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	05/09/2025

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

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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. 26991 Based on interview and record review it was determined the facility failed to obtain a consent for use of a mood stabilizer prior to administration for 1 of 5 sampled residents (#54) reviewed for unnecessary medications. This placed residents at risk for lack of consent. Findings include: Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's Physician Order Details revealed she/he was to be administered Depakote (anti-seizure medication which can be used to treat manic depression) for her/his mental health diagnosis. Resident 54's 2/1/25 Quarterly MDS revealed she/he was cognitively intact. Review of Resident 54's clinical record did not reveal a consent for the use of Depakote to treat her/his mental health diagnosis. On 5/9/25 at 9:09 AM Staff 4 (Resident Care Manager) stated on 1/31/25 Resident 54 was started on Depakote as a mood stabilizer. Staff 4 stated Depakote was classified as an anti-seizure medication. Therefore, she did not obtain a consent and did not review the risks and benefits of the medication with Resident 54. On 5/9/25 at 9:34 AM Staff 3 (Regional Nurse) stated if a medication was used as a mood stabilizer a consent was to be obtained.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident had a bed to accommodate her/his needs, a room had adequate room for transfers, and a resident's call light was within reach for 3 of 4 sampled residents (#s 17, 26, and 54) reviewed for environment. This placed residents at risk for lack of a homelike environment and inability to call for assistance. Findings include: 1. Resident 17 was admitted to the facility in 6/2021 with a diagnosis of shoulder surgery. Resident 17's 4/4/25 Quarterly MDS revealed she/he was cognitively intact and was at risk for pressure ulcers. On 5/5/25 at 10:50 AM Resident 17 stated her/his bed was not comfortable and she/he reported her/his concerns to staff. On 5/7/25 at 3:29 PM Resident 17 was observed on an air mattress on her/his back with her/his arms resting at her/his side. Residents 17's arms were at the edge of the bed. Resident 17 stated she/he needed a bigger bed. On 5/8/25 at 9:30 AM Staff 1 (Administrator) stated Resident 17 always had a 36 inch wide bed and was not aware of concerns the bed was too narrow. On 5/8/25 at 12:45 PM Staff 15 (Resident Care Manager) observed Resident 17 in bed and acknowledged her/his bed was too narrow. Staff 27 (CNA) stated Staff 1 told Resident 17 she could not have a bigger bed. 2. Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's care plan initiated 10/25/24 revealed she/he required a mechanical lift and the assistance of two staff for transfers. A 2/1/25 Quarterly MDS revealed Resident 54 was cognitively intact. On 5/5/25 at 10:11 AM, 5/6/25 at 1:02 PM, and 5/7/25 at 8:33 AM Resident 54 stated it was hard for staff to assist her/him out of bed because she/he shared a room with two additional residents. Resident 54 stated staff had to move and angle her/his bed in order to maneuver the mechanical lift in the room, and at times staff left the door open in order to accommodate maneuvering the mechanical lift. Resident 54 further stated the room did not have space to maneuver her/his manual wheelchair when she/he was out of bed. On 5/7/25 at 8:57 AM Staff 28 (CNA) stated it required two staff and the use of a mechanical lift to transfer Resident 54 to and from bed. Staff 28 stated they tried to shut the door during transfers but at times the door was left open and the curtain was pulled between the resident and door to maintain privacy. Staff 28 stated other times the bed was moved at an angle in order to accommodate Resident 54's transfer. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 9:02 AM Staff 27 (CNA) stated if staff angled the bed, the door did not have to be opened in order to transfer Resident 54 with a mechanical device. If the bed was not moved at an angle, the door had to be left opened, and the privacy curtain was pulled around the bed. Staff 27 stated the room did not have enough space to transfer Resident 54 out of bed. On 5/9/25 at 1:27 PM Staff 3 (Regional Nurse) acknowledged it would be difficult to transfer Resident 54 with a mechanical lift in a room, shared with two additional residents, with her/his current room set up. 41455 3. Resident 56 was admitted to the facility in 12/2024 with diagnoses including stroke and heart disease. The 3/29/25 Quarterly MDS indicated Resident 56 had a BIMS score of 13 (cognitively intact) and her/his upper and lower extremities were impaired on one side. The 4/22/25 revised care plan indicated to keep Resident 56's call light within her/his reach. On 5/7/25 at 1:48 PM Resident 56 was observed in bed after her/his brief was changed and the door to her/his room was open. Resident 56 was heard from from the hall and requested assistance. Resident 56 had no call light within her/his reach. Resident 56 indicated this happens all the time when the resident demonstrated she/he was not able to reach her/his call light. On 5/7/25 at 1:52 PM Staff 10 indicated she continued other CNA duties after Resident 56's brief was changed and did not check the placement of the resident's call light before leaving her/his room. On 5/7/25 at 1:58 PM Staff 3 (Regional Nurse) acknowledged Resident 56's call light was not within her/his reach. Staff 3 expected staff to check all care needs before leaving the room to ensure Resident 56's call light was clipped to her/his blanket because she/he was unable to use her/his hands.