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	12/19/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review it was determined the facility failed to assess, implement treatment and provide on-going monitoring to prevent pressure ulcers for 1 of 2 sampled residents (#30) reviewed for pressure ulcers. This failure resulted in Resident 30 developing a facility acquired Stage 2 pressure ulcer (a shallow wound involving partial skin loss). Findings include: The facility's 10/2024 Skin Management Policy and Procedure directed the following:-If new skin impairments are found, the licensed nurse will notify the resident, notify the provider, obtain treatment orders, initiate and document pertinent details in the risk management, document findings in the clinical record and place the resident on alert. -Wounds rounds and photo documentation will be completed within seven days for a pressure ulcer/injury. -If a resident refuses skin evaluation, education will be provided and documented. If the resident continues to refuse for 24 hours, staff will notify the RCM or designee who will meet with the resident and complete a managed risk agreement. Resident 30 was admitted to the facility in 11/2022 with diagnoses including quadriplegia (paralysis affecting all four limbs and the torso) and dependence on a ventilator (when a person cannot breathe adequately on their own and relies on a machine for life). Resident 30's 9/25/25 Braden Scale for Predicting Pressure Sore Risk indicated the resident was at high risk to develop pressure ulcers. Resident 30's 10/1/25 Annual MDS revealed the resident was cognitively intact, experienced upper and lower extremity impairment on both sides, was dependent upon staff assistance to complete all ADLs and was at risk of developing pressure ulcers. Resident 30's 12/2/25 Skin Impairment Care Plan revealed the following:-The resident had pressure ulcers on her/his right gluteus (buttocks), left plantar great toe (bottom of her/his big toe), left medial (inner part) ankle and right elbow. -The licensed nurse was to be notified of any new skin issues. -Weekly treatment documentation was to include measurement of each area of skin's breakdown's width, length, depth and type of tissue, exudate (fluid that leaks from blood vessels into nearby tissues, often in response to injury, infection or inflammation) and any other notable changes or observations. -Abnormalities, failure to heal, signs and symptoms of infection and maceration (skin breakdown from being too wet) were to be reported to the physician. A 12/13/25 Skin Integrity Form initiated by Staff 21 (LPN) revealed a pressure ulcer was found by Staff 21 on Resident 30's right ring finger after the resident requested the dressing on her/his right hand to be changed. The form did not indicate any additional details about the wound including staging, size, wound bed appearance, exudate (fluid that has been forced out of the tissues or its capillaries because of inflammation or injury) or presence of signs of infection. The form did not provide any information regarding who or why a dressing was placed on the resident's right ring finger prior to it being changed on 12/13/25.A 12/13/25 Progress Note indicated Resident 30 had a pressure ulcer on her/his right ring finger, and the resident's right hand was to be elevated in order to relieve pressure on the area.On 12/15/25 at 10:12 AM, Resident 30 was observed in her/his room in bed. The back of the resident's right hand was observed to push into the mattress on her/his bed. No pillow or padding was observed in place to help reduce the pressure to the resident's pressure ulcer on her/his right hand. Resident 30 stated she/he was dependent on assistance from staff to move her/his right arm/hand and regularly requested staff to place a pillow under her/his right wrist to help reduce pressure, but staff refused. On 12/15/25 at 12:34 PM, Resident 30 was observed in her/his room in (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	bed. The resident's right hand was pushed into the mattress without any pillow or padding in place to help alleviate pressure to the resident's pressure ulcer. Random observations of Resident 30 on 12/16/25 from 1:20 PM to 5:03 PM revealed the resident was in her/his room in bed. A pillow was placed under the resident's right wrist in such a way that the pressure ulcer on the resident's right ring finger pushed into the bed. On 12/16/25 at 5:10 PM, Staff 21 stated Resident 30 refused most care but would allow staff to prop up her/his right hand on a pillow for pressure relief. On 12/17/25 at 1:28 PM, Staff 22 (RN) observed Resident 30 in her/his room in bed with a pillow placed under the resident's right wrist. Staff 22 stated the resident's pressure ulcer on her/his right hand was directly on the bed and did not receive any pressure relief because of how the pillow was positioned. With Resident 30's permission, Staff 22 removed the dressing that covered the resident's pressure ulcer on her/his ring finger. The wound bed was bright red and blood dripped from the wound. The wound was approximately the size of a quarter in diameter. Staff 22 completed the treatment to the wound and then propped the resident's right wrist on a pillow to offload Resident 30's right hand/ring finger. On 12/17/25 at 6:58 AM, Staff 23 (CNA) stated Staff 24 (RN) informed her Resident 30's right hand was to be floated as the resident had a wound on her/his hand. Staff 23 stated she had not had the opportunity to float the resident's right hand, and she had not seen a pillow used to offload the resident's right hand when she had been in the resident's room. On 12/17/25 at 7:16 AM, Staff 25 (CNA) stated Resident 30 wanted a pillow placed under her/his right hand and did not refuse when it was offered. Staff 25 stated he last saw a pillow used to offload the resident's right hand on 12/13/25 but had not seen the resident since this time. On 12/17/25 at 9:44 AM and 12/19/25 at 8:03 AM, Staff 24 stated she observed the pressure ulcer on Resident 30's knuckle on her/his right ring finger approximately two-to-three weeks ago during wound rounds. Staff 24 stated she did not obtain measurements of the wound, assess the wound, initiate a Skin Integrity Form or obtain treatment orders. Staff 24 stated she was just waiting for orders so she was just treating it on my own. Staff 24 stated when she initially observed the wound, it was a Stage 2 pressure ulcer and was approximately the size of a pencil eraser in diameter. Staff 24 stated she completed treatments to the resident's right hand and ensured the resident's right hand was offloaded for the two days after the wound was discovered, and the resident's wound improved. Staff 24 stated the resident wound got worse again because treatments were not completed on the days she did not work at the facility. Staff 24 stated the wound was currently a Stage 2 but had increased to approximately the size of a quarter in diameter. Staff 24 stated she informed Resident 30 she/he had a pressure ulcer on her/his fourth right finger a few weeks ago as a result of her/his hand being smashed into the bed. Staff 24 stated she educated the resident on the importance of off-loading pressure on her/his right hand. Staff 24 further stated she was the nurse assigned to Resident 30's care on 12/15/25, and no staff reported to her that Resident 30 refused to elevate her/his right hand. On 12/17/25 at 3:28 PM, Staff 26 (LPN Resident Care Manager) stated she expected Resident 30's right hand to be elevated at all times to provide pressure relief, and if the resident refused her/his hand to be elevated, staff should notify the nurse. Staff 26 further stated a Skin Integrity Form should have been initiated at the time the resident's wound was initially discovered to ensure the resident received timely treatment. On 12/18/25 at 3:01 PM Staff 21 stated the wound on the resident's right hand was beefy red but did not bleed when she initially observed it on 12/13/25. Staff 21 stated she could not remember if she measured the wound on 12/13/25 and could not provide any additional details.On 12/19/25 at 8:13 AM Staff 2 (DNS) stated a Skin Integrity Form should have been initiated at the time Resident 30's right hand wound was initially discovered so a root cause analysis could have been completed, appropriate treatments put in place and a timely assessment of the resident's wound, including staging and measurement information, was obtained.