STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385190	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gresham Post Acute Care and Rehabilitation	405 NE 5th Street Gresham, OR 97030

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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 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. 41458 Based on interview and record review it was determined the facility failed to inform residents and/or resident's responsible party of the risks and benefits, and to ensure consent was obtained for the use of psychotropic medications for 3 of 5 sampled residents (#s 14, 26, and 66) reviewed for unnecessary medications. This placed residents at risk for lack of informed consent. Findings include: 1. Resident 66 was admitted to the facility in 7/2024 with diagnoses including major depressive disorder. Resident 66's 7/20/24 Physician Order indicated the resident was prescribed citalopram hydrobromide (antidepressant medication) to be taken each morning related to major depressive disorder. Resident 66's 8/2024 MAR revealed the resident received citalopram hydrobromide, daily. Review of Resident 66's health record revealed no documentation to indicate the resident or her/his representative was informed of the risks and benefits of citalopram hydrobromide and no evidence the resident consented to receive the medication until 8/27/24. On 8/28/24 at 2:23 PM Staff 7 (LPN-Care Manager) reported it was the nursing staff's responsibility to review the risks and benefits of psychotropic medications with residents prior to residents taking the medications and confirmed Resident 66 received citalopram hydrobromide without consent being obtained prior to administration. 47005 2. Resident 26 was admitted to the facility in 1/2020 with diagnoses including depression and anxiety. Resident 26's 8/4/22 Physician Order indicated the resident was prescribed aripiprazole (antidepressant medication) to be taken at bedtime related to depression. Resident 26's 8/2024 MAR revealed the resident received aripiprazole, daily. Review of Resident 26's health record revealed no documentation to indicate the resident or her/his representative was informed of the risks and benefits of aripiprazole and no evidence the resident consented to receive the medication until 8/27/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 2:23 PM Staff 7 (LPN-Care Manager) reported it was the nursing staff's responsibility to review the risks and benefits of psychotropic medications with residents prior to residents taking the medications and confirmed Resident 26 received aripiprazole without consent being obtained prior to administration. 50927 3. Resident 14 was admitted to the facility in 7/2024 with diagnoses including anxiety disorder and major depressive disorder. The 8/2024 MAR revealed Resident 14 received Fluoxetine (an antidepressant) daily. A review of the Psychotropic Disclosure and Consent dated 7/12/24 revealed no verbal or written consent for Fluoxetine. No information was found in the resident record which showed the risks and benefits of the medication's use was reviewed with Resident 14 prior to administration. On 8/30/24 at 10:27 AM Staff 3 (RCM) verified the Consent date 7/12/24 did not include Fluoxetine. Staff 3 stated the resident should have received a consent with a review of the risks and benefits of Fluoxitine.

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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. 41458 Based on interview and record review it was determined the facility failed to ensure transfer notices with appeal rights were provided in writing to residents and their representatives, and to ensure the Office of the State Long-Term Care Ombudsman was notified of resident hospitalization s for 2 of 2 sampled residents (#s 42 and 44) reviewed for hospitalization s. This placed residents at risk for lack of information regarding their options, rights and lack of advocacy from the Ombudsman Office. Findings include: 1. Resident 44 was admitted to the facility in 11/2022 with diagnoses including chronic respiratory failure (a condition resulting in the inability to effectively exchange carbon dioxide and oxygen in the body) and quadriplegia (paralysis that effects the torso and all four limbs). A review of Resident 44's health record revealed she/he was transferred to the hospital on 3/19/24, 6/19/24 and 7/15/24. No evidence was found in Resident 44's health record to indicate a transfer notice with appeal rights was provided in writing to her/him upon transfer to the hospital or that the Office of the State Long-Term Care Ombudsman was notified of the resident's transfers to the hospital. On 8/29/24 at 1:40 PM Staff 25 (Social Service Director) indicated she was not aware the Office of the State Long-Term Ombudsman had to be notified when residents were transferred to the hospital or discharged from the facility. On 8/29/24 at 2:40 PM Staff 26 (Social Service Director) indicated she was aware the Office of the State Long-Term Ombudsman needed to be notified when residents transferred to the hospital or discharged from the facility but she did not know which facility staff was responsible for this. On 8/30/24 at 9:36 AM Staff 1 (Administrator) confirmed transfer notices with appeal rights were not being provided to residents when they transferred to the hospital and the Office of the State Long-Term Care Ombudsman was not being notified when residents transferred to the hospital or discharged from the facility. 