STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385185	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Riverpark of Eugene	425 Alexander Loop Eugene, OR 97401

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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 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. 34703 Based on observation, interview and record review it was determined the facility failed to ensure residents were treated with dignity for 1 of 1 sampled resident (#39) reviewed for medication administration. This placed residents at risk for lack of dignity. Findings include: Resident 39 admitted to the facility in 2/2024 with diagnoses including diabetes. On 10/10/24 at 11:50 AM Staff 28 (RN) performed a CBG (blood sugar measurement) check on Resident 39 in the dining room without permission from the resident with multiple residents in the dining room. Resident 39 required an insulin injection, Staff 28 raised the resident's shirt and administered the insulin into her/his abdomen. Resident 39 asked Staff 28 to administer the injection in her/his arm multiple times. Another resident in proximity to Resident 39 looked away during her/his insulin administration. On 10/10/24 at 12:05 PM Staff 3 (LPN-Resident Care Manager) and Staff 30 (LPN-Resident Care Manager) acknowledged Staff 28 failed to protect Resident 39's dignity by performing a CBG check in the dining room, and by lifting Resident 39's shirt in a populated common area to administer insulin.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 41455 Based on interview and record review it was determined the facility failed to ensure a resident's representative was included in the care planning process for 1 of 2 sampled residents (#77) reviewed for communication. This placed residents at risk for lack of input in the care planning process. Findings include: Resident 77 admitted to the facility in 12/2023 with diagnoses including stroke and aphasia (language disorder). An 4/18/24 Comprehensive Plan of Care Review indicated N/A (not applicable) related to the attendance of the responsible party. A 7/22/24 Annual MDS indicated Resident 77's BIMS assessment could not be completed, she/he was rarely understood and she/he used nonverbal communication to express her/his needs. A 7/23/24 Comprehensive Plan of Care Review indicated N/A related to the attendance of the responsible party. An 10/7/24 resident profile for Resident 77 indicated Witness 1 (Family Member) was her/his main contact. On 10/7/24 at 4:01 PM Witness 1 stated she did not receive invitations to Resident 77's care conferences and she was in the facility weekly. On 10/10/24 at 9:27 AM Staff 7 (Business Office Manager) stated invitations sent to Witness 1 for Resident 77's care conferences were completed through the mail, the invitations were returned to the facility due to an out of date address and the last attempt to contact Witness 1 was nine months earlier. Staff 9 stated Staff 6 (Social Services Coordinator) was not informed the invitations to Witness 1 were returned. On 10/10/24 at 9:39 AM Staff 6 stated family involvement at care conferences would benefit Resident 77. Staff 6 acknowledged there was no communication with Resident 77 or Witness 1 to ensure family contacts were included in the care planning process.

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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. 34703 Based on interview and record review it was determined the facility failed to notify the physician regarding refusals and changes in condition for 3 of 9 sampled residents (#s 26, 42, and 442) reviewed for medications, and change of condition. This placed residents at risk for lack of physician involvement. Findings include: The facilities 2/2021 Requesting, Refusing, and/or Discontinuing Care or Treatment Policy indicated; -the healthcare practitioner must be notified of refusal of treatment. 1. Resident 26 admitted to the facility in 10/2017 with diagnoses including kidney failure. A 9/25/24 physician order indicated staff were to complete daily weights, and call the physician for a weight gain of two to three pounds per day over a two-day period or five pounds in one week. A review of the 9/2024 and 10/2024 TARs indicated Resident 26 refused daily weights from 9/25/24 through 10/9/24. A 9/25/24 physician order indicated staff were to check Resident 26's CBG (blood sugar measurement) level four times a day and to notify the physician for a CBG level less than 70 or greater than 400 before meals and at bedtime. No documentation was found in Resident 26's clinical record the physician was notified of the refusals of daily weights and CBG checks from 9/25/24 through 10/9/24. On 10/9/24 at 3:44 PM Staff 2 (DNS) confirmed the physician was not notified at any time of refusals for daily weights or CBG checks from 9/25/24 through 10/9/24. 