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to provide the risk and benefits for the use of a psychotropic medication to a resident prior to administration for 1 of 5 sampled residents (#2) reviewed for medications. This placed residents at risk for lack of informed consent. Findings include: Resident 2 admitted to the facility in 6/2025 with diagnoses of bipolar disorder, ADHD (Attention Deficit Hyperactive Disorder), and depression. Review of Resident 2's physician orders revealed a new psychotropic medication for bupropion (an antidepressant) 75 mg was added on 12/9/25 and included an indication a consent was required before administering the medication.The 12/2025 MAR revealed bupropion 75mg was administered to Resident 2 starting 12/11/25.Review of Resident 2's medical record found no consent was obtained prior to administering the medication.On 12/18/25 at 1:15 PM Staff 20 (Resident Care Manager/LPN) confirmed nurses were expected to obtain consent for psychotropic medications prior to administering psychotropic medication. Staff 20 acknowledged a consent was not obtained prior to Resident 2 starting bupropion 75mg.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure call devices and overbed lights were accessible for 2 of 5 sampled residents (#s 5 and 30) reviewed for accommodation of needs. This placed residents at risk for delayed assistance and unmet needs. Findings include: 1. The facility's 9/2022 Answering the Call Light Policy directed staff to ensure the call light was accessible to the resident when in bed. Resident 30 was admitted to the facility in 11/2022 with diagnoses including quadriplegia (paralysis affecting all four limbs and the torso) and dependence on a ventilator (when a person cannot breathe adequately on their own and relies on a machine for life). Resident 30's 10/1/25 Annual MDS revealed the resident was cognitively intact, experienced upper and lower extremity impairment on both sides and was dependent upon staff assistance to complete all ADLs. Resident 30's 10/3/25 Care Plan indicated the resident utilized a soft touch call light (an assistance device, often a lightweight button or pad, designed for individuals with poor dexterity or limited movement) with her/his left hand to make her/his needs known. On 12/15/25 at 10:04 AM, Resident 30 was observed in her/his room in bed. The resident's call light was positioned on the left side of the bed near the resident's head. The resident demonstrated she/he was unable to independently access the call light as it was positioned too high on her/his bed. The resident stated her/his call light was placed out of reach on a daily basis, and as a result, she/he had to yell out to get staff's attention. On 12/16/25 at 1:20 PM, Resident 30 was observed in her/his room in bed. The resident's call light was positioned near the resident's left shoulder. The resident demonstrated she/he was unable to independently access the call light as it was positioned too high on her/his bed. The resident stated an unidentified staff person just assisted her/him in bed, left her/his room and did not ensure she/he could reach her/his call light before they left. On 12/16/25 at 5:03 PM, Resident 30 was observed in her/his room in bed. The resident attempted to reach her/his call light but was unable to do so. The state surveyor activated the resident's call light at the request of the resident, and it was answered at 5:05 PM by Staff 42 (CNA). Staff 42 assisted the resident and exited the room without ensuring the resident was able to reach her/his call light. Staff 42 stated the positioning of Resident 30's call light was dependent upon the resident's strength for the day. Staff 42 stated staff usually did a call light test with the resident to ensure the resident could reach her/his call light before they left the room. On 12/17/25 at 6:19 AM, Resident 30 was observed in her/his room in bed. The resident's call light was placed by her/his left hip, and the resident independently activated her/his call light. At 6:27 AM Staff 43 (CNA) answered the resident's call. Staff 43 raised the head of the bed to assist the resident with a drink of water and then lowered it after the resident was finished. Staff 43 did not confirm with the resident if she/he could reach her/his call light and exited the room. The resident demonstrated at this time she/he could no longer reach her/his call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/25 6:34 AM, Staff 43 stated Resident 30's call light was to be placed on her/his left side and staff were supposed to ensure the resident was able to reach it before leaving her/his room. On 12/17/25 at 1:28 PM, Resident 30 was observed in her/his room in bed. Staff 22 (RN) and Staff 25 (CNA) observed Resident 30 was unable to reach her/his call light. Staff 25 stated the placement of the resident's call light needed to be frequently adjusted due to her/his level of strength and after care was completed. On 12/17/25 at 3:28 PM, Staff 26 (LPN Resident Care Manager) stated she expected Resident 30's call light to be placed on her/his left side and in a place where she/he could reach it. Staff 26 further stated staff were to do a return demonstration if they moved the resident's call light. On 12/18/25 at 10:23 AM, Staff 2 (DNS) stated Resident 30's mobility was so limited that he expected staff to ensure the resident was able to reach it before exiting the resident's room. 2. Resident 5 was admitted to facility in 3/2025 with diagnoses including muscle weakness and somatoform disorder (a mental illness that causes bodily symptoms, including pain). Observations on 12/15/25 at 3:54 PM revealed two overbed lights in Resident 5's room were missing their cords. Resident 5 was sitting up in bed and stated she/he had to use the call light for staff assistance to turn the light on and off because the only working light was controlled by a switch located at the entrance of her/his room. The Quarterly MDS dated [DATE] revealed Resident 5 required extensive assistance with all ADLs. On 12/17/25 at 11:50 AM, Staff 36 (CNA) stated if something was broken in a resident's room, she would inform maintenance by inputting the issue into the computer. She stated maintenance would notice it right away and fix it. On 12/17/25 at 11:53 AM, Staff 39 (Lead CNA) stated if the lights needed to be fixed in a resident's room, the issues were reported to maintenance by inputting the concerns into a computer system. On 12/17/25 at 3:14 PM, Staff 15 (Maintenance Director) confirmed there were no cords for two of Resident 5's overbed lights. He stated residents shouldn't have to call staff to turn off and on their overbed lights. On 12/19/25 at 10:45 AM, Staff 1 (Administrator) acknowledged the broken cords in Resident 5's room and stated all overhead lights should be available for residents to use.