47000 2. Resident 42 was admitted to the facility in 3/2024 with diagnoses including chronic respiratory failure. A review of Resident 42's health record revealed the resident was sent to the hospital on 5/29/24, 6/12/24, 7/11/24 and 8/23/24. No evidence was found in Resident 42's health record to indicate transfer notices with appeal rights were provided in writing to her/him and their representatives or the Office of the State Long-Term Care Ombudsman was notified of the resident's transfers 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 8/30/24 at 9:34 AM Staff 6 (LPN) stated he did not provide residents or their representatives with transfer notices with appeal rights in writing at the time of a resident transfer. On 8/30/24 at 10:05 AM Staff 26 (Social Services Director) stated she did not provide residents or their representatives with transfer notices with appeal rights in writing at the time of a resident transfer or notify the Office of the State Long-Term Care Ombudsman of resident transfers or discharges. On 8/30/24 at 10:27 AM Staff 1 (Administrator) confirmed the facility did not provide written transfer notices with appeal rights to residents or their representatives following a resident transfer or inform the Ombudsman of resident transfers and discharges.

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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. 41458 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 2 of 2 sampled residents (#s 42 and 44) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 44 was admitted to the facility in 11/2022 with diagnoses including chronic respiratory failure (a condition resulting in the inability to effectively exchange carbon dioxide and oxygen in the body) and quadriplegia (paralysis that effects the torso and all four limbs). A review of Resident 44's health record revealed she/he was discharged to the hospital on 3/19/24, 6/19/24 and 7/15/24. No evidence was found in Resident 4's health record to indicate written notice of the facility's bed hold policy was provided to Resident 44 when she/he was transferred to the hospital on 3/19/24, 6/19/24 or 7/15/24. On 8/27/24 at 2:30 PM Staff 26 (Social Service Director) stated she was unfamiliar with the bed hold policy and how to complete it. She stated a written bed hold policy was not provided to Resident 44 upon her/his transfer to the hospital on 3/19/24, 6/19/24 or 7/15/24. On 8/30/24 at 9:36 AM Staff 1 (Administrator) confirmed a written bed hold policy was not provided to Resident 44 when she/he was transferred to the hospital on 3/19/24, 6/19/24 or 7/15/24. 47000 2. Resident 42 was admitted to the facility in 3/2024 with diagnoses including chronic respiratory failure. A review of Resident 42's health record revealed the resident was sent to the hospital on 5/29/24, 6/12/24, 7/11/24 and 8/23/24. No evidence was found in Resident 42's health record to indicate written notice of the facility's bed hold policy was provided to the resident or their representative on 5/29/24, 6/12/24, 7/11/24 or 8/23/24. On 8/30/24 at 9:34 AM Staff 6 (LPN) stated he did not provide residents or their representatives with a copy of the facility's bed hold policy at the time of a resident transfer. On 8/30/24 at 10:14 AM Staff 1 (Administrator) acknowledged these findings and confirmed the facility did not provide residents or their representatives with any written notification of the facility's bed hold policy at the time of a resident transfer.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 17271 Based on record review and interview it was determined the facility failed to complete MDS assessments which reflected accurate mental health diagnoses for 1 of 5 sampled residents (#33) reviewed for unnecessary medications. This placed residents at risk for inaccurate assessment and care. Findings include: Resident 33 was readmitted in 10/2023 with diagnoses including generalized anxiety disorder and major depressive disorder-recurrent. A 3/13/24 physician's note (internal medicine) identified the resident reported significant anxiety and depression with psychiatric treatment in the past. Resident 33 did not recall the use of antipsychotic medication. The physician suggested a diagnosis of schizoaffective disorder (a chronic mental health disorder characterized by symptoms of both schizophrenia and mood disorder) but it was unclear if the resident met the diagnostic criteria. Further consultation with a colleague was planned. On 3/14/24, a diagnosis of schizoaffective disorder, depressive type was entered in the medical record. According to the record, the diagnosis was made by Staff 34 (Former Nurse Practitioner). There was no evidence in the medical record a mental health practitioner was involved when determining the diagnosis or that the resident met the criterion for schizoaffective disorder. The 4/2024 Pharmacy Review identified the resident had no history of schizoaffective disorder and the diagnosis was inappropriate. On the 5/8/24 Significant Change MDS and the 8/6/24 Quarterly MDS, Schizophrenia was coded in Section I. The medical record did not support the coding of this diagnosis. On 8/29/24 at 2:46 PM, Staff 2 (DNS) stated there was no evidence in the medical record that a mental health professional was involved in the diagnosis of the resident and the diagnosis had been questioned by both the pharmacist and physician. Staff 2 acknowledged the diagnosis should not have been coded on the MDS.