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was offered information to formulate an advance directive (AD) for 1 of 3 sampled residents (#54) reviewed for AD. This placed Residents at risk for end-of-life choices not being honored. Findings include: The facility's Advance Directives policy last revised on 9/2022 revealed if a resident did not have an AD the resident or representative was given the option to accept or decline assistance in establishing ADs. Nursing staff would document in the medical record the offer to assist and the resident's decision to accept or decline assistance. Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's care plan revised on 12/16/24 revealed Resident 54's Advance Directive indicated a POLST [physician orders for life sustaining treatment] indicated she/he was to be treated if found without a pulse and respirations and the residents AD and/or POLST for treatment would be in the resident's medical record at all times. Resident 54's 1/30/25 Quarterly Social History Review revealed she/he did not have an AD. The form did not indicate if AD information was offered. Resident 54's 2/1/25 Quarterly MDS revealed she/he was cognitively intact. On 5/6/25 at 1:02 PM Resident 54 stated no one spoke to her/him about ADs. On 5/6/25 at 1:44 PM and 5/9/25 at 8:39 AM Staff 5 (Social Services) stated upon admit and quarterly, residents were asked if they had an AD. If they did not have an AD a blank form was offered. Staff 5 stated the facility had a new care conference form for the quarterly meetings and there was no longer a box to indicate AD information was provided. Staff 5 acknowledged there was no documentation in Resident 54's record to indicate she/he was offered AD information.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41455 Based on interview and record review it was determined the facility failed to have a grievance policy which included a reasonable time frame to complete review of grievances and timely resolution for a resident's grievance for 1 of 2 sampled residents (#26) reviewed for oxygen. This placed residents at risk for unaddressed concerns and grievances. Findings include: Resident 26 was admitted to the facility in 4/2025 with diagnoses including respiratory failure and chronic pain. The facility's 8/1/2024 Grievance Policy and Procedure indicated to complete grievances with appropriate action and follow-up. The 4/12/25 Admission MDS indicated Resident 26 had a BIMS score of 13 (cognitively intact) and required assistance with eating. A 4/9/25 physician order indicated Resident 26 was to receive continuous oxygen at 2.5 liters per minute. A 4/23/25 Grievance/Complaint Report, submitted by Witness 3 (Family), indicated there were concerns related to Resident 26's oxygen, meal assistance, pressure ulcer interventions, and missing items. The grievance report indicated Resident 26's care plan was reviewed and updated on 4/23/25, Staff 2 (DNS) was to resolve the concerns by 4/30/25 (seven days after the grievance was received), and a meeting was scheduled on 5/6/25. On 5/7/25 at 8:10 AM Witness 4 (Complainant) indicated the family was afraid to leave Resident 26 alone in the facility since reported concerns were not addressed timely. On 5/8/25 at 8:30 AM Staff 2 (DNS) stated she spoke with Staff 11 (RN) related to issues of Resident 26's oxygen. The conversation with Staff 11 was not documented in the medical record and Witness 3 was not informed of any findings or updated until the 5/6/25 meeting. On 5/8/25 at 9:12 AM Staff 3 (Regional Nurse) expected to see a full investigation to the concerns related to Resident 26's oxygen to ensure there was no negative impact to the resident, immediate resolve to Witness 3's concerns for the resident's pressure ulcer interventions and meal assistance, and a response to Witness 3 within five days. On 5/9/25 at 9:03 AM Staff 5 (Social Services) indicated she was the grievance officer and the first time she spoke with Witness 3 was on 5/6/25 during the scheduled meeting. Staff 5 indicated the facility expected resoluion to grievances within seven days. Staff 3 stated she communicated to Witness 8 (Ombudsman) about Witness 3's concerns before the 5/6/25 meeting but Witness 3 was not contacted directly. Staff 3 acknowledged the facility's grievance policy required a revision to formalize the grievance process timeline for residents and family members.