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview it was determined the facility failed to ensure personal fans were clean for 2 of 2 sampled residents (#s 44 and 67) reviewed for personal fans and 1 of 1 sampled resident (#10) reviewed for privacy curtains. This placed residents at risk for not having a clean hygienic and comfortable homelike environment. Findings include:1.Resident 10 admitted to the facility in 9/2025 with diagnoses including diabetes. Resident 10's 12/2/25 Significant Change MDS assessment indicated she/he was cognitively intact. On 12/15/25 at 12:41 PM and 12/17/25 at 11:37 AM Resident 10's privacy curtain was observed with multiple small stains on the lower half of the curtain and a large brownish stain in the bottom right corner of the curtain. Resident 10 stated the curtain was dirty for many weeks and had asked multiple staff to have dirty curtain washed. Resident 10 stated she/he did not like to look at the dirty curtain. On 12/17/25 at 12:10 PM Staff 17 (Housekeeping) stated her department was responsible to ensure the resident's privacy curtains were washed and clean in resident rooms. On 12/17/25 at 3:32 PM Staff 2 (DNS) and Staff 14 (Regional Corporate Nurse) confirmed Resident 10's privacy curtain was not clean and needed to be changed. Staff 2 stated he expected all residents to have clean privacy curtains. 2. Resident 44 was admitted to the facility in 2023 with diagnoses including a stroke. On 12/17/25 at 11:38 AM Resident 44's room door was observed with a black box fan positioned in front of it. The fan was coated with a layer of dust and dirty, dust layered coated with visible strings of dust were blowing from the fan. On 12/17/25 at 1:35 PM, Staff 38 (Housekeeping Manager) and at 3:14 PM Staff 15 (Maintenance Director) stated they were not responsible for cleaning residents' personal fans. Staff 38 stated she had not cleaned the personal fans for approximately the past six months. On 12/17/25 at 3:26 PM, Staff 2 (DNS) and Staff 14 (Regional Corporate Nurse) confirmed Resident 44 had a dirty personal box fan in her/his room. They stated staff were expected to keep the fan clean and free from dust. 3. Resident 67 was admitted to facility in 11/2023 with diagnoses including anoxic brain damage (lack of oxygen to the brain leading to severe cognitive, physical and emotional issues) and spastic quadriplegic cerebral palsy (severe stiffness in limbs and severe mobility limitations). The Annual MDS with an ARD of 12/1/25 revealed Resident 67 had a BIMS score of 0, which indicated the resident had severe cognitive impairment. The resident was in a persistent vegetative state with no discernible consciousness. On 12/15/25 at 2:55 PM, Resident 67's bedside table was observed to have a fan covered in a thick layer of dust and cobwebs. The fan was off and pointed towards Resident 67's face. On 12/16/25 at 2:13 PM and on 12/17/25 at 9:04 AM, Resident 67's fan was observed to have a thick (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	layer of dust, was turned on and pointed towards her/his face. Resident 67's mouth was observed to be open on both occasions. On 12/17/25 at 11:53 AM, Staff 39 (Lead CNA) stated nursing staff only cleaned bodily fluids in a resident's room. On 12/17/25 at 12:11 PM, Staff 37 (Housekeeping) stated she and housekeeping staff were not responsible for cleaning the personal fans of residents. On 12/17/25 at 1:35 PM, Staff 38 (Housekeeping Manager) and at 3:14 PM Staff 15 (Maintenance Director) both entered Resident 67's room acknowledged the thick layer of dust on Resident 67's fan. Staff 38 and Staff 15 both stated they were not responsible for cleaning the personal fans in resident's rooms. On 12/17/25 at 3:26 PM, Staff 2 (DNS) entered Resident 67's room and acknowledged her/his fan was on, dirty and pointed towards Resident 67's face.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to accurately reassess for ongoing restraint use for 1 of 1 sampled resident (#58) reviewed for restraints. This placed residents at risk for unnecessary restraint use and reduced communication. Findings include:Resident 58 was admitted to the facility in 11/2023 with diagnoses including diffuse traumatic brain injury (widespread damage to the brain).A review of progress notes from Resident 58's date of admission through 12/18/25 revealed Resident 58 had a mitten hand restraint on her/his left hand since 11/3/23. Review of physician orders for Resident 58 revealed the resident had a weighted mitten hand restraint in use on her/his left hand since 3/14/24, which demonstrated the facility utilized the restraint prior to obtaining a physician's order. The current order dated 2/20/25 directed staff to use the restraint mitten on the resident's left hand; remove every two hours to assess skin and to wash the mitten every shift. Review of the SNF Managed Risk Agreement dated 4/16/24 revealed Witness 1 (Family Member) requested a mitten be used on Resident 58's left hand, a weighted elbow sleeve used on the resident's left elbow, and, as a last resort, soft wrist restraints to keep the resident safe. The reason for the restraints was because the resident frequently pulled out her/his tracheostomy tube, injured self, and pulled out her/his g-tube (tube inserted into the abdomen for feeding). A 1/13/25 revised care plan indicated Resident 58's physical restraint use interventions were initiated on 12/13/23. The care plan directed staff to monitor/document/report PRN any changes regarding effectiveness of the restraint, less restrictive devices attempted, and, if appropriate any negative or adverse effects noted.Review of care conference notes dated 7/15/25 and 9/11/25 revealed the question for ?Assistive/Restrictive device(s) continue to be appropriate' was marked as yes. There were no details documented of what was reviewed including, alternate options to restraint use, any monitoring or reassessment of the restraint need, or any risks associated with the restraint use. Review of the 11/2025 and 12/2025 MAR/TAR and task logs revealed the resident had no documented targeted behavior of restlessness or fidgeting, pulling or grabbing at equipment or staff, or erratic movements. The 11/2025 and 12/2025 MAR/TAR revealed the restraint was used daily.An Annual MDS dated [DATE] assessed Resident 58 with no physical restraints in place, no behaviors that posed a risk to self or others, and cognitive function was not assessed due to the resident being in a persistent vegetative stated. There was no evidence found in Resident 58's clinical record to indicate the resident's mitten was re-assessed for continued need or if less-restrictive alternate options were explored. Random observations between 12/15/25 through 12/19/25 between 8:00 AM to 4:30 PM each day revealed Resident 58 had the mitten on her/his left hand. No observations were made of the resident as restless or attempting to pull on her/his g-tube. On 12/17/25 at 3:32 