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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 18073 Based on interview and record review it was determined the facility failed to ensure a baseline care plan was sufficient to meet the needs of a resident admitted with a pressure injury for 1 of 2 sampled residents (#173) reviewed for pressure ulcers. This placed residents at risk for a delay in treatment. Findings include: Resident 173 was admitted to the facility in 8/2024 with diagnoses including recent onset of paralysis of the lower extremities and a documented history of pressure injury to the sacrum that occurred during hospitalization . A Hospital History and Physical dated 8/16/24 indicated Resident 173 had a new pressure injury to sacrum (area above the tailbone) found on 8/14/24. The wound was described as an intact, discolored DTI (deep tissue Injury). Treatment included protective ointment, a foam dressing, frequent repositioning and pressure reduction. Documentation on the facility Clinical Admission Form dated 8/21/24 did not identify the presence of the wound on the resident's sacrum. Resident 173's Initial Care Plan dated 8/22/24 did not identify the presence of an actual pressure injury. A Care Plan focus area related to potential impairment to skin integrity related to immobility was initiated on 8/26/24, five days after admission. On 8/27/24 at 10:53 AM Staff 4 (LPN) stated she completed the resident's admission but was unable to visualize the resident's sacrum at that time. Staff 4 confirmed she received information regarding a pressure wound in a report received from the hospital. On 8/28/24 at 3:54 PM Staff 2 (DNS) and Staff 3 (LPN, Resident Care Manager) stated the Baseline Care Plan was derived from data entered on the Clinical Admission Form. Resident 173 refused a full assessment at the time of admission. The refusal was not documented and the next shifts did not follow up.

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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. 43690 Based on observation, interview, and record review it was determined the facility failed to ensure care plans were revised to accurately to reflect the needs of residents for 3 of 7 sampled residents (#s 19, 66 and 67) reviewed for accidents, care plans and nutrition. This placed residents at risk for unmet needs. Findings include: 1. Resident 19 admitted to the facility in 11/2017 with diagnoses including dysphagia (difficulty swallowing) and epilepsy (seizure disorder). A Care Plan initiated on 3/3/21 revealed Resident 19 used bilateral fall mats related to risk of injury from seizure activity and was to be shaved daily. A 8/16/24 Quarterly MDS revealed Resident 19 had severe cognitive impairment. Observations on 8/28/24 from 8:00 AM to 3:00 PM revealed Resident 19 did not have bilateral fall mats in place in her/his room while the resident was in bed and she/he had facial hair growth that was a quarter to half an inch long. On 8/28/24 at 12:29 PM Staff 5 (CNA) stated Resident 19 was to have bilateral fall mats in place at all times. Staff 5 also stated he did not shave Resident 19 on a daily basis. On 8/28/24 at 12:44 PM Staff 3 (LPN-Resident Care Manager) stated Resident 19 no longer required bilateral fall mats and was not to be shaved daily. Staff 3 stated Resident 19's family assisted the resident with shaving or staff took care of it on her/his shower days. Staff 3 stated she expected the care plan to accurately reflect Resident 19's current needs. 47000 2. Resident 66 was admitted to the facility in 7/2024 with diagnoses including compression of the brain. Resident 66's 8/26/24 Care Plan indicated the following: -The resident was to wear a protective helmet when out of bed as tolerated related to the surgical wound to her/his scalp. -Staff were to ensure the resident's helmet was on when she/he was out of bed as the resident was at risk to fall. -The resident was to wear a helmet when out of bed and when sitting at the edge of the bed related to her/his ADL performance deficit. On 8/27/24 at 9:04 AM the resident was observed to sit in her/his wheelchair in her/his room. The resident's protective helmet was on top of her/his bedside table. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 9:13 AM Staff 5 (CNA) stated Resident 66 wore her/his helmet when she/he was in her/his wheelchair. Staff 5 further stated she obtained information about when the resident wore her/his helmet in the resident's care plan. On 8/30/24 at 11:07 AM Staff 7 (LPN-Care Manager) stated she needed to review the physician's orders to determine which intervention was appropriate for the resident's care plan. On 8/30/24 at 11:19 AM Staff 2 (DNS) acknowledged the findings of this investigation and stated Resident 66's care plan was in need of revision. 3. Resident 67 was admitted to the facility in 7/2024 with diagnoses including acute kidney failure. Resident 67's 7/5/24 Admission MDS indicated the resident was cognitively intact. Resident 67's 7/12/24 Care Plan indicated the resident received dialysis treatments three times weekly. On 8/29/24 at 10:57 AM Resident 67 stated she/he was on dialysis when she/he came to the facility but had been off of dialysis for weeks. On 8/30/24 at 11:15 AM Staff 2 (DNS) stated Resident 67's care plan should have been revised in 7/2024 when she/he stopped receiving dialysis treatments.

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F 0658 Level of Harm - Minimal harm or potential for 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** 17271 Based on interview and record review it was determined the facility failed to ensure 1 of 1 Nurse Practitioner's (Former Staff 34) diagnostic practices were confined to his specified clinical discipline. This placed residents at risk for diagnosis by unqualified staff. Findings include: According to [NAME] [PHONE NUMBER], Nurse Practitioner Scope of Practice: (7)The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her nurse practitioner expertise by consulting with or referring clients to other health care providers. (8)The nurse practitioner will only provide health care services within the nurse practitioner's scope of practice for which he/she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic coursework, workshops or seminars, provided both theory and clinical experience are included. (9)The scope of practice as previously defined is incorporated into the following specialty categories and further delineates the population served: (d)Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP): Independently provides comprehensive primary health care for adolescents to the older adults; Resident 33 was readmitted to the facility in 10/2023 with diagnoses including generalized anxiety disorder and major depressive disorder-recurrent. A 3/13/24 physician's note (internal medicine) identified the resident reported significant anxiety and depression with psychiatric treatment in the past. Resident 33 did not recall the use of antipsychotic medication. The physician suggested a diagnosis of schizoaffective disorder (a chronic mental health disorder characterized by symptoms of both schizophrenia and mood disorder)might be appropriate but it was unclear if the resident met the diagnostic criteria. Further consultation with a colleague was planned. On 3/14/24, a diagnosis of schizoaffective disorder, depressive type was entered in the medical record. The diagnosis was made by the Staff 34 (Former Nurse Practitioner). Staff 34 was accredited as an AGNP (Adult-Gerontology Primary Care Nurse Practitioner). There was no evidence a mental health practitioner was involved when determining the diagnosis. The same day, quetiapine (an antipsychotic medication) was ordered related to the diagnosis of schizoaffective disorder. A 4/3/24 Pharmacy Review noted [AGE] year old patient's Seroquel [quetiapine] was increased to 400 mg daily for schizoaffective disorder. Patient has NO HISTORY OF schizoaffective disorder Use of the diagnosis of schizoaffective disorder is INAPPROPRIATE for this patient . A 6/17/24 Pharmacy Review noted no response had been provided in regards to the April recommendations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of survey, the diagnosis of schizoaffective disorder remained on Resident 33's active diagnoses list. On 8/9/24 at 2:47 PM, Staff 2 (DNS) stated the diagnosis of schizoaffective disorder had been made by Staff 34 and she could find no evidence a mental health professional had been involved when determining the diagnosis. Staff 2 was aware the diagnosis had been questioned by the pharmacist and the physician, but could provide no additional follow up to their concerns. Staff 34 no longer worked in the facility.