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 34703 Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary medications for 1 of 5 sampled residents (#31) reviewed for medications. This placed residents at risk for adverse side effects of medication. Findings include: Resident 31 was admitted to the facility in 9/2023 with diagnoses including PTSD (Post Traumatic Stress Disorder) and insomnia. The 4/16/25 clinical psychologist management plan indicated Resident 31 should transition from Ambien (sedative) to an alternative sleep aid and indicated Resident 31 was open to try something else. The 4/2025 and 5/2025 MAR indicated Resident 31 received Ambien nightly from 4/1/25 through 4/30/25, and 5/1/25 through 5/7/25. On 5/8/25 at 4:01 PM Staff 3 (Regional Nurse) acknowledged Resident 31 had not stopped her/his Ambien and her expectation was for staff to follow-up with the psychologist's recommendation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident's PASRR II (Pre-admission Screening and Resident Review) recommendations were incorporated into her/his care plan for 1 of 5 sampled residents (#54) reviewed for unnecessary medications. This placed residents at risk for unmet behavioral health needs. Findings include: Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's PASRR II was completed on 1/8/25. The evaluation indicated Resident 54 was assessed due to a history of mental health disorders, suicidal ideations, and aggressive behavior toward staff. Recommendations included: -Environmental and social structuring to assist with Resident 54's behaviors. Encourage the resident to engage with staff and peers and spend time in the fresh air. -Memory cues: place photos of loved ones in her/his room and/or create a memory book with the resident. -Provide art supplies at the bedside to allow her/his ability for creative self expression. -Given Resident 54's reports of being an avid reader, increase her/his access to books. -Staff were to contact a Crisis Team (mental health) as needed (a phone number was provided). Resident 54's care plan initiated 10/25/24 was not updated after the 1/8/25 PASRR II evaluation to include the Crisis Team phone number, it did not direct staff to provide books or art supplies, and it did not instruct staff to assist Resident 54 to create a memory book or hang personalized photos in her/his room. A 2/1/25 Quarterly MDS revealed Resident 54 was cognitively intact. On 5/7/25 at 1:25 PM Resident 54's room was observed to not have books, art supplies, or photos of loved ones in her/his room. Resident 54 stated he did not have books to read or any art supplies in her/his room. On 5/9/25 at 8:39 AM Staff 5 (Social Services) stated after a PASRR II was obtained she reviewed the recommendations, provided the assessment to medical records staff, and he uploaded it into the resident's medical record. If the PASRR II had medication recommendations, she forwarded the information to the physician or mental health provider, and if there were nursing recommendations, she would provide the assessment to the Resident Care Manager. Staff 5 stated she did not recall what she did with Resident 54's PASRR II recommendations. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 9:09 AM Staff 4 (Resident Care Manager) stated after a PASRR II was completed the results were provided to the social service department. Staff 4 stated she did not see Resident 54's PASRR II after it was completed. On 5/9/25 at 9:34 AM Staff 3 (Regional Nurse) stated after a PASRR II was completed staff were expected to review the recommendations, implement recommendations appropriate for the resident, and update the care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 26991 Based on interview and record review it was determined the facility failed to develop a resident centered care plan for 3 of 4 sampled residents (#s 17, 47, and 62) reviewed for hospice, smoking and incontinence. This placed residents at risk for unmet care needs. Findings include: 1. Resident 17 was admitted to the facility in 6/2021 with a diagnosis of arthritis. Resident 17's 7/2/24 Annual MDS revealed Resident 17 did not refuse care, required substantial assistance with toileting hygiene, and was frequently incontinent. Resident 17's Care Plan last revised 10/12/24 revealed she/he was occasionally incontinent of urine, and staff were to provide incontinence care. Resident 17's care plan also indicated she/he was depressed and behaviors exhibited could include false accusations made against staff, refusing basic care, and increased anxiety with new staff. The care plan instructed staff to re-approach the resident at a later time. Resident 17's 4/4/25 Quarterly MDS revealed she/he was cognitively intact and did not have behaviors, including refusing cares. On 5/5/25 at 11:01 AM Resident 17 stated she/he was not assisted with incontinent care since 5/4/25 at 9:00 PM and she/he did not refuse assistance. On 5/6/25 at 1:09 PM Staff 27 (CNA) stated on 5/5/25 she worked day shift and Resident 17 reported the night shift CNA did not change or check on her/him. Staff 5 stated she checked on Resident 17 at 8:00 AM but Resident 17 requested she return to assist her/him at 11:30 AM. Staff 27 stated Resident 17 was very particular and did not like staff to check on her/him every two hours, did not like new staff, and had certain times she/he preferred care to