PM, Resident 58 was observed without the mitten during an activity. The resident did not attempt to remove her/his g-tube, be combative, or attempt self-inflicted harm. During interviews on 12/16/25 at 2:24 with Staff 5 (LPN), and at 3:08 PM with Staff 16 (CNA), 12/17/25 at 9:29 AM with Staff 17 (CNA), and 12/18/25 at 9:22 AM with Staff18 (CNA) all staff stated the reason for continued use of the mitten was Resident 58 was combative with cares and in the past tried to pull out tubes.On 12/18/25 at 1:15 PM Staff 20 (Resident Care Manager/LPN) confirmed a reassessment of the restraint was not completed and a discussion with the family regarding the appropriateness of continued use or alternative options were needed. On 12/19/25 at 8:07 AM Staff 27 (CNA/Restorative Aide) stated Resident 58 was more active with her left hand and used her/his left hand to communicate with others. She stated Resident 58 could not see or speak, so the resident used a left thumbs up signal or raised her/his left hand to respond yes to questions, would lower her/his thumb to answer no to questions, would reach out to touch Staff 27, and would stick up her/his middle finger to express frustration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to accurately identify restraint use in the comprehensive assessment for 1 of 1 sampled resident (#58) reviewed for restraints. This placed residents at risk for injuries and unidentified care needs. Findings include:Resident 58 was admitted to the facility in 11/2023 with diagnoses including diffuse traumatic brain injury (widespread damage to the brain).Review of progress notes revealed Resident 58 had a mitten hand restraint in use on her/his left hand since 11/3/23.Review of physician orders for Resident 58 revealed the resident had a weighted mitten hand restraint in use on her/his left hand since 3/14/24. Review of the 11/2025 and 12/2025 MAR/TAR revealed documentation demonstrating the restraint was used on every Day and NOC shift. The Annual MDS dated [DATE] indicated Resident 58 had no physical restraints in place.Random observations from 12/15/25 through 12/19/25 between the hours of 8:00 AM to 4:30 PM each day revealed Resident 58 had the mitten on her/his left hand.On 12/19/25 at 10:55 AM Staff 29 (MDS Coordinator/LPN) confirmed she completed the comprehensive MDS on 12/8/25 and the restraint section was inaccurately coded.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide the necessary care and assistance to maintain good grooming for 2 of 3 sampled residents (#s 5 and 58) reviewed for ADLs. This placed residents at risk for poor grooming. Findings include: 1. Resident 58 was admitted to the facility in 11/2023 with diagnoses including diffuse traumatic brain injury (widespread damage to the brain). A review of Resident 58's 12/8/25 annual comprehensive MDS revealed she/he was dependent on staff for personal hygiene tasks and did not have any rejection of care. Resident 58's care plan dated 1/23/25 revealed the resident was dependent on staff and required two staff members for ADL care and for daily shaving. Care conference notes dated 7/15/25 and 9/11/25 revealed Witness 3 (Family Member) had raised concerns of Resident 58 not receiving personal hygiene cares daily. Daily observations from 12/15/25 through 12/18/25 from the hours of 9:00 AM to 12:00 PM revealed Resident 58 to have dark hairs of varying lengths up to one half inch growing from her/his chin. On 12/16/25 at 9:22 AM Witness 3 stated Resident 58 was unable to shave independently and relied on facility staff to complete the care. Witness 3 stated she/he reported concerns to facility staff that daily hygiene cares were not being completed, and she/he purchased an electric razor to make it easier for staff to shave Resident 58. Witness 3 stated prior to the brain injury, it was important to Resident 58 to always look good and would not have wanted visible facial hair. On 12/16/25 at 3:08 PM Staff 16 (CNA) reported Resident 58 liked to be shaved after showers and sometimes refused to be shaved by shaking her/his hands. Staff 18 stated female residents were shaved after showers and male residents were shaved when they want to be shaved. On 12/17/25 at 9:29 AM Staff 17 (CNA) reported she never shaved Resident 58 because she was scared to shave her/him due to the resident swinging her/his arms during cares. Staff 17 stated she had not noticed Resident 58 had facial hair when she provided cares and stated the resident would not have wanted to have facial hair. On 12/18/25 at 9:22 AM Staff 18 (CNA) stated she and a second CNA assisted Resident 58 on 12/18/25 in the morning had not shaved the resident because the activity department shaved Resident 58. On 12/18/25 at 10:46 AM Staff 19 (LPN) reported Resident 58 was to be shaved daily and as needed. She stated it was not okay to leave Resident 58 with facial hair. On 12/18/25 at 1:15 PM Staff 20 (Resident Care Manager/LPN) stated staffed were expected to shave Resident 58 daily during morning cares. Staff 20 stated staff were expected to review and implement the care plan for Resident 58. 2. Resident 5 was admitted to facility in 3/2025 with diagnoses including muscle weakness and somatoform disorder (a mental illness that causes bodily symptoms, including pain). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE] revealed Resident 5 was cognitively intact and dependent with personal hygiene, including shaving. Resident 5's Care Plan dated 6/1/25 revealed Resident 5 required one staff person to assist with shaving. On 12/15/25 at 3:20 PM, Resident 5 was observed to have unshaven facial hair above her/his upper lip area. On 12/15/25 at 3:52 PM, Resident 5 was observed covering her/his unshaven facial hair when the resident was about it. Resident 5 stated she/he used to shave her/his facial hair every two or three weeks and did not know staff could perform the task for her/him. On 12/18/25 at 9:40 AM, Staff 17 (CNA) stated she was not comfortable asking Resident 5 if she/he would like to be shaved and did not offer the service to her/him. On 12/18/25 at 10:20 AM, Staff 20 (LPN Care Manager) stated staff were uncomfortable to ask Resident 5 if she/he would like her/his facial hair shaved. Staff 20 stated she expected staff to implement Resident 5's care plan when providing care, including performing shaving tasks. On 12/19/25 at 10:31 AM, Staff 2 (DNS) and Staff 40 (RN Regional Nurse Coordinator) acknowledged Resident 5 required one staff person assist with shaving because Staff 5 was dependent on staff for ADL care. Staff 40 stated although it was a sensitive topic, she expected staff to offer shaving services to residents who required assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review it was determined the facility failed to reassess resident's ability to swallow medications for 1 of 6 sampled residents (#12) reviewed for medications, failed to complete neurological checks for 1 of 1 sampled resident (#6) reviewed for accidents and obtain a physician order for 1 of 1 sampled resident (#8) reviewed for suction devices. This placed residents at risk for side effects related to missed medications, unassessed injuries and medical complications. Findings include:1. Resident 6 was admitted to the facility in 2/2025 with a diagnosis of cerebellar ataxia (a neurological condition causing poor muscle control (ataxia) due to damage or disease in the cerebellum, leading to issues with