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18073 Based on observation, interview and record review it was determined the facility failed to initiate treatment for a pressure injury present upon admission for 1 of 2 sampled residents (#173) reviewed for pressure ulcers. The wound progressed from a DTI (deep tissue injury) to unstageable and required medical intervention for debridement. Findings include: Resident 173 was admitted to the facility on [DATE] with diagnoses including recent onset of paralysis of the lower extremities, diabetes, obesity, and a documented history of pressure injury to the sacrum that occurred during hospitalization . A Hospital History and Physical dated 8/16/24 indicated Resident 173 had a new pressure injury to sacrum (area above the tailbone) found on 8/14/24. The wound was described as an intact, discolored DTI (deep tissue injury). Treatment included protective ointment, a foam dressing, frequent repositioning and pressure reduction. The admission orders to the facility did not include orders for wound care. The facility Clinical Admission form dated 8/21/24 did not identify the presence of the wound to the resident's sacral area. A Braden Scale (standard form used to determine level of risk for developing pressure ulcers) dated 8/21/24 identified the resident to have no sensory perception impairment although resident had a spinal cord injury with paralysis from the waist down. The form indicated the resident had slightly limited mobility and a potential problem with friction and shearing. Resident 173's Care Plan was revised on 8/22/24 to indicate the need for the extensive assistance of two persons for bed mobility, bathing and toileting. The resident had an indwelling urinary catheter and was incontinent of bowel. The care plan was updated on 8/26/24 to include a focus area for potential skin impairment related to immobility. On 8/26/24 a therapy note indicated OT and PT collaborated with nursing staff regarding [the resident's] sacral wound. On 8/27/24 at 10:53 AM Staff 4 (LPN) confirmed she completed the resident's Clinical Admission form but was unable to visualize the resident's sacrum at that time. Staff 4 stated she received information regarding the wound in a report received from the hospital. She visualized the pressure injury on 8/26/24 and described it as crusted over and greenish and with an adjacent superficial open area. Resident 173 was scheduled to be seen by the facility wound nurse, who would recommend treatment. Staff 4 confirmed there were no current orders for treatment. On 8/27/24 the facility's certified wound specialist, Staff 6 (LPN) assessed the wound and initiated treatment. There was no documented evidence in the resident's record to indicate treatment was initiated prior to 8/27/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/27/24 at 10:57 AM Staff 6 stated Resident 173 had two wounds, one to her/his sacrum and another adjacent wound near the coccyx (tailbone). The pressure ulcers were unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured) and covered with slough (non-viable yellow, tan, gray, green or brown tissue). Treatment was to include initiation of an air mattress and Santyl ointment to remove the slough through enzymatic debridement. On 8/28/24 at 12:11 PM Staff 3 (LPN, Resident Care Manager) stated if a resident was admitted with no wound care orders, the nurse was to enter a generic order to clean and cover then contact the provider for a more specific order. The expectation was for the generic order be entered right away and more specific orders entered by the second day. On 8/28/24 at 12:20 PM Resident 173 who was alert and oriented, confirmed the pressure wound started at the hospital. The area was not painful due to a general lack of sensation below the waist. On 8/28/24 at 3:54 PM Staff 2 (DNS) and Staff 3 (LPN, Resident Care Manager) stated the resident may have had a sacral dressing at the time of admission and refused a full assessment. The refusal was not documented and the next shifts did not follow up. They confirmed the Braden Scale completed at the time of admission was inaccurate and the resident did not receive wound care until 8/27/24, six days after admission.

