STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385197	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Post Acute	135 Maple Street Ashland, OR 97520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42222 Based on interview and record review it was determined the facility failed to treat residents with dignity and respect for 1 of 3 (#19) sampled residents reviewed for dignity and respect. This placed residents at risk for loss of dignity. Findings include: Resident 19 admitted to the facility in 1/2024, with diagnoses including palliative (end of life) care. Resident 19's 1/11/24 MDS Admission Assessment revealed a BIMS score of 8, indicating moderate impairment. Resident 19's care plan dated 1/9/24 revealed she/he was incontinent of bowel and bladder and required two persons to assist her/him with a bedpan. On 1/11/24, the facility reported to the State Survey Agency (SSA), which noted on 1/11/24 at 2:05 PM, Resident 19 requested assistance as she/he needed to use the bathroom. She/he was told by Staff 10 (Former CNA) to go in her/his incontinence brief rather than use the bedpan. Staff 1 (Administrator) had walked by the resident's room and overheard the conversation. Staff 1 intervened, asked Staff 10 to exit the room and requested Staff 3 (RCM) and another aide to assist the resident with toileting. Staff 10 was placed on administrative leave while the facility conducted an investigation. Due to discharging from the facility, Resident 19 was not interviewed . On 8/27/24 at 3:00 PM, Staff 1 confirmed the incident occurred and stated Staff 10 was terminated from employment due to the incident. On 8/28/24 at 10:43 AM, Staff 3 stated she recalled the incident on 1/11/24 and assisted Resident 19 with toileting. She stated the resident wasn't too upset and there were no further concerns. On 8/29/24, the State Surveyor attempted to contact Staff 10, but did not receive a return call.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 33179 Based on interview and record review it was determined the facility failed to accurately assess MDS assessments for 1 of 3 sampled residents (#16) reviewed for pressure ulcers. This placed residents at risk for unassessed pressure ulcer care needs. Findings include: Resident 16 admitted to the facility in 7/2024, with diagnoses including diabetes and heart failure. The 7/3/24 Admission Assessment indicated Resident 16 admitted to the facility with a coccyx pressure ulcer. The 7/2024 TARS revealed physician orders to treat Resident 16's coccyx wound from 7/5/24 through the resident's discharge on 7/24/24. The 7/9/24 Admission MDS indicated Resident 16 did not have a pressure ulcer. The 7/24/24 Discharge MDS indicated Resident 16 did not have a pressure ulcer. On 8/29/24 at 2:00 PM, Staff 2 (DNS) verified the 7/9/24 Admission MDS and the 7/24/24 Discharge MDS were coded inaccurately.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 33179 Based on interview and record review it was determined the facility failed to provide necessary information to continuing care providers pertaining to the coccyx pressure ulcer treatment for 1 of 3 sampled resident (#16) reviewed for skin conditions. This placed residents at risk for unmet treatment care needs after discharge. Findings include: Resident 16 admitted to the facility in 7/2024, with diagnoses including diabetes. The 7/2024 TARS revealed Resident 16 had a coccyx pressure ulcer. The 7/30/24 Discharge Summary indicated Resident 16 had macerated skin to the coccyx. There was no treatment listed for the care of Resident 16's pressure ulcer to her/his coccyx. On 8/29/24 at 2:00 PM, Staff 2 (DNS) verified Resident 16's Discharge Summary did not include information about Resident 16's coccyx pressure ulcer and treatment.

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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** 33179 Based on interview and record review it was determined the facility failed to bathe residents for 1 of 5 sampled residents (#2) reviewed for ADL assistance. This placed residents at risk for lack of hygiene. Findings include: Resident 2 admitted to the facility on [DATE], with diagnoses including heart failure. Resident 2's 4/2023 ADL Bathing documentation revealed from 4/14/23 through 4/30/23, staff did not offer the resident the opportunity to bathe. On 8/27/24 at 9:27 AM, Staff 2 (DNS) verified Resident 2 was not offered the opportunity to bathe from 4/14/23 through 4/30/23.