2. Resident 442 admitted to the facility in 4/2024 with diagnoses including stroke. A 4/6/24 physician order indicated staff were to administer chlorpromazine (antipsychotic for mental disorder) PO, vitamin D3 PO, Protonix (treat reflux) PO, lithium ER (extended release for bipolar disorder) PO, and propranolol (for high blood pressure) PO. On 10/10/24 Drugs.com indicated the above medications should not be crushed or chewed. A public complaint was received on 5/30/24 which alleged on 5/29/24 at 7:30 AM Staff 28 (RN) administered Resident 442's morning medications, and within 30 minutes Witness 2 (Complainant) noticed the resident was not responding to staff when spoken to and became out of it. On 10/7/24 at 2:13 PM Witness 2 stated Resident 442 was brought to the dining room for breakfast but did not eat. Witness 2 stated the resident was lethargic. Witness 2 stated Staff 28 was notified of the change of condition but the resident was not assessed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 1:55 PM Staff 32 (CNA) stated on 5/29/24 Resident 442 was lethargic in the morning and was placed back in bed. Staff 32 stated Staff 28 was notified but the resident was not assessed. Staff 32 stated the resident was placed in her/his wheelchair for lunch but the resident was more lethargic and not responsive to stimuli. Staff 32 stated Staff 28 was again notified but the resident was not assessed. Staff 32 stated Staff 34 (CNA) was notified and requested Staff 3 (LPN-Resident Care Manager) to assess Resident 442. On 10/8/24 at 1:06 PM Staff 3 stated Staff 32 and Staff 34 requested she assess Resident 442. Staff 3 stated the resident was lethargic and sent out and admitted to the hospital. A 5/29/24 Progress Note indicated Resident 442 had a difficult time swallowing her/his morning medications, so the medications were crushed and placed in pudding for administration. A 5/29/24 Hospital Summary Note indicated Resident 442 arrived to the emergency room with altered mental status, and mildly elevated lithium levels. Normal lithium levels were 1.2 millequivents per liter and the resident's level was 2.5 millequivents per liter. Resident 442 was transferred to the ICU (intensive care unit). No documentation was found in Resident 442's clinical record the physician was notified of the change of condition the morning of 5/29/24. On 10/9/24 at 12:11 PM Staff 28 stated Resident 442 took her/his medication whole in applesauce or pudding, but on the morning of 5/29/24 she/he could not swallow her/his medications and was lethargic. Staff 28 stated she crushed Resident 442's morning medications and placed them in pudding. Staff 28 acknowledged she crushed medications, which should not be crushed, and did not notify the physician of the resident's change of condition. On 10/9/24 at 3:03 PM Staff 2 (DNS) acknowledged Staff 28 crushed Resident 442's morning medications, which were not to be crushed, and did not notify the physician of the resident's change of condition timely. 41455 3. Resident 42 admitted to the facility in 6/2024 with diagnoses including cellulitus (deep infection of the skin) and heart failure. A 7/8/24 Alert Note indicated Resident 42 was observed with a reddened area above her/his left ankle and the resident requested to be sent to the emergency department. Resident 42 returned to the facility with a diagnoses of cellulitis and new orders for antibiotics. There was no indication Resident 42's physician was notified of the resident's change of condition. A 9/12/24 progress note indicated Resident 42 complained of uncontrolled pain and an inability to move her/his leg which had copious amounts of drainage. Resident 42 was transported to the emergency department. There was no indication Resident 42's physician was notified of the resident's change of condition. On 10/11/24 at 12:29 PM Staff 2 (DNS) acknowledged no physician was notified on 7/8/24 or 9/12/24 of the resident's change of condition.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41455 Based on interview and record review it was determined the facility failed to ensure the required parties were notified of resident hospitalization s for 3 of 7 sampled residents (#s 42, 44, and 89) reviewed for hospitalization and change of condition. This placed residents at risk for lack of advocacy. Findings include: 1. Resident 42 admitted to the facility in 6/2024 with diagnoses including cellulitus (deep infection of the skin) and heart failure. A 9/12/24 Progress Note indicated Resident 42 was transported to the emergency department due to complaints of uncontrolled pain. A 9/12/24 MDS Discharge Assessment was completed with an anticipated return from the hospital. Review of Resident 42's clinical record revealed no transfer notice was provided to Resident 42, her/his representative, or a representative of the Office of the State Long-Term Care Ombudsman. On 10/11/24 at 12:29 PM Staff 2 (DNS) acknowledged a transfer notice was not provided to Resident 42, her/his representative, or a representative of the Office of the State Long-Term Care Ombudsman. 42270 2. Resident 44 admitted to the facility in 2/2024 with diagnoses including seizures. An 8/12/24 Progress Note revealed Resident 44 was transported to the hospital. No evidence was found in Resident 44's health record to indicate a transfer notice was provided to Resident 44, her/his representative, or a representative of the Office of the State Long-Term Care Ombudsman. On 10/10/24 at 3:57 PM Staff 1 (Administrator) reviewed the transfer to the hospital and stated the facility did not provide a transfer notice to Resident 44, her/his representative, or a representative of the Office of the State Long-Term Care Ombudsman. 49676 3. Resident 89 admitted to the facility in 10/2024 with diagnoses including non-infective gastroenteritis (inflammation of the stomach) and colitis (inflammation of the colon). A 9/7/24 Progress Note revealed Resident 89 discharged to the hospital on 9/7/24. No evidence was found in Resident 89's health record to indicate a transfer notice with appeal rights was provided in writing to her/him or the Office of the State Long-Term Care Ombudsman was notified of the resident's transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at Staff 1 (Administrator) acknowledged the facility did not provide transfer notices to residents, their representatives, or the Office of the State Long-Term Care Ombudsman.