balance, walking (unsteady gait), speech (slurring), swallowing, and fine motor skills like writing, often described as appearing drunk). A review of progress notes revealed Resident 6 had the following falls: -On 9/20/25 an unwitnessed fall and hit her/his head -On 10/15/25 an unwitnessed fall -On 10/18/25 an unwitnessed fall -On 10/20/25 a witnessed fall and hit her/his face -On 10/25/25 an unwitnessed fall and hit her/his forehead -On 11/3/25 an unwitnessed fall A review of the Neurological Assessment Flow Sheets revealed incomplete neurological assessments with missing assessments on the following dates: -9/20/25 -10/15/25 -10/18/25 -10/20/25 -10/25/25 -11/3/25 On 12/18/25 at 9:42 AM Staff 3 (LPN Resident Care Manager) stated neurological assessments were to be completed after unwitnessed falls and after witnessed falls if the resident hit their head. On 12/18/25 at 10:13 AM, Staff 3 stated neurological assessments were to be completed every 15 minutes for one hour, every 30 minutes for an hour, every hour for four hours, and every four hours for 24 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/25 at 10:33 AM, Staff 3 acknowledged the neurological assessments on 9/20/25, 10/15/25, 10/18/25, 10/20/25, 10/25/25, and 11/3/25 were incomplete. On 12/19/25 at 8:35 AM, Staff 2 (DNS) stated neurological assessments were to be completed per the above schedule, so issues were identified and acted on promptly. Staff 2 acknowledged the neurological assessments on 9/20/25, 10/15/25, 10/18/25, 10/20/25, 10/25/25, and 11/3/25 were not completed per the schedule and were missing assessments. 2. Resident 12 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and Bell's Palsy (a sudden, temporary weakness or paralysis of the muscles on one side of the face). A review of physician orders revealed a 12/4/25 order for speech therapy to evaluate and treat Resident 12. A review of the 12/5/25 speech therapy notes evaluation indicated Resident 12's plan of treatment was to be seen three times a week for treatment of swallowing dysfunction. A review of the speech therapy progress notes revealed the following: -On 12/8/25 resident was unable to be seen due to a scheduling conflict. -On 12/10/25 resident was in bed asleep, not alert enough for safe oral intake trial or to participate in swallow exercises. -On 12/12/25 resident was in bed asleep, not alert enough for safe oral intake trial or to participate in swallow exercises. -On 12/15/25 resident was unable to be seen due to a scheduling conflict. -On 12/17/25 resident refused treatment, was in bed, not alert enough for safe oral intake trial or to participate in swallow exercises. A review of physician orders revealed a 12/12/25 order to hold all of Resident 12's medication from 12/12/25 until 12/15/25. A review of the meal monitor task revealed Resident 12 consumed the following meals: -On 12/12/25 76-100% dinner. -On 12/13/25 51-75% breakfast and lunch. -On 12/14/25 76-100% breakfast and 51-75% dinner. A review of Resident 12's medical record showed no documentation of increased swallowing difficulty on 12/12/25 and no evidence of any reassessment of swallowing ability. On 12/15/25 at 10:41 AM, Witness 4 (Family Member) stated the facility put a hold on Resident 12's medications over the weekend due to her/his inability to swallow. Witness 4 stated the facility was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	giving Resident 12 her/his medications crushed in pudding, and they tried to get her/him to take the medication in one big bite, which was too much for Resident 12 to swallow. On 12/17/25 at 10:58 AM, Staff 32 (CNA) stated Resident 12 was having a hard time swallowing last week but was eating and swallowing better this week. On 12/17/25 at 11:51 AM, Staff 3 (LPN Resident Care Manager) stated she placed Resident 12's medications on hold on 12/12/25 because Resident 12 was having a hard time swallowing anything and everyone was scared, she/he would aspirate. Staff 3 stated she was unsure if Resident 12 had speech therapy since admission. On 12/18/25 Staff 31 (Speech Therapist) stated Resident 12 was overall very weak and had delayed swallowing. Staff 31 stated she had not seen Resident 12 since the evaluation on 12/5/25 due to days where Resident 12 was too sleepy to participate or there were scheduling conflicts. Staff 31 stated she was the only speech therapist in the facility and attempted to see residents as often as she was able. Staff 31 stated she was not informed about Resident 12's inability to swallow on 12/12/25 and was not informed Resident 12's medications were held over the weekend. On 12/19/25 at 8:32 AM Staff 2 (DNS) acknowledged Resident 12's speech therapy plan of care was to be seen three times a week for dysphagia. Staff 2 stated he expected Resident 12 to be seen per the plan of care and acknowledged Resident 12 was not seen three days a week per the plan of care. Staff 2 stated Resident 12 was eating over the weekend per the documentation, and he expected Resident 12's swallowing to be reassessed for her/his ability to swallow medications as she/he was able to swallow food. Staff 2 acknowledged there was no evidence Resident 12's swallowing ability was assessed or reassessed from 12/12/25 through 12/15/25. 3.Resident 8 admitted to the facility in 2016 with diagnoses including a stroke. Resident 8's 10/22/25 Annual MDS Assessment indicated she/he was cognitively intact and used no suction machine (a medical device that creates a vacuum to remove fluids for a person's airway). On 12/15/25 at 12:44 PM Resident 8 stated she/he used the suction machine at her/his bedside. A suction machine was observed on the left side of her/his bedside table. Record review of Resident 8's health record on 12/16/25 revealed there was no physician order for the use of a suction machine and no plan of care was found for the use of a suction machine. On 12/17/25 at 11:16 AM Staff 20 (Resident Care Manager/LPN) stated Resident 8 had previously used a suction machine and acknowledged the suction machine was on Resident 8's bedside table. Staff 20 stated the resident did not have a physician order for the use of the suction machine and stated the ongoing use of a suction machine required a physician order. She stated Resident 8 did not have any health indication or assessment in her/his health record which indicated the need for the use of a suction machine.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review it was determined the facility failed to follow up on resident's request for new hearing aids for 1 of 2 sampled resident (#6) reviewed for hearing. This placed resident at risk for unmet needs. Findings include:Resident 6 was admitted to the facility in 2/2025 with a diagnosis of bilateral hearing loss.An 8/29/25 care plan indicated Resident 6 had a hearing deficit and to assist her/him with putting the hearing aids in every morning.An 8/29/25 care conference indicated Resident 6 had hearing aids but requested a new pair.On 12/15/25 at 11:43 AM, Resident 6 stated she/he was eligible for new hearing aids and requested assistance with getting them. Resident 6 stated she/he was eligible in 7/2025. Resident 6 stated her/his old pair of hearing aids were lost during one of the room moves. On 12/17/25 at 11:34 AM, Staff 33 (Social Service Director) stated she was unaware of Resident 6's hearing aids missing. Staff 33 stated Resident 6 requested a new pair during the care conference in 8/2025. Staff 33 acknowledged she had not followed up on this request.On 12/17/25 at 11:38 AM, Staff 32 (CNA) stated Resident 6 was hard of hearing but did not have hearing aids.On 12/17/25 at 11:57 AM, Staff 3 (LPN Resident Care Manager) stated she was unaware of if Resident 6 had hearing aids, but she/he was care planned for hearing aids. On 12/17/25 at 12:35 AM, Staff 4 (Social Service Director) stated she was unaware Resident 6's hearing aids were missing. Staff 4 stated when a resident request new hearing aids, it was expected staff complete as soon as possible. Staff 4 stated Resident 6 requested new hearing aids on 8/29/25 and there was no follow up. On 12/19/25 at 8:42 AM, Staff 2 (DNS) stated when residents requested new hearing aids the request should be followed up immediately including if they are eligible for new hearing aids. Staff 2 stated Resident 6 requested new hearing aids on 8/29/25 and acknowledged there was no follow regarding the request.