be provided. Staff 27 stated Resident 17 was able to transfer to the bedside commode without assistance. On 5/6/25 at 2:34 PM Staff 11(RN) stated Resident 17 did not like to work with new CNAs and often refused care if she/he was not familiar with a CNA. Staff 11 stated Resident 17 at times transferred to the bedside commode without assistance, depending on her/his pain level. Staff 11 also stated Resident 17 reported she/he did not receive incontinent care on 5/4/24 night shift but refused care from the day shift CNA until approximately noon. On 5/7/25 at 8:45 PM Staff 29 (CNA) stated 5/4/25 night shift was the first time she worked with Resident 17. At approximately 11:00 PM she checked on Resident 17, Resident 17 yelled at her, and told her to leave the room. Staff 29 stated she peaked into Resident 17's room a few times during the night but did not go into the room. On 5/8/25 at 8:01 AM Staff 30 (CNA) stated Resident 17 had specific times she/he preferred her/his care be provided, however, even if you go in at the designated times, she/he at times refused care, but would plan for the next planned check for assistance. Other times Resident 17 would indicate she/he would call when she/he needed assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 8:22 AM Staff 15 (Resident Care Manager) stated she worked with Resident 17 when she was a floor nurse. Staff 15 stated Resident 17 directed her/his care and was very particular about her/his care and the specific times she/he wanted staff in her/his room. Staff 15 also stated she usually did not like new staff to work with her/him because they did not know her/his routine. Staff 15 acknowledged the care plan did not have resident specific instructions to ensure staff knew her/his particular times she/he preferred care, in order to prevent refusal of cares. Staff 15 also stated if specific times were identified on Resident 17's care plan it would make it easier for new staff to know when to approach to the resident to make their first interaction more successful. On 5/8/25 at 10:35 AM Staff 3 (Regional Nurse) stated it would be helpful for Resident 17's care plan to be resident centered with specific interventions to ensure staff knew how best to approach her/him to prevent behaviors. 2. Resident 62 was admitted to the facility in 2/12/25 on hospice services with a diagnosis of cancer. A 2/12/25 Activity Assessment revealed it was very important for Resident 62 to have books and magazines to read, listen to music, be around animals, be with groups of people, be outside, and to participate in the activities she/he identified. Resident 62's Care Plan initiated 2/12/25 revealed she he/had dementia and staff were to escort her/him to activities as desired. The care plan did not identify which activities Resident 62 identified as important. On 5/8/25 at 4:09 PM Staff 21 (Activities Director) stated she completed Resident 62's activity assessment. Staff 21 stated she was not aware the MDS did not automatically populate a resident specific care plan. Staff 21 was not aware CNAs were not able to see what Resident 62 identified as activities she/he enjoyed. On 5/8/25 at 4:32 PM Staff 2 (DNS) stated the care plan was to have meaningful activities identified for the resident. Staff 2 stated she would provide an activity care plan if one was developed. No additional information was provided. Refer to F-689. 50897 3. Resident 47 was admitted to the facility in 12/2024 with diagnoses including osteomyelitis of vertebra (infection in the bones of the back). A review of the facility's undated Smoking Policy for Independent Smokers revealed residents approved to smoke independently would keep all smoking materials secured when not in use. The facility policy did not address individual care plans for residents evaluated and approved for independent smoking. A review of the resident's medical record revealed a smoking assessment was completed on 3/31/25 indicating the resident was safe to independently smoke off-site. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 2:35 PM Staff 15 (Resident Care Manager) stated she did not know whether or not Resident 47 was allowed to possess smoking materials or where her/his smoking materials were kept. On 5/9/25 at 2:40 PM Staff 20 (CNA) stated he did not know where Resident 47's smoking materials were kept and did not know whether or not Resident 47 had a lighter in her/his room. On 5/9/25 at 2:42 PM Staff 24 (Agency LPN) stated she did not think residents were supposed to have lighters in their room and she did not know where Resident 47's lighter or other smoking materials were kept. On 5/9/25 at 2:48 PM Staff 1 (Administrator) and Staff 3 (Regional Nurse) stated smoking should have been added to Resident 47's care plan so staff were aware of the guidelines regarding the resident's possession of smoking materials and were able to ensure other residents did not have access to Resident 47's lighter and smoking materials. Staff 1 stated Resident 47 had not been given a lock box for his smoking materials and the facility could not ensure other residents did not have access to Resident 47's lighter and smoking materials.