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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** 41455 Based on interview and record review it was determined the facility failed to provide residents with a written notice of the facility's bed hold policy at the time of transfer to the hospital for 3 of 7 sampled residents (#s 42, 44, and 89) reviewed for hospitalization and change of condition. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 42 was admitted to the facility in 6/2024 with diagnoses including cellulitus (deep infection of the skin) and heart failure. A 9/12/24 progress note indicated Resident 42 was transported to the emergency department due to complaints of uncontrolled pain. A 9/12/24 MDS Discharge Assessment was completed with return anticipated. A reviewed of Resident 42's clinical record revealed no documentation the resident or her/his representative was provided information regarding the facilty bed hold policy. On 10/11/24 at 11:09 AM Staff 14 (LPN) stated she did not understand the process to provide bed hold information to Resident 42 when she/he was transferred to the hospital and did not receive training related to the expectations. On 10/11/24 at 12:29 PM Staff 2 (DNS) acknowledged the requirement to provide bed hold information to Resident 42 was not met. 42270 2. Resident 44 admitted to the facility in 2/2024 with diagnoses including seizures. A 8/12/24 Progress Note revealed Resident 44 was transported to the hospital. A review of the medical record revealed no documentation a bed hold policy was provided to Resident 44 or her/his resident representative. On 10/10/2024 at 3:57 PM Staff 1 (Administrator) reviewed the transfer to the hospital and stated the facility did not provide the bed hold to Resident 44 or his/her resident representative at the time of or after her/his transfer to the hospital. 49676 3. Resident 89 was admitted to the facility on ,d+[DATE] with a diagnosis of noninfective Gastroenteritis and Colitis (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 89's 8/20/24 review 5-day MDS Assessment revealed she/he was cognitively intact. A review of Resident 89's nursing progress notes revealed she/he was discharged to the hospital on 9/7/24 and was readmitted to the facility on [DATE]. No evidence was found in Resident 89's health record to indicate a transfer notice with appeal rights was provided in writing to her/him or the Office of the State Long-Term Care Ombudsman was notified of the resident's transfer to the hospital. On 10/11/24 at 12:51 PM Staff 27 (Guest Services Coordinator) stated she was not able to get a hold of resident 89 and documented late entry.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49677 Based on interview and record review it was determined the facility failed to complete comprehensive care plans within the required timelines and revise care plan interventions for 2 of 7 sampled residents (#s 38 and 42) reviewed for change of condition, ADL care and edema. This placed residents at risk for unmet needs. Findings include: 1. Resident 38 admitted to the facility in 8/2022 with diagnoses including kidney disease and UTI. On 10/7/24 at 11:25 AM Resident 38 reported recurrent UTIs every three months, and also reported chronic bladder discomfort, burning with urination, and a sense of urinary urgency. The 7/21/23 care plan documented Resident 38 was at risk for UTIs with history of UTIs. There were no documented updates or revisions to the goals or interventions since the original date of care plan initiation on 7/21/23. On 10/9/24 at 5:17 PM Staff 3 (LPN-Resident Care Manager) reported the 7/21/23 care plan included Resident 38's recurring UTIs however the interventions were not revised or updated since the date the care plan was initiated. On 10/11/24 at 8:18 AM Staff 2 (DNS) reported Resident 38 was diagnosed with six UTI's in 2023. Staff 2 confirmed the 7/21/23 care plan was not revised to address Resident 38's recurring UTIs. 41455 2. Resident 42 admitted to the facility in 6/2024 with diagnoses including heart failure and severe obesity. The 6/14/24 Admission MDS indicated Resident 42 was occasionally incontinent of bladder and required substantial to maximum assistance with toileting hygiene. An 10/3/24 revised care plan indicated staff were to provide intermittent supervision for Resident 42's personal hygiene including her/his perineum (genital area), and staff were to monitor for signs of heart failure including edema. On 10/9/24 at 3:42 PM Resident 42 stated when staff entered her/his room they often left without asking if she/he need additional assistance. Resident 42 stated she/he did not ask for toileting hygiene from those who did not know her/him well because the request was embarrassing and she/he stated toileting hygiene should be offered. Resident 42 stated because of all her/his care needs, it was difficult to remember to request assistance to elevate her/his legs to reduce the swelling. On 10/10/24 at 5:38 PM Staff 2 (DNS) and Staff 1 (Administrator) acknowledged Resident 42's care plan was not personalized to meet the needs of the resident related to personal hygiene and edema interventions and Resident 42's care needs increased since her/his 9/2024 hospitalization .

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34703 Based on observation, interview, and record review it was determined the facility failed to ensure professional standards were followed for 2 of 6 sampled residents (#s 39 and 442) for medication administration. Resident 442's medications were inappropriately administered resulting in a change of condition which required hospitalization . Findings include: Per [NAME] [PHONE NUMBER] Scope of Practice Standards for All Licensed Nurses (1) Standards related to the licensee's responsibility for safe nursing practice. The licensee shall: (A) Adhere to professional practice and performance standards; Per [NAME] [PHONE NUMBER] Conduct Derogatory to the Standards of Nursing Defined: Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to: (2) Conduct related to achieving and maintaining clinical competency: (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established; (3) Conduct related to the client's safety and integrity: 1. Resident 442 admitted to the facility in 4/2024 with diagnoses including bipolar disorder (mental health disorder). A public complaint was received on 5/30/24 which alleged on 5/29/24 at 7:30 AM Staff 28 (RN) administered Resident 442's morning medications, and within 30 minutes Witness 2 (Complainant) noticed the resident was not responding to staff when spoken to and became out of it. An 4/6/24 physician order indicated staff were to administer chlorpromazine (antipsychotic for mental disorder) PO, vitamin D3 PO, Protonix (treat reflux) PO, lithium ER (extended release for bipolar disorder) PO, and propranolol (for high blood pressure) PO. On 10/10/24 Drugs.com indicated lithium ER should not be crushed, chewed, or broken. A 5/29/24 Progress Note indicated Resident 442 had a difficult time swallowing her/his medication in the morning, so Staff 28 (RN) crushed Resident 442's medication and administered the medication in pudding. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A 5/29/24 Hospital Summary note indicated Resident 442 arrived to the emergency room with altered mental status, and mildly elevated lithium levels. Normal lithium levels are 1.2 millequivents per liter and the resident's level was 2.5 millequivents per liter. Resident 442 was transferred to the ICU (Intensive Care Unit). On 10/7/24 at 2:13 PM Witness 2 stated Resident 442 was brought to the dining room for breakfast but did not eat. Witness 2 stated the resident was lethargic. Witness 2 stated Staff 28 was notified of the change of condition but the resident was not assessed. On 10/8/24 at 1:06 PM Staff 3 stated Staff 32 and Staff 34 requested she assess Resident 442. Staff 3 stated the resident was lethargic and sent out and admitted to the hospital. On 10/8/24 at 1:55 PM Staff 32 (CNA) stated on 5/29/24 Resident 442 was lethargic in the morning and was placed back in bed. Staff 32 stated Staff 28 was notified but the resident was not assessed. Staff 32 stated the resident was placed in her/his wheelchair for lunch but the resident was more lethargic and not responsive to stimuli. Staff 32 stated Staff 28 was again notified but the resident was not assessed. Staff 32 stated Staff 34 (CNA) was notified and requested Staff 3 (LPN-Resident Care Manager) to assess Resident 442. On 10/9/24 at 12:11 PM Staff 28 (RN) acknowledged she crushed Resident 442's lithium, which was not to be crushed, and no Medication Error documents were found in the resident's electronic record. On 10/9/24 at 3:03 PM Staff 2 (DNS) acknowledged Staff 28 crushed Resident 442's lithium medication, which was not to be crushed, and no Medication Error documents were found in the resident's electronic record. 2. Resident 39 admitted to the facility in 2/2024 with diagnoses including diabetes. On 10/9/24 at 11:50 AM Staff 28 (RN) was observed to check Resident 39's CBG (blood sugar measurement) level in the dining room. Staff 28 placed the glucometer on the North medication cart and cleaned the glucometer with small alcohol prep wipes. On 10/9/24 at 12:10 PM Staff 28 stated she always used alcohol prep wipes to sanitize the glucometer, and she was not aware of another sanitizing wipe. On 10/9/24 12:15 PM Staff 3 (LPN-Resident Care Manager) and Staff 30 (LPN-Resident Care Manager) stated the glucometer should be sanitized with the proper sanitizing wipes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 42270 Based on observation, interview, and record review it was determined the facility failed to provide meaningful activities to dependent residents for 2 of 3 sampled residents (#s 21 and 37) reviewed for activities. This placed residents at risk for a diminished quality of life. Findings include: 1. Resident 37 admitted to the facility in 7/2023 with diagnoses including stroke. The 7/15/24 Annual MDS revealed Resident 37's cognition was severely impaired, her/his family was involved in her/his care and indicated she/he enjoyed listening to music, spending time outside, and participating in religious activities. Resident 37's comprehensive care plan revealed her/his activities of interests were gospel music, Christmas, and bible study. The care plan interventions included staff were to provide one on one time, help Resident 37 go to activities, remind her/him of the activities she/he enjoyed, and leave music on for Resident 37. The 10/2024 Activities Calendar included weekly bible study social visits and weekly bible study. Resident 37's medical record included no documentation of her/his participation in group activities or one on one activities for the last thirty days. There were no Activity Progress Notes for Resident 37. On 10/7/24 at 10:59 AM Resident 37 was laying in bed. On 10/8/24 at 1:03 PM bible study social visits were occurring in the activity room, but Resident 37 was not in the activity room. Staff 4 (Activity Director) stated the residents in the activity were praying with the bible studies ladies. On 10/8/24 at 1:05 PM Resident 37 was laying in bed and the television was on, but the volume was off. On 10/8/24 at 2:01 PM the facility had bible study in the activity room. Resident 37 was laying in bed with the television on, but the volume was off. On 10/9/24 at 2:21 PM Resident 37 was laying in bed and the television was on, but the volume was off. On 10/9/24 at 2:41 PM Staff 36 (CNA) stated she did not see Resident 37 participate in activities. Staff 36 stated after Resident 37 finished meals she/he was helped to bed and left with the television on. Staff 36 stated Resident 37's family wanted the television and volume on for her/him because that was what she/he did at home. (continued on next page)

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Avamere Riverpark of Eugene	425 Alexander Loop Eugene, OR 97401

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 9:49 AM Staff 4 stated the activities department provided one on one visits for residents who did not attend group activities. Staff 4 stated Resident 37 was very religious, however the CNA staff did not assist her/him into the wheelchair so the activities staff could take Resident 37 to the religious activities she/he enjoyed. Staff 4 stated there was no documentation of group or one on one activities provided for Resident 37 in the last 30 days. On 10/10/24 at 10:12 AM Staff 35 (CNA) stated she was unaware of any group activities in which Resident 37 was interested in attending. Staff 35 stated after meals she helped Resident 37 back to bed. Staff 35 stated activities of interest for residents should be on the care plan. On 10/10/24 at 10:21 AM Resident 37 was laying in bed and the television was on, but the volume was off. On 10/10/24 at 2:31 PM Staff 37 (CMA) stated Resident 37 did not go to activities at all. Staff 37 said there was a time when Resident 37 had the television on with the volume on but the roommate did not want the sound on. On 10/10/24 at 2:35 PM Staff 19 (CNA) stated Resident 37 was generally lying down in bed in her/his in room watching television. Staff 19 stated Resident 37 was never in activities and she was not aware of any activities she/he should attend. On 10/10/24 at 3:55 PM Staff 1 (Administrator) stated she had seen Resident 37 in the dining room and with the television and music on. Staff 1 stated she expected staff to know what activities in which residents wanted to participate, and for those to be listed on the care plan. 47001 2. Resident 21 admitted to the facility in 2/2021 with diagnoses including depression. On 10/7/24 at 11:18 AM Resident 21 stated she/he was not interested in group activities and staff did not provide in-room activities. On 10/9/24 at 11:26 AM Staff 4 (Activities Director) stated Resident 21 preferred to stay in bed. Staff 4 stated Resident 21's in-room activities included use of electronics, television, music and one-to-one visits. An 10/10/24 medical record review revealed Resident 21 had one-to-one activity once in the last 30 days. On 10/10/23 at 11:07 AM Staff 1 (Administrator) stated she was unable to locate any other one-to-one activity documentation for Resident 21 in the last 30 days.

