 at 12:53 PM Staff 5 (CMA/CNA) verified there were two medications not given (Oxycodone and gabapentin), and multiple late medications for the 8/28/24 AM medication administration. She stated she was the only person responsible for passing all the resident medications and she struggled to administer medications on time due to high resident acuity. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated the facility had flex and scheduled medication administration times and the expectation was all medications were administered at those times. On 8/28/24 at 3:05 PM Staff 8 (RN) stated multiple residents complained regarding late medications on day shift. 8. Resident 41 admitted to the facility in 2/2024 with diagnoses including diabetes and chronic kidney disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 8/28/24 Medication Admin Audit Report of Resident 41's AM medication administration revealed the following: -Staff were to administer metformin HCL (diabetic medication) at 8:00 AM, but the metformin HCL was not administered until 11:35 AM (three hours and 35 minutes late). On 8/28/24 at 12:53 PM Staff 5 (CMA/CNA) verified there were multiple late medications for the 8/28/24 AM medication administration. She stated she was the only person responsible for passing all the resident medications and she struggled to administer medications on time due to high resident acuity. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated the facility had flex and scheduled medication administration times and the expectation was all medications were administered at those times. On 8/28/24 at 3:05 PM Staff 8 (RN) stated multiple residents complained regarding late medications on day shift. 9. Resident 203 admitted to the facility in 5/2024 with diagnoses including sepsis (severe infection) and chronic pain syndrome. An 8/28/24 Medication Admin Audit Report of Resident 203's AM medication administration revealed the following: -Staff were to administer gabapentin (nerve pain medication) at 8:00 AM, but the gabapentin was not administered until 9:38 AM (one hour and 38 minutes late). -Staff were to administer apixaban (blood thinner) at 8:00 AM, but the apixaban was not administered until 9:37 AM (one hour and 37 minutes late). -Staff were to administer acetaminophen (pain medication) at 8:00 AM, but the acetaminophen was not administered until 9:37 AM (one hour and 37 minutes late). -Staff were to administer Oxycontin (opioid pain medication) at 8:00 AM, but the Oxycontin was not administered until 9:38 AM (one hour and 38 minutes late). This medication was scheduled for every 8 hours. On 8/28/24 at 12:53 PM Staff 5 (CMA/CNA) verified there were multiple late medications for the 8/28/24 AM medication administration. She stated she was the only person responsible for passing all the resident medications and she struggled to administer medications on time due to high resident acuity. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated the facility had flex and scheduled medication administration times and the expectation was all medications were administered at those times. On 8/28/24 at 3:05 PM Staff 8 (RN) stated multiple residents complained regarding late medications on day shift.

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to assist residents to obtain prescription glasses for 2 of 2 sampled residents (#s 3 and 18) reviewed for vision. This placed residents at risk for impaired vision. Findings include: 1. Resident 18 admitted to the facility in 10/2018 with bowel and stomach dysfunction. A 6/13/24 Eye Exam Summary revealed Resident 18 reported blurred distant vision and a new prescription was provided. A 7/15/24 quarterly MDS revealed Resident 18 was cognitively intact. On 8/26/24 at 4:12 PM Resident 18 stated she/he had a vision appointment, was to get new glasses, but never received her/his glasses. On 8/28/24 at 12:22 PM and 3:16 PM Staff 4 (Social Services) and Staff 20 (Social Services Coordinator) stated Resident 18 just had her/his eyes examined and they did not have the after visit summary. If Resident 18 required new glasses the facility would assist the resident to obtain new glasses. Staff 4 and Staff 20 stated they did not know a new prescription was written. 50897 2. Resident 3 admitted to the facility in 3/2023 with diagnoses including diabetes. Progress Notes on 7/27/24 at 6:03 PM revealed Resident 3 inquired about the status of her/his prescription glasses. A review of Resident 3's clinical record revealed no evidence staff followed up on her/his prescription glasses. In an interview on 8/26/24 at 3:51 PM Resident 3 stated she/he saw an ophthalmologist about six weeks ago and was prescribed prescription glasses. Resident 3 said she/he was told it would take about three weeks to receive the glasses, but she/he had still not received them. In an interview on 8/28/24 at 3:20 PM Staff 4 (Social Services Director) and Staff 13 (Social Services Coordinator) stated they were aware Resident 3 had an appointment with the ophthalmologist. Staff 4 provided a copy of the invoice for Resident 3's prescription glasses dated 6/13/24. Staff 4 said the glasses had to be ordered through the insurance provider and said she would be meeting with Resident 3 to complete the order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 26991 Based observation, interview, and record review it was determined the facility failed to prevent pressure ulcers for 1 of 4 sampled residents (#47) reviewed for pressure ulcers. This placed residents at risk for skin injury. Findings include: Resident 47 admitted to the facility in 7/2024 with a diagnosis of paralysis after spinal surgery. A 7/25/24 Admission Nursing Datbase (sic.) revealed Resident 47 did not have a pressure ulcer. A care plan was initiated on 7/26/24 indicating Resident 47 was at risk for pressure ulcers. Interventions included staff were to educate the resident and family on the requirements for positioning. 