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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 - Minimal harm or potential for 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** 33179 Based on interview and record review it was determined the facility failed to properly assess and treat a pressure ulcer for 1 of 4 sampled residents (#16) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: The National Pressure Injury Advisory Panel defines pressure ulcers as: *Stage I: Non-blanchable erythema (redness) of intact skin. *Stage II: Partial-thickness skin loss with exposed dermis. *Stage III: Full-thickness skin loss in which adipose (fat) tissue is visible. Slough and/or eschar may be visible. *Stage IV: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. *Unstageable: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. When slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed. *Deep Tissue Injury (DTI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. The Centers for Medicare and Medicaid Services (CMS) defines the following: *Slough: Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. *Eschar: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Resident 16 admitted to the facility on [DATE] with diagnoses including diabetes and heart failure. a. The 7/3/24 Admission Assessment indicated Resident 16 admitted to the facility with a Stage III pressure ulcer. The 7/3/24 Skin Assessment indicated Resident 16 had a Stage II pressure ulcer to her/his coccyx. The 7/4/24 Physician Orders indicated Resident 16 had a DTI/coccyx wound. The 7/9/24 Admission MDS indicated Resident 16 did not have any pressure ulcers. The 7/10/24 Skin Assessment identified Resident 16 had a Stage II coccyx wound to be a DTI. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 7/12/24 Progress Note revealed Resident 16's coccyx wound had greater than 95% slough, which would have indicated this to be an unstageable pressure ulcer. The 7/17/24 Skin Assessment identified the Stage II coccyx wound to be a DTI. The 7/24/24 Skin Assessment identified the Stage II coccyx wound to be a DTI. On 8/29/24 at 2:00 PM, Staff 2 (DNS) acknowledged the inconsistencies related to pressure ulcer staging related to Resident 16's coccyx wound assessments. b. The 7/3/24 Skin Assessment indicated Resident 16 had a Stage II pressure ulcer to her/his coccyx. The 7/8/24 Physician Orders for Resident 16's DTI coccyx wound included to cleanse the wound with normal saline, pat dry, apply Santyl (an ointment used to remove dead skin tissue; not used in a Stage II pressure ulcer or DTI), apply a calcium alginate pad (used for high draining wounds to maintain moisture balance; not used in a DTI) and cover with a foam dressing daily and as PRN (as needed) until resolved. The 7/10/24, 7/17/24 and 7/24/24 Skin Assessments identified the Stage II coccyx wound to be a DTI. On 8/29/24 at 2:00 PM, Staff 2 (DNS) acknowledged the 7/8/24 ordered wound treatment was not correct for a Stage II pressure ulcer or DTI, stated she visualized the wound on 7/17/24 and the wound was closed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33179 Based on interview and record review it was determined the facility failed to accurately document in the medical record for 1 of 3 sampled residents (#16) reviewed for pressure ulcers. This placed residents at risk for inaccurate medical records. Findings include: Resident 16 admitted to the facility in 7/2024, with diagnoses including diabetes and heart failure. Review of Resident 16's medical record found the following inaccurate records related to the resident's pressure ulcer staging: -The 7/3/24 Admission Assessment indicated the resident admitted to the facility with a Stage III, measuring 1.5 cm x 2.2 cm. -The 7/3/24 Skin Assessment indicated the resident had a Stage II pressure ulcer to her/his coccyx, measuring 1.5 cm x 2.2 cm x 0.5 cm. -The 7/2024 TARS revealed treatment orders for a DTI (Deep Tissue Injury - purple or maroon localized area of discolored intact skin or a blood-filled blister) coccyx wound. -The 7/6/24 Care Plan did not indicate the resident had a pressure ulcer to her/his coccyx. -The 7/9/24 Admission MDS indicated the resident did not have any pressure ulcers. -The 7/10/24 Skin Assessment revealed the resident had a Stage II coccyx wound with a red wound bed, the area was non-blanchable and the wound appeared to be a DTI (DTI's had an intact outer layer of skin, the wound under the skin such as the wound bed, would not be visible.) -A 7/12/24 Progress Note revealed the resident's coccyx wound had greater than 95% slough (moist, loose, stringy dead tissue in the wound bed which obscures the true depth of the wound.) Ulcers covered with slough were considered unstageable. -The 7/17/24 Skin Assessment revealed the resident's Stage II coccyx wound bed was red, the area was non-blanchable and the wound appeared to be a DTI. -The 7/23/24 Nutrition Admission Assessment indicated the resident's skin was intact. -The 7/24/24 Skin Assessment revealed the resident's Stage II coccyx wound with a red wound bed, the surrounding area was red and non-blanchable and appeared as a DTI. -The 7/24/24 Discharge MDS revealed the resident did not have a pressure ulcer. -The 7/30/24 Discharge Summary revealed the resident had coccyx maceration (skin broken down by moisture on a cellular level). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 2:00 PM, Staff 2 (DNS) acknowledged the inaccuracies in Resident 16's medical record related to the resident's pressure ulcer located on her/his coccyx.