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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. 34703 Based on observation, interview and record review it was determined the facility failed to properly assess pressure ulcers for 2 of 4 sampled residents (#s 13 and 62) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: 1. Resident 13 admitted to the facility in 7/2024 with diagnoses including muscle weakness. The 7/28/24 Admission MDS indicated Resident 13 was at risk for pressure ulcers due to incontinence and decreased mobility. The 7/25/24 care plan revised on 9/26/24 indicated Resident 13 had current skin concerns including pressure injuries to the bilateral buttocks. A 9/24/24 incident report indicated Resident 13 was being monitored for redness and a CNA found two large blisters. There was no documentation which indicated where the pressure ulcers were located on the resident. A 9/25/24 Weekly Skin assessment indicated the resident's skin was intact. A 9/25/24 Wound Evaluation indicated the resident had a pressure ulcer to her/his sacrum (bone at the end of the lower back). The 10/1/24 Wound Evaluation indicated the resident had a pressure ulcer to her/his sacrum. The 10/8/24 Wound Evaluation indicated the resident had a pressure ulcer to her/his sacrum. On 10/9/24 at 10:24 AM Resident 13 was observed with pressure ulcers on her/his bilateral buttocks not her/his sacrum. On 10/9/24 at 4:51 PM Staff 29 (RN) stated the wounds were on Resident 13's bilateral buttocks not the sacrum and there was no documentation in Resident 13's medical record which identified blisters to the bilateral buttocks. On 10/9/24 at 5:03 PM Staff 2 (DNS) acknowledged Resident 13's pressure ulcer investigation was not accurate or thorough. 47001 2. Resident 62 admitted to the facility in 12/2022 with diagnoses including a left below the knee amputation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/20/24 investigation indicated Resident 62 had a wound to her/his left knee. The wound was described as a 3 cm red area with a white area in the center. Resident 62 stated the wound was a pressure wound due to friction from her/his prosthetic leg rubbing on her/his knee. The investigation concluded the wound was an abrasion caused by the prosthetic leg rubbing on Resident 62's left knee. Resident 62 was encouraged to take breaks from wearing the prosthetic leg during the day. A 9/20/24 Wound Evaluation indicated Resident 62 had a 1.27 cm by 1.02 cm abrasion to her/his left knee. On 10/7/24 at 10:46 AM Resident 62 stated she/he had a pressure wound on her/his left knee. On 10/10/24 at 10:59 AM Staff 18 (LPN) stated Resident 62 had some weight loss and due to the weight loss, Resident 62's prosthetic leg did not fit correctly which resulted in a wound on Resident 62's left knee. On 10/11/24 at 9:20 AM Staff 3 (LPN-Resident Care Manager) stated Resident 62's wound on her/his left knee was caused by the prosthetic leg being too big, which caused friction between the knee and the prosthetic, and resulted in an abrasion to Resident 52's left knee. On 10/11/24 at 9:23 AM Staff 20 (LPN-Resident Care Manager) stated Resident 62's prosthetic leg was adjusted twice and padding was added to help the prosthetic leg fit Resident 62 better. On 10/11/24 at 9:30 AM Staff 3 acknowledged Resident 62's wound on her/his left knee was classified incorrectly, and the wound met the definition of a pressure wound.