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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. 41455 Based on observation, interview and record review it was determined the facility failed to ensure a dependent resident received assistance with ADLs for 1 of 2 sampled residents (#26) reviewed for oxygen. This placed residents at risk for unmet needs and injuries. Findings include: Resident 26 was admitted to the facility in 4/2025 with diagnoses including respiratory failure and chronic pain. A 3/26/25 Hospital Encounter note indicated Resident 26 had a lumbar spinal fusion (surgical procedure that joins two or more sections in the lower back) in 2011 and cervical spine (neck area) surgery in 2015. A 4/10/25 through 5/9/25 CNA Bathing Task indicated Resident 26 refused her/his shower on 4/17/25 and received one shower on 4/21/25. All additional shower opportunties were identified as no (not scheduled for this shift). The 4/12/25 Admission MDS indicated Resident 26 had a BIMS score of 13 (cognitively intact), the resident required one staff to assist with bathing and bed mobility, and a shower was not attempted during the seven day review period due to medical concerns. A 4/23/25 revised care plan indicated Resident 26 was to receive showers on Mondays and Thursdays, the resident required a front wheel walker, and one staff to assist with transfers. On 5/6/25 at 8:14 AM Witness 4 (Complainant) stated Witness 3 was called by Resident 26 after an unknown CNA twisted and lifted her/him during a transfer over a recent weekend (in 4/2025) using a bear hug. When Witness 3 arrived to the facility, Resident 26 indicated her/his chest and ribs hurt. On 5/5/25 at 10:34 AM Resident 26 was observed in bed with hair strands that stuck together and stated she/he was not in pain. On 5/6/25 at 3:25 PM Staff 39 (CNA) stated therapy staff made it clear not to transfer any resident with bear hugs due to safety. Staff 39 indicated Resident 26's transfer needs continued to change as therapy revised her/his transfer status and it was important to review the resident's care plan often. On 5/6/25 at 3:49 PM Staff 11 (RN/Charge Nurse) stated Resident 26 needed showers as scheduled and it was Staff 11's responsibility to ensure the task was completed by CNAs. Staff 11 acknowledged he needed to improve his plan to remind CNAs to complete showers and was unaware Resident 26 had not received a shower since 4/21/25. On 5/7/25 at 5:38 PM Staff 40 (LPN) stated he worked the last weekend in 4/2025 and no new pain issues were reported by staff or Resident 26. (continued on next page)

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	385197	A. Building B. Wing	05/09/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 6:00 PM Staff 8 (CNA) stated Resident 26 did report someone lifted her/him and hurt him, but her/his pain was temporary and not reported. Staff 8 also indicated he worked on Thursdays and could help with missed showers but he was not informed by the day shift when bathing for Resident 26 was not provided. On 5/8/25 at 4:26 PM Staff 9 (RN) stated she was not able to verify refusals of showers for Resident 26 and indicated refusals of showers should be documented by CNAs and reported to nurses. On 5/8/25 at 11:04 PM Staff 25 (LPN) stated there was no system to track missed showers for residents and CNAs did not inform nursing of missed showers. On 5/9/25 at 9:32 AM Staff 18 (CNA) stated he was often responsible for Resident 26's showers, did not chart all refused showers due to the resident's pain and neglected to inform nursing staff of any missed showers. On 5/9/25 at 10:25 AM Staff 14 (CNA) stated he worked with Resident 26 one weekend day, on 4/26/25, when he transfered the resident to her/his wheelchair for a meal. Staff 14 stated he gave Resident 26 a bear hug to transfer her/him, was unaware of the resident's spinal fusion, and agreed his method of transfer might cause the resident pain but Resident 26 did not express pain during the transfer. On 5/9/25 at 12:31 PM Staff 2 (DNS) acknowledged staff were not to transfer residents using bear hugs and expected staff to follow Resident 26's care plan for transfers. Staff 2 expected staff to follow the shower schedule for Resident 26 and nurses needed to track residents' showers.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41455 Based on observation, interview, and record review it was determined the facility failed to provide meaningful activities for dependent residents for 2 of 2 sampled residents (#s 2 and 62) reviewed for activities. This placed residents at risk for lack of social interaction and isolation. Findings include: 1. Resident 2 was admitted to the facility in 3/2025 with diagnoses including anxiety and sepsis (extreme immune response to an infection). The 3/12/25 Activity Assessment indicated Resident 2 liked easy crossword books, painting, and it was very important to do activities with others. The 3/14/25 Admission MDS indicated Resident 2 had a BIMS score of 14 (cognitively intact), was at risk for lack of socialization, and required two staff to transfer the resident out of bed. Resident 2 had no activity care plan related to her/his interest in activities. The 4/5/25 through 5/6/25 CNA Activities Task indicated Resident 2 participated in no activities for 30 days. On 5/5/25 at 2:19 PM Resident 2 was observed in bed watching television. Resident 2 stated art activities were not offered and would consider getting out of bed if a group activity was interesting. A calendar of events was observed on her/his wheelchair which