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to assess bowel and bladder continence for 1 of 1 sampled resident (#12) reviewed for bladder and bowel incontinence. This placed residents at risk for incontinence. Finding include:Resident 12 was admitted to the facility on [DATE] with diagnoses including dementia and mixed incontinence (when a person experiences symptoms of both stress incontinence and urge incontinence at the same time).On 12/15/25 at 10:32 AM, Witness 4 (Family Member) stated Resident 12 was continent of bowel and bladder at home. Witness 4 stated Resident 12 had been in the facility for two weeks, and they did not take Resident 12 to the bathroom, they just let her/him be incontinent.A review of Resident 12's care plan revealed a 12/5/25 care plan indicating Resident 12 needed one-person extensive assist for toileting and was at risk for incontinence with a goal to always remain continent but no evidence of interventions to assist Resident 12 with remaining continent. On 12/15/25 at 10:44 AM, Resident 12 stated the staff waited until she/he was incontinent and then changed her/him instead of taking her/him to the bathroom.On 12/17/25 at 10:58 AM, Staff 32 (CNA) stated she thought Resident 12 was incontinent and Resident 12 did not ask to use the bathroom.On 12/17/25 at 11:51 AM, Staff 3 (LPN Resident Care Manager) stated Resident 12 requested and got up to the bathroom on 12/16/25,On 12/17/25 at 12:03 PM, Staff 3 stated when a resident admitted to the facility and were continent, the care plan indicated staff were to ask the resident every time they were in the room and if the resident needed to use the bathroom. Staff 3 stated there were no interventions on Resident 12's care plan to assist her/him to remain continent. On 12/18/25 at 11:35 PM, Staff 29 (LPN Resident Care Manager/MDS Coordinator) stated she assessed Resident 12's continent status by reviewing CNA charting. Staff 29 stated the facility does not initiate toileting programs to assist residents in remaining continent.On 12/18/25 at 12:11 PM, Witness 5 (Family Member) stated at home Resident 12 was continent of bowel and bladder.On 12/18/25 at 12:23 PM, Staff 3 stated residents should be assessed for continence upon admission to the facility. Staff 3 stated Resident 12 was not assessed for continence when she/he admitted to the facility.On 12/19/25 at 8:32 AM, Staff 2 (DNS) stated residents should be assessed for continence upon admission and residents should have a care plan based on the completed assessment. Staff 2 stated a record review of CNA charting was not sufficient for an assessment and acknowledged Resident 12 was not assessed for continence upon admission.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review it was determined the facility failed to follow the nutritional orders and care plan for 1 of 1 sampled resident (#58) reviewed for assisted nutrition and hydration. This placed residents at risk for inadequate nutrition and dehydration. Findings include:Resident 58 was admitted to the facility in 11/2023 with diagnoses including diffuse traumatic brain injury (widespread damage to the brain), persistent vegetative state, and dysphagia (difficulty swallowing).The care plan dated 1/23/25 revealed the following interventions regarding tube feeding:*Tube Feed: Continuous 24 hours. Isosource 1.5 total amount: 1440mls Flow Rate 60ml/hr. Flush Rate: 50ml/hr. *Two licensed nurses are required to verify the correct tube feed and formula when placing a new bag.*Labeling system (All TF [Tube feeding] bags labeled with 2 LN signatures and date/time hung).A physician's order dated 11/10/25 indicated the resident's tube feeding was to run continuously for 24 hours at a rate of 60ml per hour for a total of 1440 ml per day. On 12/15/25 at 11:42 AM Resident 58 was observed in bed. The resident's tube feeding was connected but the pump used to administer the feeding was turned off. Two bags were attached to the pump. One was labeled Isosource and dated/timed 12/14/25 6:30 AM. The other unlabeled bag contained clear liquid. The bag was not observed changed until 12/15/25 at 2:45 PM.Staff 5 (LPN) confirmed on 12/16/25 at 2:24 PM Resident 58's tube feed should have run continuously for 24 hours. She stated the bag was changed when it ran out and the only time the pump was turned off was for showers and bed baths or if Resident 58 was full or vomiting.On 12/16/25 at 3:08 PM Staff 16 (CNA) stated she would make sure the pump was always running and would notify the nurse if there were issues. She stated the nurses would disconnect the pump when it became blocked and during showers.On 12/17/25 at 10:29 AM the tube feeding was observed to be disconnected from Resident 58 when she/he was assisted to the dining room for an activity. On 12/17/25 at 3:32 PM Resident 58 was returned to her/his room by two CNAs with the pump connected and running. At 3:58 PM the pump was observed to be beeping with the alarm on the screen showing the pump had been idle for ten minutes. The nurse was not observed to respond to the alarm until 4:26 PM.On 12/18/25 at 8:57 AM Resident 58 was observed on a stretcher without her/his tube feeding attached. The resident was being transported to a medical appointment and returned to the facility within 2 hours. In an interview with Staff 18 (CNA) on 12/18/25 at 9:22 AM she reported the pump was always running and the pump would not be turned off except when the resident went out to appointments. She stated the pump was supposed to go with the resident when she/he went to the dining room. On 12/18/25 at 4:01 PM Staff 28 (LPN) confirmed she had worked with Resident 58 on 12/15/25 for the 6:00 AM to 6:00 PM shift but had not observed the pump not running until she changed the bag. She stated the last time she recalled seeing the pump running before she changed the bag was between 8:00 AM and 9:00 AM on 12/15/25 when she had given Resident 58 her/his medications. Staff 20 (Resident Care Manager/LPN) confirmed on 12/18/25 at 1:15 PM Resident 58's tube feed should run for 24 hours and there were no orders to stop the feeding or administer a bolus feeding, so the resident would not have made up missing fluid and nutrients when the pump was stopped for extended periods of time. Staff 20 stated she unaware there were time periods Resident 58 was not receiving tube feeding and confirmed the nurse should have noticed the pump was off for at least three hours on 12/15/25.