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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 observation, interview, and record review it was determined the facility failed to supervise a resident while eating for 1 of 4 sampled residents (#292) reviewed for change of condition. This placed residents at risk for aspiration or choking. Findings include: Resident 292 admitted to the facility in 2/2024 with diagnoses including dementia. A 2/20/24 Admission MDS revealed Resident 292 had swallowing difficulties. A review of Resident 292's 3/11/24 care plan revealed an intervention of close supervision while eating. A 3/19/24 investigation revealed on 3/14/24 after 10:30 PM Staff 24 (former staff member) assisted Resident 292 into the Central Dining Room, gave her/him a peanut butter and jelly sandwich and then went to the Central Nursing Station to chart. Staff 24 stated she asked Staff 26 (LPN) to supervise Resident 292 while she/he ate. Staff 26 was charting at the Central Nursing Station and was not in the dining room. On 10/10/24 at 11:09 AM Staff 22 (CNA) stated close supervision of a resident meant the staff were to remain within arm's length of the resident while eating. On 10/10/24 at 2:45 PM Staff 3 (LPN-Resident Care Manager) stated close supervision of a resident meant the staff were to remain within arm's length of the resident while eating. On 10/10/24 at 4:01 PM Staff 25 (ST-Rehab Manager) stated close supervision of residents when eating meant staff must sit at the same table or an adjoining table and the resident was not left unattended with the food tray. On 10/10/24 at 7:56 PM Staff 26 stated he was unaware Resident 292 was eating a sandwich in the Central Dining Room, and he was not supervising Resident 292 while she/he was eating. On 10/11/24 at 10:05 AM Staff 2 (DNS) stated close supervision required staff to sit at the same table or the next table with the resident. Staff 2 observed the Central Dining Room from the Central Nursing Station and acknowledged the dining room could not be observed from the Central Nursing Station. Staff 2 stated Resident 292 did not receive close supervision while eating on 3/14/24. The deficient practice was identified as Past Noncompliance based on the following: On 3/15/24 the deficient practice was identified by the facility and was corrected by 3/18/24 when the facility completed a root cause analysis of the incident and determined the facility failed to provide needed supervision for a resident when eating. The Plan of Correction included: -A facility-wide audit to verify all aspiration risk-related documentation and care plans were current to orders and therapy recommendations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Educate staff on supervision levels. -Spot audit residents during meals or snack time to verify they received the appropriate supervision level. -Audit staff to quiz recall on different supervision levels.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47001 Based on observation, interview and record review it was determined the facility failed to thoroughly assess and monitor respiratory status and maintain respiratory equipment for 2 of 2 sampled residents (#s 17 and 42) reviewed for respiratory services. This placed residents at risk for worsening respiratory status. Findings include: 1. Resident 17 admitted to the facility in 7/2023 with diagnoses including chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe), congestive heart failure (a long-term condition that occurs when the heart is unable to pump enough blood to meet the body's needs) and pulmonary hypertension (a condition that affects the blood vessels in the lungs, making it harder for blood to flow to the lungs and causing the heart to work harder to pump blood). A 9/22/24 Progress Note indicated Resident 17 had a wet productive cough, generalized body aches and tested negative for COVID 19. A 9/23/24 Progress Note indicated Resident 17 had increased weakness, a moist cough, lethargy, nausea, coarse lungs sounds, COVID 19 negative and the provider was notified. A 9/24/24 Progress Note indicated the provider saw Resident 17 and new antibiotics orders were received for an upper respiratory infection (a viral, contagious illness that affects the upper respiratory system). A 9/25/24 Progress Note indicated Resident 17 had coarse lungs, a productive cough, oxygen saturation was at 91% without oxygen and was tired and weak. No further documentation was found to indicate thorough respiratory assessments were completed for Resident 17 after 9/25/24. An 10/1/24 Provider Progress Note indicated Resident 17 reported mild improvement in cough and pulmonary congestion. Resident 17 was noted to have normal respiratory effort and a mild cough. The note did not include evidence of a thorough respiratory assessment. An 10/2/24 Progress Note indicated Resident 17 refused RA due to being sick. A review of progress notes from 10/3/24 through 10/8/24 revealed no further documentation of Resident 17's respiratory status. On 10/7/24 at 12:54 PM Resident 17 was observed in her/his bed with oxygen on at two liters per minute via nasal cannula. Resident 17 had a moist cough. On 10/9/24 at 11:34 AM Staff 12 (CNA) stated Resident 17 had a moist cough for the last two to three weeks. Staff 12 stated Resident 17's cough worsened and she/he needed oxygen continuously since the resident started coughing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 10:56 AM Resident 17 was observed in bed, oxygen in place at two liters per minute via nasal cannula, and a moist cough was noted. On 10/11/24 at 11:50 AM Staff 2 (DNS) stated she expected alert charting with respiratory symptoms to include assessment of lung sounds, cough, temperature, oxygen saturation and related respiratory symptoms until the respiratory symptoms resolved. Staff 2 agreed Resident 17 continued to experience respiratory symptoms and did not receive thorough respiratory assessments after 9/25/24. 