indicated at 2:00 PM on 5/5/25, there was a group activity in the courtyard with food. Resident 2 indicated she/he was not informed of the group activity and was disappointed to not attend. On 5/6/25 at 5:03 PM Staff 17 (LPN) stated CNAs encouraged Resident 2 to get out of bed and the resident may refuse due to pain. On 5/7/25 at 9:34 AM Staff 35 (CNA) stated he cared for Resident 2 often and knew she/he liked group activities and socialization when Resident 2 felt well. Staff 35 acknowledged there was a lack of activity for Resident 2 and not all CNAs were aware of the resident's interests due to the lack of information in the resident's care plan. On 5/7/25 at 10:14 AM Staff 21 (Activities Director) stated she left the activities calendar at Resident 2's bedside if she/he was sleeping. Staff 21 stated she was unable to invite each resident to activities and relied on CNAs to assist based on the interests of residents. Staff 21 was unaware CNAs had no access to ithe nformation in a resident's MDS or activity assessment and did not know how to generate a care plan for activities. Staff 21 acknowledged Resident 2 had no activities during the last 30 days because the resident continued to refuse the activities Staff 21 offered. On 5/7/25 at 11:25 AM Staff 7 (Resident Care Manager) acknowledged the activities care plan for Resident 2 was missed. Staff 7 expected a care plan related to activities for Resident 2 in order for staff to assist and encourage the resident in activities of her/his interest (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 1:05 PM Staff 2 (DNS) and Staff 3 (Regional Nurse) expected Resident 2's activity care plan to evolve as the resident's needs changed. 26991 2. Resident 62 was admitted to the facility in 2/2025 on hospice services with a diagnosis of cancer. A 2/12/25 Activity Assessment revealed Resident 62 reported it was very important for her/him to have books and magazines to read, listen to music, be around animals, be with groups of people, be outside, and participate in the activities she/he identified. Resident 62's Care Plan initiated 2/12/25 revealed she/he had dementia and staff were to escort her/him to activities as desired. The care plan did not identify which activities Resident 62 identified as important. Resident 62's Group Activities log from 4/8/25 through 5/8/25 revealed Resident 62 did not attend any activities. Observations revealed the following: -5/6/25 at 1:00 PM Resident 62 was sitting in bed eating independently. A CNA was sitting in a corner of Resident 62's room observing her/him. -5/7/25 at 11:14 AM Resident 62 was in bed with her/his eyes shut. A CNA was sitting in a corner of Resident 62's room observing her/him. -5/8/25 at 10:30 AM Resident 62 was sitting in her/his wheelchair in her/his room looking toward her/his television. A CNA staff stated the resident liked the crime show. On 5/7/25 at 8:20 AM Staff 31 (CNA) stated as Resident 62's 1:1 CNA, he talked to her/him in between cares, otherwise, she/he ate and slept. On 5/7/25 at 3:01 PM Staff 27 (CNA) stated resident specific activities were usually not found on a resident's care plan. If a resident was alert and able to communicate she asked the residents if they wanted to participate in the daily activities. If a resident was not able to communicate and the care plan did not address activities, Staff 27 stated she would not know what to offer. On 5/9/25 at 11:10 AM Staff 32 (CNA) stated as a 1:1 CNA he was to be in the room to ensure a resident was safe and report to the nurse if there were any concerns. Staff 32 stated Resident 62 was able to eat independently and staff provided personal cares. Staff 32 stated Resident 62 stayed in her/his room and was in bed most of the time, and fiddles with sheets and pillows, he talked with her/him, and she/he vaguely watched television. On 5/8/25 at 5:05 PM Staff 33 (CNA) stated if a resident was assigned 1:1 care, the resident was to stay in her/his room at all times. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 4:09 PM Staff 21 (Activities Director) stated Resident 62 was on 1:1 care. On 5/7/25 Staff 21 stated she walked by Resident 62's room and noticed she/he was just sitting in the room with a 1:1 CNA but the resident should be in the community in the sun and provided more quality care. On 5/8/25 at 4:32 PM Staff 2 (DNS) stated the care plan was to have meaningful activities identified for a resident. Staff 2 stated she would provide an activity care plan if one was developed and if additional activities were provided for Resident 62.

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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** 26991 Based on interview and record review it was determined the facility failed to assess a resident and failed to follow physician orders for a follow-up doctor's appointment for 2 of 3 sampled residents (#s 17 and 24) reviewed for catheter care and hospitalization . This placed residents at risk for tooth decay and delayed care. Findings include: 1. Resident 17 was admitted to the facility in 6/2021 with a diagnosis of arthritis. A 4/4/25 Quarterly MDS revealed Resident 17 was cognitively intact. On 5/5/25 at 10:51 AM Resident 17 stated in 2/2025 she/he had a lung x-ray at 9:00 AM but the physician was not notified of the results until late in the evening. Resident 17 stated she/he was really sickwhen she/he was admitted to the hospital. Progress Notes revealed the following: -2/3/25 the facility physician assessed Resident 17 and an order was obtained for a chest x-ray which was scheduled