| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385197 | A. Building<br>B. Wing | 11/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ashland Post Acute | 135 Maple Street<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on interview and record review it was determined the facility failed to inform residents of the risks and benefits of psychotropic medication use for 1 of 3 sampled residents (#7) reviewed for medications. This placed residents at risk for being uninformed. Findings include:Resident 7 was admitted to the facility in 5/2025 with diagnoses including depression. A review of a 5/3/25 physician order revealed she/he received Lexapro (antidepressant) daily.A review of the medical record revealed no documentation of the risks or benefits for Lexapro and her/his signed consent for the medication.On 11/13/25 at 11:23 AM Staff 2 (DNS) verified the risks and benefits information was not reviewed with Resident 7 and there was no signed consent to receive the medication. |

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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>Based on interview and record review it was determined the facility failed to treat a resident with respect for 1 of 3 sampled residents (#7) reviewed for dignity. This placed residents at risk for lack of dignified treatment. Findings include: Resident 7 was admitted to the facility in 5/2025 with diagnoses including stroke and feeding tube placement.The 5/5/25 admission MDS indicated Resident 7 was cognitively intact. On 11/13/25 at 6:39 PM Witness 1 (Family) indicated staff took her/him to the dining room during meals. Resident had a new feeding tube and was prohibited from eating but was hungry. Witness 1 asserted complaints were made to staff, but she/he continued to be situated in the dining room during mealsOn 11/14/25 at 10:42 AM Staff 14 (CNA) stated she took Resident 7 to the dining room during meals for interaction with other residents. Staff 14 stated Resident 7 was unable to ingest food and acknowledged escorting her/him to the dining room was undignified and inappropriate. Staff 14 further stated Resident 7 expressed a desire not to go to the dining room because she/he missed eating.On 11/14/25 at 11:23 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged taking Resident 7 to the dining room during meal service when she/he was unable to consume food was undignified |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide wound care and assess a resident for use of a motorized wheelchair for 2 of 5 sampled residents (#s 2 and 4) reviewed for wounds and resident rights. This placed residents at risk for wound complications and lack of resident rights. Findings include: 1. Resident 2 was re-admitted to the facility in 1/27/2025 with a diagnosis of infection.Resident 2's 1/27/25 Nursing Admission/readmission Evaluation/Assessment form revealed she/he had a surgical incision to the neck that was almost healed and open to air. The incision was 18 cm long by 0.2 cm wide. Resident 2's Nurse Practitioner Encounter note indicated Resident 2 had a surgical incision to the neck which was covered with a dressing. Resident 2's clinical record had no orders for dressing changes and no additional wound assessments after her/his readmission. Resident 2's 2/7/25 Progress Note revealed her/his surgical incision fully dehisced (surgical complication when a wound reopens), had a moderate amount of blood on her/his shirt and sheets, emergency transport was called, and she/he was transported to the hospital for evaluation and treatment. On 11/14/25 at 7:48 AM Staff 6 (RN) stated if a resident had a wound the care was documented on the TAR. Wounds, including incisions were monitored weekly until healed. Staff 6 stated Resident 2 always had a dressing in place, because she/he wore a neck brace, and the brace irritated the incision if it was not covered. Staff 6 stated she did not recall what the incision looked like prior to 2/7/25. Staff 6 stated when she entered Resident 2's room on 2/7/25 she observed blood on her/his bedding, removed the brace, old dressing, and observed the wound to be dehisced. Staff 6 stated she immediately called emergency services and Resident 2 was transported to the hospital. On 11/14/25 at 8:02 AM Staff 2 (DNS) stated staff were to complete an initial assessment of a surgical incision upon admission to the facility. If the incision was not healed staff were to obtain wound care orders and monitor the site until healed. Staff 2 stated staff did not obtain orders for Resident 2's wound care and did not assess the incision after the resident was readmitted on [DATE]. 2. Resident 4 was admitted to the facility in 12/2024 with a diagnosis of seizures. Resident 4's 12/23/24 admission CAA revealed she/he required assistance for most ADLs and was cognitively intact. Resident 4's Care Plan initiated on 12/2024 revealed she/he had ADL and mobility decline and required assistance due to weakness. Resident 4 did not walk and was dependent on staff for assistance when in a wheelchair. The care plan was revised on 8/1/25 to indicate Resident 4 was not to use her/his electric wheelchair at any time due to safety concerns. Resident 4's clinical record did not include a Power Mobility Device Screen assessment form. On 6/3/25 Resident 4 reported to the State agency the facility took away her/his power wheelchair. On 11/13/25 at 7:39 AM Staff 1 (Administrator) stated residents who had a power wheelchair were to be assessed prior to use to ensure they were safe to use it independently while in the facility. On 11/13/25 at 8:06 AM Staff 8 (CNA) stated Resident 4, at times, used a power wheelchair in the facility for short periods of time. On 11/13/25 at 11:07 AM Staff 3 (LPN Resident Care Manager) stated Resident 4 was medically unstable and not safe to drive her/his power wheelchair. Staff 3 stated she did not do a formal assessment. On 11/14/25 at 8:28 AM Staff 2 (DNS) stated Resident 4 should have been assessed and the findings reviewed with the resident. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide necessary care and services for pressure ulcers for 1 of 3 sampled residents (#3) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include:Resident 3 was admitted to the facility on [DATE] with diagnoses including a left femur fracture.CMS defines a Stage II Pressure Injury as a wound with partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed.CMS defines an Unstageable Pressure Injury as pressure wound that cannot be staged due to slough/eschar (dead or dying tissue) covering the wound bed.A 2/4/25 admission Evaluation indicated Resident 3 was admitted with a pressure wound to her/his coccyx.A 2/4/25 Skin and Wound Evaluation indicated Resident 3 had a stage 2 pressure injury to her/his sacrum.A 3/3/25 Skin and Wound Evaluation indicated Resident 3 had an unstageable pressure injury to her/his sacrum. The wound was described as deteriorated with suspected infection.The 3/10/25 emergency department progress notes indicated Resident 3 was admitted to the hospital due to an infected sacrum wound.A review of Resident 3's care plan revealed a 2/4/25 pressure ulcer care plan with evidence the care plan was updated after Resident 3's sacrum wound worsened on 3/3/25.A review of Resident 3's medical record revealed no indication Resident 3's provider was notified her/his sacrum wound deteriorated with suspected infection on or after 3/3/25.On 11/13/25 at 1:33 PM, Staff 3 (LPN Resident Care Manager) stated Resident 3 was admitted with a stage 2 pressure injury to their sacrum. Staff 3 stated according to the 3/3/25 wound assessment, Resident 3's pressure injury to her/his sacrum deteriorated to an unstageable wound due to slough and appeared infected. Staff 3 acknowledged there was no indication Resident 3's provider was notified the wound appeared infected on 3/3/25 and acknowledged Resident 3's care plan was not updated after the wound worsened.On 11/14/25 at 11:44 AM, Staff 2 (DNS) stated Resident 3 was admitted on [DATE] with a stage 2 pressure injury to her/his sacrum which had deteriorated to an unstageable pressure injury to her/his sacrum. Staff 2 stated there were no new interventions added to Resident 3's care plan when the wound worsened and there were no indications the provider was notified of the wound appearing infected on the 3/3/25 wound assessment. Staff 2 acknowledged Resident 3 went to the hospital on 3/10/25 and was diagnosed with an infected unstageable pressure injury to her/his sacrum. |