41455 2. Resident 42 admitted to the facility in 6/2024 with diagnoses including sleep apnea (a pause in breathing during sleep). A 6/10/24 care plan indicated Resident 42's CPAP (Continuous Positive Airway Pressure) machine was to be worn as tolerated. A 7/30/24 physician order directed staff to empty the water reservoir of Resident 42's CPAP machine daily and wash her/his CPAP mask each morning. The 9/2024 and 10/2024 TARs indicated to refer to nursing notes on 9/4/24, 9/5/24, 9/26/24, 9/28/24, 10/2/24 and 10/3/24 related to the care of Resident 42's CPAP reservoir and mask by Staff 10 (LPN). No nursing notes were found. On 10/9/24 at 3:42 PM Resident 42 was observed with her/his CPAP machine in use and stated the machine was rarely cleaned. On 10/10/24 at 5:19 PM Staff 10 stated she was often unable to complete the task to clean and service Resident 42's CPAP machine due to the request by the resident to return at a later time during the day when the machine was not in use. Staff 10 indicated Resident 42 rarely removed her/his CPAP machine. On 10/10/24 at 5:38 PM Staff 2 (DNS) acknowledged Resident 42's CPAP machine needed to be emptied and mask cleaned as ordered even if the resident's equipment was often in use.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41455 Based on observation, interview, and record review it was determined the facility failed to provide sufficient staffing for 2 of 8 sampled residents (#s 42 and 76) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. Resident 42 admitted to the facility in 6/2024 with diagnoses including heart failure, diabetes and severe obesity. A 6/14/24 Admission MDS indicated Resident 42 was occasionally incontinent of bladder and required substantial to maximum assistance with toileting hygiene. A 9/26/24 through 10/9/24 CNA Task for Toileting Hygiene document identified Resident 42 required substantial assistance or was dependent on staff for toileting hygiene for 20 of 40 opportunities. An 10/3/24 revised care plan indicated staff were to provide intermittent supervision for Resident 42's personal hygiene including her/his perineum (genital area) and care after incontinent episodes. On 10/7/24 at 1:59 PM Resident 42 stated she/he urinated often due to her/his medication and frequently waited up to an hour for assistance with toileting hygiene. Resident 42 stated she/he complained to Staff 1 (Administrator) about her/his concerns of her/his inability to thoroughly complete toileting hygiene independently, but the lack of staffing assistance continued. Resident 42 stated she/he received a meal tray an hour late a few weeks ago due to insufficient staffing and it was difficult to get timely assistance due to her/his requirement for two-person assistance. On 10/9/24 at 10:32 AM Resident 42's hall call light was observed on and no staff were in her/his room. At 11:03 AM Staff 12 (CNA) entered Resident 42's room and shut off the call light before exiting the room to look for additional staff assistance. At 11:06 AM two staff entered Resident 42's room. On 10/9/24 at 3:19 PM Staff 9 (CNA) stated over the last few weeks there were less staff assigned to Resident 42's hall than in prior months and stated she observed one 30 minute call light wait time for Resident 42 while Staff 9 was on her break. On 10/10/24 at 2:35 PM Staff 19 (CNA) stated staffing was a concern especially on weekends due to staff absences. Staff 19 stated she did not believe the facility had a working system to address weekend staffing issues and posted schedules did not take into consideration the staffing needs for those residents with behaviors who required two-person assistance. On 10/10/24 at 2:46 PM Staff 5 (CNA) stated the issues related to heavy care needs on Resident 42's hall were communicated to the Resident Care Manager, but there was no change. Light duty staff were added to the hall, but it was not effective because they could not assist with bariatric care needs. Staff 5 confirmed Resident 42's hall was short of staff the evening the resident's meal was not delivered timely. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 5:19 PM Staff 10 (LPN) stated because of the lack of timely response for assistance, Resident 42 attempted to complete her/his personal hygiene care independently. Staff 10 confirmed Resident 42's hall had a high level of care needs and staff voiced their concerns to management. On 10/11/24 at 12:49 PM Staff 1 (Administrator) acknowledged staffing needs based on the acuity of Resident 42 were not met and the call light response times needed improvement. 42270 2. Resident 76 admitted to the facility in 4/2024 with diagnoses including quadriplegia. The comprehensive care plan for Resident 76 revealed she/he had a sip and puff call light (a call light activated by the mouth) to request help and staff were to ensure it was placed so Resident 76 could reach it with her/his mouth to activate it. The care plan also indicated Resident 76 was dependent on staff for all care due to quadriplegia and required two staff with a mechanical lift to transfer from chair to bed. On 10/9/24 at 11:14 AM Resident 76 was in her/his wheelchair in front of the television in her/his room, and the call light was across the room at the bedside. A CMA was in the room and provided medications and, as she left, Resident 76 stated she/he wanted to go back to bed and asked the CMA to activate the call light. The call light was activated. On 10/9/24 at 11:20 AM Staff 22 (CNA) entered Resident 76's room, turned off the call light, but did not provide care to Resident 76 and did not move the call light within her/his reach. Staff 22 assisted another resident into the shower. On 10/9/24 at 11:46 AM Staff 22 returned to Resident 76's room with Staff 21 (CNA) and stated they were going to assist Resident 76 back to bed. On 10/10/24 at 2:31 PM Staff 37 (CMA) stated residents often complained about not receiving care timely. On 10/10/24 at 2:35 PM Staff 19 (CNA) stated staff were mandated to work extra shifts and were often called in to work extra. Staff 19 also stated the facility had many residents who required two people for care due to both transfer assistance and behaviors, but the facility did not take that into consideration when determining how many staff worked each shift. 10/10/24 at 3:43 PM Staff 2 (DNS) stated she expected staff to answer call lights within 12 to 15 minutes and the call light should be left on until staff were ready to provide care. Staff 2 stated she expected staff to ensure Resident 76 had her/his call light properly placed so she/he could call for assistance.