for 2/4/25. Resident 17's Progress Notes did not have a nursing assessment of her/his respiratory status or the physical condition which warranted a chest X-ray. A radiology results report revealed Resident 17's chest x-ray results were reported on 2/4/25 at 8:44 AM. The form did not indicate who the results were reported to. Resident 17's 2/5/25 Progress note written at 12:20 AM revealed Resident 17 was assessed to have a productive cough and the resident reported the cough worsened from before. Resident 17's lungs were assessed to have abnormal breath sounds on the left side. The note indicated the x-ray results were available on the previous shift and revealed she/he had pneumonia. Resident 17 was short of breath, oxygen levels dropped, was placed on oxygen, and was sent to the hospital for evaluation. No additional nursing assessments of her/his lung status prior to the 2/5/25 note. A 2/5/25 Encounter note revealed Resident 17's physician assessed her/him digitally following complaints of shortness of breath and wheezing. Resident 17 had an x-ray which revealed she/he had pneumonia. Resident 17 was placed on oxygen with an oxygen level of 88% and was transported to the local hospital for evaluation and treatment. On 5/8/25 at 11:18 AM a message was left for Staff 34 (Physician). A return call was not received. On 5/9/25 at 8:35 AM Witness 5 (Radiology Support Staff) stated Resident 17's 2/4/25's x-ray was faxed to the facility on [DATE] at 5:05 PM. On 5/8/25 at 10:35 AM Staff 3 (Regional RN) stated on 2/3/25 Resident 17 was evaluated by her/his primary provider but acknowledged there were no nursing assessments of the resident's condition which warranted the evaluation and chest x-ray. Staff 3 also stated if a resident had a change of condition staff were to assess the resident and document each shift, which was not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34703 2. Resident 24 was admitted to the facility in 12/2023 with diagnoses including heart failure and kidney disease. 3/26/25 Care Conference notes indicated Resident 24 and family members requested a Urology appointment. On 5/7/25 at 3:47 PM Resident 24 stated she/he and family members asked staff to schedule her/him an Urology appointment for a while but staff had not scheduled one. On 5/9/25 at 8:04 AM Staff 4 (Resident Care Manager) stated she was in charge of making medical appointments for residents. Staff 4 acknowledged Resident 24 and her/his family members asked during the 3/26/25 Care Conference for an Urology appointment and the appointment was not scheduled. On 5/9/25 at 1:41 PM Staff 3 (Regional Nurse) stated her expectation was for staff to follow-up with medical appointments when residents and family request an appointment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26991 Based on interview and record review it was determined the facility failed to ensure a fall investigation was completed timely for 1 of 1 sampled resident (#54) reviewed for falls. This placed residents at risk for a delay in implementing new interventions. Findings include: Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's 11/1/24 Admission MDS revealed she/he was cognitively intact, required assistance with ADLs, did not have a history of falls but was at high risk for falls due to her/his diagnosis of stroke and weakness. Resident 54 required two staff and the use of a mechanical lift for transfers. Resident 54's care plan initiated on 10/25/24 revealed she/he was at risk for falls. Interventions included Resident 54 was to call for assistance for transfers, her/his call light was to be kept within reach, and appropriate footwear was to be worn. A 12/27/24 Progress Note revealed Resident 54 completed working with therapy and was sitting in her/his wheelchair in her/his room. Staff left the room to find additional staff to assist with Resident 54's mechanical lift transfer. Resident 54 attempted to self-transfer from the wheelchair to bed and fell . A 12/27/24 Unwitnessed fall investigation revealed Resident 54 completed therapy and was in her/his her/his wheelchair. Staff left the room to find a second staff to assist with a mechanical lift transfer and before staff returned to the room Resident 54 attempted to self transfer and fell . The investigation was completed on 1/13/25 and indicated the care plan would be updated to include Resident 54 would be assisted back to bed after therapy. Resident 24's care plan was not updated until 1/13/25 to include she/he was to be assisted to bed after therapy, 17 days after the fall. Resident 24's Progress Notes from 12/30/24 through 1/13/25 did not indicate she/he fell due to being left in her/his room after therapy. On 5/7/25 at 11:43 AM Staff 3 (Regional Nurse) stated the investigation was not completed within a week. On 5/9/25 at 9:43 AM Staff 2 (DNS) stated Resident 54's care plan was not updated timely to prevent additional falls due to the investigation not being completed for over two weeks.