7/2024 and 8/2024 Progress Notes revealed the following: -7/26/24 Resident 47 was assisted to turn from side to side. The note did not indicate the frequency of turns. -7/27/24 no education was provided. -7/28/24 Resident 47 was assisted with bed mobility. The note did not indicate the frequency of bed mobility. -7/29/24 Resident 47 reported back incision pain and did not want to move any more than necessary. No education was provided. -7/30/24 Resident 47 was assisted to turn from side to side. The note did not indicate the frequency of turns. -7/31/24 no education was provided. -8/1/24 Resident 47 was assisted to turn from side to side. The note did not indicate the frequency of turns. -8/2/24 Resident 47 was assisted to turn from side to side. The note did not indicate the frequency of turns. -8/3/24 Resident 47 was assessed to have an open area less than a dime size on her/his sacrum. There was no additional description of the wound. Orders for wound care and an air mattress were requested. An 8/5/24 Skin Evaluation Form revealed on 8/3/24 Resident 47 was identified to have a deep tissue injury (no open area but the tissue beneath the surface was damaged; the area may be dark purple or red and could be caused by prolonged pressure and or shearing). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 8/5/24 Skin Tear/Bruise/Abrasion/Other Skin Impairment form revealed on 8/3/24 a nurse identified skin impairment to Resident 47's coccyx/sacral area. The Resident Care Manager assessed the wound to be a deep tissue injury with a moisture component observed to the center area of the ulcer. On 8/27/24 at 1:17 PM Staff 21 (CNA) stated Resident 47 was not able to turn independently and at times refused to be turned, especially on night shift. On 8/27/24 at 6:01 PM Witness 2 (Spouse) stated she/he often stayed at the facility for up to nine hours because she/he was from out of town. Witness 2 stated during her/his extended visits she did not observe staff to turn Resident 47 every two hours. On 8/28/24 at 3:10 PM Staff 11 (CMA) stated Resident 47 reported she/he was often not assisted to be turned every two hours. On 8/28/24 at 2:59 PM Staff 22 (LPN) stated Resident 47 was usually compliant with care but did not always stay on her/his side when turned. If education was provided to the resident it would be documented in the progress notes. On 8/28/24 at 11:06 AM Staff 3 (RNCM) stated when Resident 47 was first admitted to the facility the resident did not like to be turned and often was on her/his back. Staff placed pillows on each side of the resident but her/his coccyx was still on the bed. Staff 3 also stated Resident 47 liked to keep her/his head of bed elevated which placed additional pressure on her/his coccyx region. Staff 3 stated when the ulcer was first identified it was light purple with no open area. A request was made to provide documentation Resident 47 was provided risks of not turning prior to the development of a pressure ulcer. No additional information was provided On 8/29/24 at 10:26 AM Staff 6 (CNA) stated it was standard of care to turn a resident every two hours, but in reality, turning a resident every two hours could not be completed due to lack of time.

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to provide a splint for 1 of 2 sampled residents (#2) reviewed for mobility. This placed residents at risk for worsening contractures. Findings include: Resident 2 admitted to the facility in 3/2010 with a diagnosis of cancer. Occupational Therapy Treatment Encounter Note dated 5/9/24 revealed staff obtained measurements for Resident 2's right finger splint to treat a contracture. An Occupational Therapy Discharge Summary form dated 6/27/24 revealed Resident 2 tolerated the right finger splint for approximately one hour. A care plan last revised on 7/5/24 did not include Resident 2 required a right finger splint. A 7/24/24 physician appointment note revealed Resident 2 was seen for right finger swelling and redness. The note indicated Resident 2 had a right finger contracture and a hand therapy referral for a finger splint was made. On 8/26/24 at 2:46 PM Witness 1 (Family) stated Resident 2 was not able to straighten her/his finger, needed a splint, but did not have one. On 8/27/24 at 1:59 PM Resident 2 was observed without a finger splint. On 8/29/24 at 12:21 PM Staff 4 (Social Services) stated she made appointments for referrals to outside providers. Staff stated she was not aware of the need for a hand therapist or splint. On 8/29/24 at 12:39 PM Staff 15 (Therapy Director) stated Resident 2 had an assessment for a contracture of the right finger and a splint was ordered. In 6/2024 at the end of therapy, Resident 2 was documented to tolerate one hour of splint use. On 8/29/24 at 12:47 PM Staff 23 (CNA) stated if a resident was to wear a splint it was on the care plan. Staff 23 stated she was familiar with Resident 23 and she/he did not have a splint. On 8/29/24 at 12:50 PM Staff 5 (CMA) stated she never saw Resident 2 wear a finger splint. On 8/29/24 at 12:56 PM Staff 24 (CNA) stated she never applied a splint to Resident 2's finger. On 8/29/24 at 1:22 PM Staff 3 (RNCM) stated Resident 2 should have a splint in her/his room because Staff 3 helped order one. Staff 3 acknowledged the splint was not on Resident 2's care plan.