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NAME OF PROVIDER OR SUPPLIER Gresham Post Acute Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 405 NE 5th Street Gresham, OR 97030	

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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. 47005 Based on observation, interview, and record review it was determined the facility failed to maintain oxygen equipment for 1 of 1 sampled resident (#5) reviewed for oxygen therapy. This placed residents at increased risk for respiratory failure. Findings include: Resident 5 was admitted to the facility in 6/2024 with diagnoses including chronic obstructive pulmonary disease (chronic lung disease that causes breathing difficulty). The 6/7/24 Admission MDS indicated Resident 5 was cognitively intact. The 6/3/24 physician order revealed the resident used continuous oxygen and to clean the oxygen concentrator and filter every Tuesday NOC (night) shift. Observations on 8/26/24 at 11:26 AM revealed Resident 5's oxygen concentrator was covered in dust and the external filter had a thick gray layer of dust. On 8/26/24 at 11:28 AM Resident 5 stated she/he did not recall staff cleaning the concentrator or filter the whole time she/he has been in the facility. The 6/2024 TAR revealed no documentation for 6/4/24, 6/11/24, 6/18/24 or 6/28/24 to indicate NOC shift staff cleaned Resident 5's oxygen concentrator and filter as ordered. The 7/2024 TAR revealed no documentation for 7/2/24, 7/9/24, 7/16/24, 723/24, or 7/30/24 to indicate NOC shift staff cleaned Resident 5's oxygen concentrator and filter as ordered. The 8/2024 TAR revealed no documentation for 8/6/24, 8/13/24 or 8/20/24 to indicate NOC shift staff cleaned Resident 5's oxygen concentrator and filter as ordered. On 8/28/24 at 4:07 PM Staff 14 (LPN) stated NOC shift was responsible to clean Resident 5's concentrator and filter. On 8/29/24 at 10:53 AM Staff 7 (LPN-Resident Care Manager) acknowledged Resident 5's concentrator and filter were not cleaned. Staff 7 stated it was her expectation staff cleaned the concentrator and filter every week as ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 17271 Based on interview and record review it was determined the facility failed to identify clinical indications for the use of an antipsychotic medication for 1 of 5 sampled residents (#33) reviewed for unnecessary medications. This placed residents at risk for the unnecessary use of psychotropic medication. Findings include: Resident 33 was readmitted in 10/2023 with diagnoses including cancer, generalized anxiety disorder and major depressive disorder-recurrent. The Behavior Monitor for Resident 33 tracked behaviors of: Withdrawal, difficulty sleeping, a history of accusations, easily overwhelmed, irritability and tangential. The 2/2024 Behavior Monitor identified two episodes of difficulty sleeping during the month and no behaviors/concerns were identified in progress notes. A 2/29/24 nurse practitioner visit described Resident 33's behavior as appropriate, with an open attitude, anxious mood, clear speech and concrete thought process. The resident's focus during the visit was her/his pain which was all the time, anxiety and insomnia. A GAD (Generalized Anxiety Disorder) scale was completed and identified a score of 16, indicating anxiety symptoms were severe. On 3/1/24 quetiapine (an antipsychotic medication) 25 mg BID for depression was ordered. There was no rationale provided in the medical record which identified the clinical indications for the use of an antipsychotic medication or how the effectiveness of the medication would be evaluated. On 3/12/24, the quetiapine dose was increased to 100 mg BID. No clinical rationale was found for the increase in dose. A 3/14/24 progress note identified the resident as having a pleasant mood, being compliant with care and experiencing no changes in behavior or mood. On the same day, Staff 34 (Former Nurse Practitioner) changed the quetiapine dose to 200 mg one time a day for the diagnosis of schizoaffective disorder, depressive type. This was a new diagnosis for the resident which was not supported by a mental health practitioner's evaluation or diagnostic criterion. On 3/21/24, the quetiapine dose was increased to 400 mg at bedtime. No clinical rationale was found for the increase in dose. The 3/2024 Behavior Monitor identified no targeted behaviors during the month and progress notes reflected no behavior or mood concerns. On 8/29/24 at 2:47 PM, Staff 2 (DNS) provided information regarding the prescription of quetiapine but was unable to locate supporting documentation which identified why the quetiapine was ordered, what symptoms it treated, or how effectiveness was determined. Staff 2 stated there was no evidence of a mental health professional involved in the diagnosis of schizoaffective disorder and agreed the diagnosis had been questioned by the pharmacist and physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on observation and interview it was determined the facility failed to ensure staff wore appropriate hair restraints during meal preparation for 1 of 1 kitchen reviewed for sanitation and properly stored and labeled food for 2 of 2 resident refrigerators reviewed for storage. This placed residents at risk for unsanitary food and cross contamination. 