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34703 Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 4 sampled residents (#442) reviewed for change of condition. Resident 442's medications were inappropriately administered resulting in a change of condition which required hospitalization . Findings include: Resident 442 admitted to the facility in 4/2024 with diagnoses including bipolar disorder (mental health disorder). An 4/6/24 physician order indicated staff were to administer lithium ER (extended release antipsychotic for bipolar disorder) PO. On 10/10/24 Drugs.com indicated lithium ER should not be crushed, chewed, or broken. A 5/29/24 Progress Note indicated Resident 442 had a difficult time swallowing her/his medication in the morning, so Staff 28 (RN) crushed Resident 442's medication and administered the medication in pudding. A 5/29/24 Hospital Summary note indicated Resident 442 arrived to the emergency room with altered mental status, and mildly elevated lithium levels. Normal lithium levels are 1.2 millequivents per liter and the resident's level was 2.5 millequivents per liter. Resident 442 was transferred to the ICU (Intensive Care Unit). On 10/9/24 at 12:11 PM Staff 28 (RN) acknowledged she crushed Resident 442's lithium, which was not to be crushed, and no Medication Error documents were found in the resident's electronic record. On 10/9/24 at 3:03 PM Staff 2 (DNS) acknowledged Staff 28 crushed Resident 442's lithium medication, which was not to be crushed, and no Medication Error documents were found in the resident's electronic record. Refer to F658

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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. 49676 Based on interview and record review it was determined the facility failed to ensure residents understood the meaning of an arbitration agreement (disputes resolved with a neutral party and not in court) for 2 of 5 sampled residents (#s 13 and 76) reviewed for arbitration. This placed residents at risk for being uninformed of their legal rights. Findings include: 1.Resident 13 admitted to the facility in 7/2024 with diagnoses including muscle weakness. A 7/28/24 Medicare 5-Day MDS indicated Resident 13 was cognitively intact. An 10/7/24 facility provided list of residents who signed a facility Arbitration Agreement indicated Resident 13 signed an Arbitration Agreement. On 10/10/24 at 11:56 AM Resident 13 stated she/he was not aware of signing an arbitration agreement. On 10/11/24 at 3:00 PM Witness 3 (Family Member) stated she did not recall speaking to anyone regarding arbitration agreements when the arbitration form was offered. On 10/11/24 at 8:51 AM Staff 1 (Administrator) acknowledged they should ensure residents or their representatives understood the arbitration agreement. 2.Resident 76 admitted to the facility in 4/2024 with diagnoses including a pressure ulcer. A 4/7/24 Admission MDS indicated Resident 76 was cognitively intact. An 10/7/24 facility provided list of residents who signed a facility Arbitration Agreement indicated Resident 76 signed an Arbitration Agreement. On 10/10/24 at 11:52 AM Resident 76 stated she/he did not remember signing an arbitration agreement and arbitration was not explained to her/him. On 10/11/24 at 8:51 AM Staff 1 (Administrator) acknowledged they should ensure residents or their representatives understood the arbitration agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34703 Based on observation, interview and record review it was determined the facility failed to ensure the community use glucometer was properly sanitized between resident uses for 1 of 1 sampled resident (#39) reviewed during CBG checks. This placed all residents who required CBG checks at risk for bloodborne illness. Findings include: Resident 39 admitted to the facility in 2/2024 with diagnoses including diabetes. On 10/9/24 at 11:50 AM Staff 28 (RN) was observed to check Resident 39's CBG (blood sugar measurement) level in the dining room. Staff 28 placed the glucometer on the North medication cart and cleaned the glucometer with small alcohol prep wipes. On 10/9/24 at 12:10 PM Staff 28 stated she always used alcohol prep wipes to sanitize the glucometer, and she was not aware of another sanitizing wipe. On 10/9/24 12:15 PM Staff 3 (LPN-Resident Care Manager) and Staff 30 (LPN-Resident Care Manager) stated the glucometer should be sanitized with the proper sanitizing wipes.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 47001 Based on observation, interview, and record review it was determined the facility failed to ensure an antibiotic was indicated for use for 1 of 2 sampled residents (#17) reviewed for respiratory care. This placed residents at risk for antibiotic resistant organisms. Findings include: Resident 17 admitted to the facility in 7/2023 with diagnoses including chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe), congestive heart failure (a long-term condition that occurs when the heart is unable to pump enough blood to meet the body's needs) and pulmonary hypertension (a condition that affects the blood vessels in the lungs, making it harder for blood to flow to the lungs and causing the heart to work harder to pump blood). A 9/22/24 Progress Note indicated Resident 17 had a wet productive cough, generalized body aches and tested negative for COVID 19. A 9/24/24 Progress Note indicated a provider visit with Resident 17 and a new antibiotic order was received for an upper respiratory infection (an illness that affects the upper respiratory system). On 10/7/24 at 12:54 PM Resident 17 was observed in her/his bed with oxygen on at two liters per minute via nasal cannula. Resident 17 had an occasional moist cough. On 10/11/24 at 10:28 AM Staff 17 (Infection Preventionist) stated Resident 17 tested negative for COVID 19 on 9/18/24 and 9/22/24 and Resident 17 was started on an antibiotic for an upper respiratory infection on 9/24/24. Staff 17 stated a chest x-ray was not completed and no other lab tests were completed to confirm Resident 17 had an upper respiratory infection or to confirm Resident 17 did not have complications from her/his respiratory diagnoses. Staff 17 stated the facility used the McGeer's Criteria for antibiotic stewardship to ensure residents were not treated unnecessarily with antibiotics. Staff 17 acknowledged Resident 17 did not meet the McGeer's Criteria for an upper respiratory infection, and Resident 17 required further diagnostic testing before starting an antibiotic.