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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. 47001 Based on interview and record review it was determined the facility failed to provide supervision during an outing involving alcohol for 1 of 1 sampled resident (#43) reviewed for change of condition. This placed residents at risk for accidents. Findings include: Resident 43 admitted to the facility in 2/2024 with diagnoses including alcohol use. A 6/1/24 Quarterly MDS indicated Resident 43 had moderate cognitive impairment. A review of a 7/30/24 progress note written at 2:26 PM revealed Resident 43 returned from an outing fatigued with a decreased level of responsiveness, was diaphoretic, had abnormal vitals signs and EMTs were called. A review of a 7/30/24 progress note written at 2:43 PM revealed Resident 43 returned to baseline after the EMTs arrived to the facility and refused to go to the hospital. Resident 43 reported he consumed four beers while out of the facility on an outing. An 8/2/24 public complaint alleged the facility failed to ensure resident safety regarding alcohol consumption during an outing and the facility failed to notify the resident representative in a timely manner regarding the resident's change of condition. An 8/7/24 public complaint alleged the facility failed to ensure the resident's safety during a community outing. An 8/14/24 public compliant alleged the facility failed to ensure a safe environment for the resident while on an outing with staff. An investigation dated 8/16/24 revealed two staff members, Staff 26 (Staffing Coordinator) and Staff 25 (HR), took Resident 43 to the river to go rock hunting. Orders were received for Resident 43 to have up to 12 ounces of beer while on the outing. Upon arrival to the river, Staff 26 gave one 12-ounce can of beer that she/he spilled; Resident 43 drank half to three quarters of this beer before it was spilled. Staff 26 gave another 12-ounce beer to Resident 43. Staff 26 and Staff 25 were in the river rock hunting and Resident 43 was on the riverbank with Staff 25's son. Staff 25's son obtained the rest of the beers in the vehicle per Resident 43's request. Staff 26 and Staff 25 stated they were unaware Resident 43 drank more beers than what Staff 26 gave to her/him. Resident 43 stated he drank three and a half 12-ounce beers in total. Upon return to the facility Staff 26 and Staff 25 stated Resident 43's nurse was not notified of her/his consumption of more than the physician ordered limit of 12-ounces of beer. Resident 43 went back to her/his room, staff noticed her/his change of condition and called the EMTs. Resident 43 was back to baseline when the EMTs arrived and she/he declined to go to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11:53 AM Staff 25 stated Resident 43 asked her a week before they went to the river to go rock hunting she/he wanted a beer. Orders for the beer were obtained by Staff 2 (DNS). Staff 25 stated when they arrived at the river Resident 43 was given a beer, which spilled, and Staff 26 gave her/him another one. Staff 25 stated she and Staff 26 went into the river to rock hunt and Resident 43 stayed on the riverbank. Staff 25 stated she and Staff 26 were supervising Resident 43, but she was unaware Resident 43 drank more than the beer Staff 26 gave her/him, and she was unaware her son brought the rest of the beers down to the river. Staff 25 stated her son was unaware how many beers Resident 43 could drink. Staff 25 stated they became aware of how many beers were consumed when they were cleaning up and heading back to the facility. Staff 25 stated Resident 43 consumed 2 to 3 beers, but she was unsure. Staff 25 stated Staff 26 brought Resident 43 into the facility. Staff 25 stated she did not inform anyone how many beers Resident 43 drank. On 8/28/24 at 12:07 PM Staff 26 stated she verified the order with Resident 43's provider prior to the outing at the river. Staff 26 stated the provider ordered for Resident 43 to have no more than 12 ounces of beer. Staff 26 stated she and Staff 25 were supervising Resident 43, but she was unaware Resident 43 consumed more beers than what was provided. Staff 26 stated she was unaware how many beers Resident 43 drank, but thought she/he had two 12-ounce beers and maybe a sip of another can. Staff 26 stated she brought Resident 43 back into the facility after the outing and informed the nurse Resident 43 would need a change of clothes, a shower, and a nap. Staff 26 stated she did not inform the nurse how many beers Resident 43 consumed. On 8/29/24 at 12:16 PM Staff 2 stated she received orders for Resident 43 to consume up to 12 ounces of beer on the outing to the river and both Staff 26 and Staff 25 were aware of the order. Staff 2 stated Staff 25's son gave Resident 43 more beers and Resident 43 consumed three and a half 12-ounce cans of beer. Staff 2 stated Staff 26 and Staff 25 did not inform anyone of how many beers Resident 43 consumed upon return to the facility. Staff 2 confirmed Resident 43 was supposed to have been supervised by Staff 26 and Staff 25, but they were unaware of how many beers Resident 43 drank.