1. Resident 4 admitted to the facility in ,d+[DATE] with diagnoses including osteomyelitis (bone infection) and malnutrition. A [DATE] Annual MDS revealed Resident 4 was cognitively intact. On [DATE] at 10:44 AM Resident 4's personal refrigerator was observed to contain three covered cups of milk not labeled or dated, three plastic facility containers of chocolate pudding dated [DATE], [DATE] and [DATE], one facility container of vanilla pudding dated [DATE], one facility container of butterscotch pudding dated [DATE] and one small container of ranch dip not labeled or dated. On [DATE] at 10:50 AM Resident 4 stated no one in the facility checked the temperatures or expiration dates for her/his refrigerator. On [DATE] at 11:14 AM Staff 7 (LPN-Resident Care Manager) stated the items should have been dated or thrown away. Staff 7 took the undated and expired foods out of the refrigerator to dispose of them. On [DATE] at 11:23 AM Staff 1 (Administrator) stated there had been a lot of staff turnover and some things had fallen through the cracks. Staff 1 also stated the facility did not have a policy or procedure for residents' personal refrigerators. 2. Resident 21 admitted to the facility in ,d+[DATE] with diagnoses including kidney disease and hypertension. A [DATE] Quarterly MDS revealed Resident 21 was cognitively intact. On [DATE] at 10:58 AM Resident 21's personal refrigerator was observed to have three covered cups of orange juice not labeled or dated, one peach yogurt in a facility plastic container dated [DATE] and a paper container of [NAME] in the Box chicken nuggets with an opened sauce container not labeled or dated. On [DATE] at 11:00 AM Resident 21 stated staff did not check the refrigerator temperatures or for expired foods. On [DATE] at 11:14 AM Staff (LPN-Resident Care Manager) stated the items should have been dated or thrown away. Staff 7 took the undated and expired foods out of the refrigerator to dispose of them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:23 AM Staff 1 (Administrator) stated there had been a lot of staff turnover and some things had fallen through the cracks. Staff 1 also stated the facility did not have a policy or procedure for resident personal refrigerators. 47005 3. Review of the US FDA Food Code 2022 revealed: -food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food. Observations on [DATE] at 11:28 AM for lunch time tray line plating Staff 32 (Dietary Aide) was observed in the kitchen area not wearing a hair restraint and preparing the lunch trays for the start of meal service. Staff 33 (Cook) was observed in the kitchen area not wearing a hair restraint while cooking. Staff 31 (Dietary Manager) was observed walking around the kitchen area without a hair restraint. On [DATE] at 11:35 AM Staff 31 acknowledged certain kitchen staff were not wearing hair restraints and stated it was her expectation that all staff wear hair restraints at all times when in the kitchen area.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41458 Based on interview and record review it was determined the facility failed to ensure CNA staff received 12 hours of annual in-service training for 4 of 5 randomly selected staff members (#s 19, 20, 21 and 22) reviewed for evidence of in-service training. This placed residents at risk for a lack of quality care. Findings include: On 8/29/24 at 1:06 PM Staff 24 (Human Resources) provided a list of training hours for nurse aid staff which revealed the following: -Staff 19 (CNA): 1.1 annual training hours; -Staff 20 (CNA): 0 annual training hours; -Staff 21 (CNA): 0 annual training hours and -Staff 22 (CNA): 0 annual training hours. On 8/29/24 at 1:10 PM Staff 24 acknowledged Staff 19, Staff 20, Staff 21 and Staff 22 did not complete the required 12 hours of annual in-service training. On 8/30/24 at 10:51 AM Staff 1 (Administrator) acknowledged CNA staff were required to have 12 hours of annual in-service training and stated the facility needed to develop a tracking system for monitoring the hours.