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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. Based on observation, interview, and record review it was determined the facility failed to ensure resident respiratory equipment was maintained for 2 of 3 sampled residents (#s 10 and 68) reviewed for respiratory care. This placed residents at risk for increased respiratory concerns. Findings include:1.Resident 10 admitted to the facility in 9/2025 with diagnoses including diabetes. Resident 10's 12/2/25 Significant Change MDS assessment indicated she/he was cognitively intact, and the resident did not require the use of oxygen services. A review of Resident 10's health record revealed no current physician order for ongoing oxygen use unless the oxygen level dropped below 92% On 12/15/25 at 12:41 PM Resident 10 was observed with an oxygen nasal cannula (tube with two prongs that fit in the nostrils to deliver supplemental oxygen) in her/his left nostril and connected to an oxygen concentrator (medical device that provides concentrated oxygen). On 12/17/25 at 9:54 AM Staff 5 (LPN) stated residents needed a physician order for the ongoing use of oxygen and they were expected to be followed as written. Staff 5 was not aware the resident was using the oxygen ongoing. On 12/17/25 at 10:10 AM Resident 10 was observed sitting in bed with an oxygen nasal cannula in her/his nose and was connected to an oxygen concentrator. On 12/17/25 at 10:12 AM Staff 20 (Resident Care Manager/LPN) stated she completed an audit of all residents on 12/16/25, during which she discovered Resident 10 had an oxygen concentrator in the room and directed staff to remove it. Staff 20 walked to Resident 10's room, confirmed the concentrator was still present and observed the resident receiving oxygen via nasal cannula. Staff 20 stated Resident 10 had a physician order to receive oxygen only if her/his oxygen saturations dropped below 92% and her/his vital signs did not indicate the need for oxygen. 2. Resident 68 admitted to the facility in 10/2019 with diagnoses including congestive heart failure and dysphagia (difficulty swallowing foods or liquids). The 9/14/25 Quarterly MDS indicated Resident 68 had severe cognitive impairment. Resident 68's physician order dated 1/7/25 revealed she/he required oxygen as needed. On 12/15/25 at 9:55 AM the oxygen concentrator was observed to have a foam filter with a thick layer of dust. On 12/16/25 at 12:47 PM Staff 41 (CNA) stated checking and cleaning oxygen filters was the responsibility of the nurse and not an assigned duty for CNAs. On 12/16/25 at 1:02 PM Staff 15 (RN) observed Resident 68's oxygen concentrator and acknowledged the foam filter was very dirty and needed to be cleaned. On 12/16/25 at 12:28 PM Staff 2 (DNS) stated the facility did not have a cleaning schedule for Resident 68's oxygen filter and his expectation was oxygen filters would be cleaned weekly.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure resident received trauma informed care for 1 of 1 sampled residents (# 55) reviewed for behavioral and emotional care needs. This placed resident at risk for re-traumatization. Findings Include:The facility's undated Trauma Informed Care and Culturally Competent Care policy revealed the resident assessment process involved an in-depth evaluation of trauma-related symptoms and the identification of triggers. The policy revealed the facility's process involved the development of an individualized care plan to address past trauma, and to identify and decrease exposure to triggers that may re-traumatize the resident.Resident 55 was admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder (PTSD) and sleep terrors.Resident 55's 9/11/25 Social Service History, Trauma, and Substance Use Disorder (SUD) Assessment indicated no trauma history.Resident 55's 9/16/25 admission Minimum Data Set (MDS) indicated the resident was cognitively intact and had a diagnosis of PTSD.No evidence was found in Resident 55's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers.In interviews on 12/15/25 at 9:58 AM and 12/16/25 at 1:31 PM in the resident's room while she/he was in bed, Resident 55 stated she/he had a diagnosis of PTSD and experienced startle responses to loud noises that triggered increased respirations and pain levels. Resident 55 stated these symptoms were triggered when staff spoke loudly when waking the resident from sleep.On 12/17/25 at 12:07 PM Staff 7 (CNA) stated she was not aware of any trauma-related concerns for Resident 55 and was not aware of any triggers.On 12/17/25 at 12:27 PM Staff 5 (LPN) stated Resident 55 had a history of war-related trauma. Staff 5 was unaware of any issues for Resident 55 around loud noises.On 12/18/25 at 10:22 AM Staff 3 (LPN Resident Care Manager) confirmed Resident 55's care plan did not include any information related to trauma or triggers.On 12/18/25 at 10:49 AM Staff 4 (Social Services Director) stated Resident 55 denied trauma during the 9/11/25 Social Service History, Trauma, and SUD Assessment. Staff 4 stated no further investigation of Resident 55's trauma history was completed as Resident 55 answered no to the trauma question on the assessment. Staff 4 confirmed Resident 55's care plan did not include information related to Resident 55's diagnosis of PTSD, trauma history, or triggers.