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50930 Based on observation, interview and record review it was determined the facility failed to maintain a medication error rate of less than five percent. There were 2 errors in 39 opportunities resulting in a 5.13 percent error rate. This placed residents at risk for adverse medication side effects. Findings include: Resident 301 admitted to the facility in 8/2024 with diagnoses including chronic pancreatitis (difficulty with food digestion) and chronic obstructive pulmonary disease. Resident 310's 8/2024 Physician Orders included the following: - Creon Oral Capsule Delayed Release (releases food digesting enzymes) 6000-19000 unit, administer three times a day with meals at 8:00 AM, 12:00 PM, and 5:30 PM. - Advair Diskus Inhalation Aerosol Powder Breath Activated (prevents shortness of breath) 250-50mcg/act, administer twice a day at 8:00 AM and 5:00 PM. Resident 301 was to rinse mouth and spit after inhalation to prevent oral thrush. On 8/28/24 from 9:23 AM to 9:38 AM Staff 5 (CMA/CNA) administered Resident 301's medications after breakfast which included Creon and Advair Diskus Inhalation. During the medication administration observation Staff 5 did not have Resident 301 rinse her/his mouth and spit out the liquid. On 8/28/24 at 12:28 PM Staff 2 (DNS) stated she expected staff to administer medications per physician order and at the physician ordered time. On 8/28/24 at 12:53 PM Staff 5 stated the Creon was not administered at the provider ordered time of 8:00 AM, and Resident 301 did not rinse and spit after her/his Advair Diskus inhalation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creswell Post Acute	735 South 2nd Street Creswell, OR 97426

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50930 Based on observation, interview and record review it was determined the facility failed to ensure proper storage and labeling of medication and biologicals for 1 of 2 treatment carts and 1 of 1 medication and biologicals refrigerator reviewed for biologicals and medication storage. This placed residents at risk for reduced efficacy of medication, inaccurate tuberculosis testing, and decreased vaccine efficacy. Findings include: During an audit of the South Hall treatment cart with Staff 8 (RN) on [DATE] at 3:50 PM, an open vial of Insulin Glargine dated [DATE] was observed in the cart. Staff 8 examined the vial and confirmed the date on the vial was over 28 days and it should have been discarded. While conducting an audit of the medication and biologicals refrigerator on [DATE] at 11:14 AM with Staff 9 (LPN) an open and undated multi-dose vial of tuberculin solution (a solution used in testing for Tuberculosis), and multiple closed vials of Spikevax (COVID - 19 vaccine) with an expiration date of [DATE] were found in a basket on a shelf. Staff 9 verified there was no open date on the tuberculin and placed it in the sharps container (plastic container designed to safely hold needles and other sharps). Staff 9 verified the vials of Spikevax were expired and stated the facility was waiting for the pharmacy to exchange them for viable vaccines. The tuberculin manufacturer package insert, revised ,d+[DATE], indicated the tuberculin vial was to be discarded 30 days after opening. On [DATE] at 2:11 PM Staff 3 (RNCM) stated the expectation was for all medications to have an open date, the insulin and tuberculin to be put in the sharps container when expired, and for the Spikevax vaccines to be labeled as do not use and returned to the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Creswell Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 735 South 2nd Street Creswell, OR 97426	

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 36494 Based on interview and record review it was determined the facility failed to ensure a resident understood an arbitration agreement for 1 of 3 sampled residents (#47) reviewed for arbitration. This placed residents at risk for loss of legal rights. Findings include: Resident 47 admitted to the facility in 7/2024 with a diagnosis of diabetes. A 7/31/24 admission MDS revealed Resident 47 was cognitively intact. A Patient and Facility Arbitration Agreement revealed Resident 47 signed the agreement on 7/25/24. On 8/28/24 at 3:29 PM Resident 47 stated she/he did not recall signing anything regarding an arbitration agreement. The resident stated she/he was so drugged up and no one followed up with her/him regarding an arbitration agreement. On 8/29/24 at 10:43 AM Staff 3 (Social Service Director) stated she was responsible for all admission paperwork, including arbitration agreements. Staff 3 stated she explained the arbitration agreement, it's meaning, and the option to sign the arbitration agreement or not. Staff 3 stated she did not follow up with residents after they signed the arbitration agreement, considering it a one-time task. Staff 3 acknowledged she did not follow up with Resident 47 regarding the arbitration agreement.