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	385190	A. Building B. Wing	12/19/2025

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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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview and record review it was determined the facility failed to conduct a safety assessment and obtain orders prior to initiating the use of bed rails for 1 of 2 sampled resident (#18) reviewed for bed rails. This placed residents at risk for potential accidents and/or injuries. Findings include: Resident 18 was admitted to the facility in 10/2025 with diagnoses including osteoporosis (condition which bones become weak and brittle) and muscle weakness.The admission MDS Assessment 10/28/25 indicated Resident 18 required substantial assistance for bed mobility and transfer out of bed.Resident 18's current Care Plan did not include the use of bed rails, and no evidence was found in the resident's clinical record an evaluation was completed for the use of bed rails. On 12/15/25 at 12:42 PM Resident 18 was observed in bed with bilateral quarter rails in the upright position.On 12/16/25 at 3:13 PM Staff 13 (CNA) stated she was aware Resident 18 had bilateral bed rails in place on her/his bed. Staff 13 was unable to locate an order or care plan supporting the use of bilateral bed rails.On 12/16/25 at 3:25 PM Staff 3 (LPN Care Manager) confirmed there was no physician order in place for Resident 18's bilateral bed rails. Staff 3 acknowledged the bed rails should not have been in place without an order and stated this was an oversight on her part. Staff 3 further stated the use of bilateral bed rails for Resident 18 was not care planned. On 12/16/25 at 3:40 PM Staff 2 (DNS) stated his expectation was that prior to the use of bed rails, the resident would have a physician order in place, an assessment completed, and the care plan updated to reflect their use. Staff 2 confirmed appropriated steps were not completed prior to Resident 18's bed rails being in place.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review it was determined the facility failed to address pharmacy recommendations for 1 of 5 sampled residents (#3) reviewed for medications. This placed residents at risk for adverse outcomes associated with medication administration. Findings include:Resident 3 was admitted to the facility in 11/2025 with diagnoses including Amyotrophic Lateral Sclerosis (ALS, a progressive and fatal neurological disorder that causes weakness, paralysis and respiratory failure). Resident 3's 11/10/25 Pharmacist's admission Medication Regimen Review revealed the following recommendations: -Rivaroxaban (an anticoagulant medication that reduces the blood's clotting ability and places people at increased risk of bleeding) should be administered with food to increase its efficacy.-The resident should be monitored for signs and symptoms of bleeding due to her/his use of rivaroxaban. Resident 3's 12/1/25 Pharmacist's Medication Regimen Review recommended give with evening meal be added to the resident's physician orders for the rivaroxaban and/or adjust the medication's administration time if needed. Resident 3's 12/2025 Physician Orders directed the resident to receive rivaroxaban once daily at bedtime for a clotting event. No evidence was found in Resident 3's clinical record to indicate the resident was being monitored for signs and symptoms of bleeding or follow up to the pharmacist's recommendations was implemented.On 12/19/25 at 7:44 AM, Staff 21 (LPN) stated she was unfamiliar with rivaroxaban and was unaware Resident 3 received the medication. Staff 21 stated she did not know what the medication was used for, if it required monitoring or if it was to be administered with food. On 12/19/25 at 7:49 AM, Staff 24 (RN) stated she was unfamiliar with rivaroxaban and was unable to answer any questions about the medication without first looking it up. Staff 24 stated residents who received an anticoagulant medication required monitoring and Resident 3 did not have monitoring in place for an anticoagulant. Staff 24 further stated any medication that needed to be administered with food should be notated in the resident's MAR/TAR and no such indication was noted in Resident 3's MAR/TAR for the rivaroxaban. On 12/19/25 at 8:31 AM, Staff 26 (LPN Resident Care Manager) stated Resident Care Managers followed up on recommendations from the pharmacist as quick as we can. Staff 26 stated Resident 3 was supposed to be monitored for bleeding due to her/his anticoagulant use and confirmed she/he was not. Staff 26 further stated the pharmacist's recommendation to administer rivaroxaban with food did not need to be added to the resident's clinical record as the resident received continuous nutrition via a feeding tube. On 12/19/25 at 8:37 AM, Staff 2 (DNS) stated pharmacy recommendations were to be responded to within a week of receipt. Staff 2 stated Resident 3's physician orders should be updated to include not to be given on an empty stomach for the rivaroxaban and the resident's TAR and care plan should be updated to include anticoagulant monitoring.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review it was determined the facility failed to ensure the medication error rate was less than five percent for 2 of 29 attempts. This placed residents at risk for adverse side effects related to medication errors. Finding include:Resident 62 was admitted to the facility in 2/2025 with a diagnosis of heart failure.A review of physician orders revealed a 12/16/25 order for potassium chloride oral packet 20 MEQ give 2 packets twice a day and torsemide 100 mg, give 0.5 tablet twice a day.On 12/17/25 at 8:28 AM, Staff 34 (CMA) was observed to administer torsemide 100 mg and potassium chloride 20 MEQ, 1 packet.On 12/17/25 at 9:42 AM, Staff 34 confirmed Resident 34 had orders to administer torsemide 50 mg and potassium chloride 20 MEQ two packets. Staff 34 stated she was unaware the order changed and acknowledged she administered the wrong dose of torsemide and potassium chloride.On 12/19/25 at 8:45 AM, Staff 2 (DNS) stated staff are expected to administer medications per physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review it was determined the facility failed to ensure medications were not expired for 1 of 4 medication carts and 1 of 2 medication room. This placed residents at risk for decreased efficiency of medications. Finding include:On [DATE] at 9:56 AM, an expired bottle of vitamin B 12 was observed in the 100-hall medication cart. Staff 35 (CMA) confirmed the bottle of vitamin B 12 expired in 8/2025.On [DATE] at 1:29 PM two undated open vials of Tubersol were observed in the 200-hall medication room. Staff 3 (LPN Resident Care Manager) stated Tubersol was good for 30 days after opening. Staff 3 confirmed there was no open date on either open vial of Tubersol and stated there was no indication when the vials were open.On [DATE] at 1:41 PM, Staff 2 (DNS) stated medications must be destroyed when expired. Staff 2 stated Tubersol was good for 30 days after the vial was open and confirmed the two opened, undated vials of Tubersol had no indication of an open date and were to be destroyed.

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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. Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 5 sampled resident (#68) reviewed for respiratory care. This placed residents at risk for exposure and contraction of infectious diseases. Findings include:Resident 68 admitted to the facility in 10/2019 with diagnoses including congestive heart failure and dysphagia (difficulty swallowing foods or liquids).The 9/14/25 Quarterly MDS indicated Resident 68 had severe cognitive impairment.Resident 68's physician order dated 1/7/25 revealed she/he required oxygen as needed.On 12/17/25 at 8:57 AM Resident 68's oxygen cannula and tubing were observed on the floor next to her/his bed.On 12/17/25 at 9:04 AM Staff 12 (RN) was observed to provide care for Resident 68. After the provision of care, Staff 12 was observed to pick up the resident's nasal cannula and oxygen tubing from the floor. Staff 12 wiped the nasal cannula with an alcohol wipe and placed the nasal cannula and tubing on the resident's bed.On 12/17/25 at 9:12PM Staff 12 stated when Resident 68's nasal cannula and oxygen tubing were found on the floor; her process was to wipe the nasal cannula with an alcohol wipe to disinfect it before placing it back on the resident or on the resident's bed.On 12/17/25 at 12:39 PM Staff 11 (Infection Preventionist) and Staff 14 (Regional Infection Preventionist) stated oxygen tubing and nasal cannulas found on the floor were considered contaminated. Staff 14 stated the tubing and nasal cannula should not have been wiped with an alcohol wipe and reused but should have been discarded and replaced. Staff 14 further stated wiping equipment with an alcohol wipe did not meet infection prevention standards.