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview and record review it was determined the facility failed to ensure resident needs were met for 4 of 4 sampled residents (#13, 17, 41 and 54) observed during dining and staffing observations. This placed residents at risk for late meals and pain. Findings include: 1. Resident 13 was admitted to the facility in 10/2024 with a diagnosis of chronic lung disease. Resident 13's 1/29/25 Quarterly MDS revealed she/he was cognitively intact. Resident 13's clinical record revealed she/he resided in room [ROOM NUMBER]. Dining observations on the [NAME] wing revealed the following: -On 5/5/25 at 7:46 AM two food trays were observed on a open cart in front of room [ROOM NUMBER]. Both trays had oatmeal on the trays. The room was identified to require TBP. -On 5/5/25 at 8:09 AM the two food trays with oatmeal were observed to be on the cart in front of room [ROOM NUMBER]. -On 5/5/25 at 8:19 AM Staff 36 (CMA) put on PPE and entered the room with a medication cup but did not take a food tray into the room. -On 5/5/25 at 8:29 AM two food trays with oatmeal were observed on a cart by room [ROOM NUMBER] -On 5/5/25 at 8:56 AM two food trays with oatmeal on a open cart were observed by room [ROOM NUMBER]. -On 5/5/25 at 9:10 AM a CNA was observed to put on PPE and take a food tray which was in front of room [ROOM NUMBER] into the room. On 5/5/25 at 8:25 AM Staff 27 (CNA) stated she was the only CNA working on the [NAME] wing at the time and was not able to pass the food trays to the residents. Staff 27 stated at the start of the morning shift three CNAs were sent home due to being COVID-19 positive. Staff 27 stated there were usually four CNAs on the [NAME] wing. On 5/5/25 at 8:50 AM Staff 35 stated the residents in room [ROOM NUMBER] would eat but there were no staff to pass the trays and the residents would be provided food eventually. On 5/6/25 at 2:55 PM Staff 37 (Staffing coordinator) stated when CNAs called in or were sent home, the staff member who had the work phone would be notified in order to help call in additional staff to cover the shift. Staff 37 stated Staff 1 (Administrator) had the work phone on the morning of 5/5/25. Staff 37 stated she did not come to work until 9:30 AM and as soon as she came in she started to call staff for CNA coverage. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/25 at 4:44 PM Staff 2 (DNS) stated she was not notified of the CNA staffing issue on 5/5/25 until approximately 9:00 AM. Staff 2 stated the short staffing affected the [NAME] wing. On 5/6/25 at 4:47 PM Staff 1 stated he carried the work phone on the morning of 5/5/25, no one called him, and he was not aware of the CNA shortage until approximately 9:30 AM. 2. Resident 41 was admitted to the facility in 11/2024 with a diagnosis of a hip fracture. Resident 41's 2/25/25 Quarterly MDS revealed she/he was cognitively impaired. Resident 41's clinical record revealed she/he resided in room [ROOM NUMBER]. Dining observations on the [NAME] wing revealed the following: -On 5/5/25 at 7:46 AM two food trays were observed on a open cart in front of room [ROOM NUMBER]. Both trays had oatmeal on the trays. The room was identified to require TBP. -On 5/5/25 at 8:09 AM the two food trays with oatmeal were observed to be on the cart in front of room [ROOM NUMBER]. -On 5/5/25 at 8:19 AM Staff 36 (CMA) put on PPE and entered the room with a medication cup but did not take a food tray into the room. -On 5/5/25 at 8:29 AM two food trays with oatmeal were observed on a cart by room [ROOM NUMBER] -On 5/5/25 at 8:56 AM two food trays with oatmeal on a open cart were observed by room [ROOM NUMBER]. -On 5/5/25 at 9:10 AM a CNA was observed to put on PPE and take a food tray, which was in front of room [ROOM NUMBER], into the room. On 5/5/25 at 8:25 AM Staff 27 (CNA) stated she was the only CNA working on the [NAME] wing at the time and was not able to pass the food trays to residents. Staff 27 stated at the start of the morning shift three CNAs were sent home due to being COVID-19 positive. Staff 27 stated there were usually four CNAs on the [NAME] wing. On 5/5/25 at 8:50 AM Staff 35 stated the Residents in room [ROOM NUMBER] would eat but there were no staff to pass the trays and the residents would be provided food eventually. On 5/6/25 at 2:55 PM Staff 37 (Staffing coordinator) stated when CNAs called in or were sent home the staff member who carried the work phone would be notified in order to help call in additional staff to cover the shift. Staff 37 stated Staff 1 (Administrator) had the work phone on the morning of 5/5/25. Staff 37 stated she did not come to work until 9:30 AM. On 5/6/25 at 4:44 PM Staff 2 (DNS) stated she was not notified of the CNA staffing issue on 5/5/25 until approximately 9:00 AM. Staff 2 stated the short staffing affected the [NAME] Wing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/25 at 4:47 PM Staff 1 stated he had the work phone on the morning of 5/5/25 but no one called him and he was not aware of the CNA shortage until approximately 9:30 AM. 3. Resident 17 was admitted to the facility in 6/2021 with a diagnosis of arthritis. Resident 17's 4/4/25 Quarterly MDS indicated she/he was cognitively intact. Resident 17's 5/5/25 Medication Administration Audit Report revealed on 5/5/25 she/he was to be administered Norco (narcotic pain medication) at 8:00 AM but it was not administered until 10:20 AM. On 5/5/25 at 10:45 AM Resident 17 stated she/he just received her/his scheduled Norco which was scheduled at 8:00 AM. On 5/6/25 at 2:34 PM Staff 36 (CMA) stated the nurse and the CMA split the medication pass. On 5/5/25 the nurse was late passing medications, therefore, when she took over the medication cart, she was late administering Resident 17's Norco. On 5/6/25 at 2:34 PM Staff 11 (RN) stated the nurse started the medication pass in the morning and then the CMA took over the medication pass. Staff 11 stated on 5/5/25 five CNAs were sent home at the beginning of the shift due to testing positive for COVID-19. Staff 11 stated he spent a lot of time trying to reorganize the CNA assignments and was late passing medications. Staff 11 stated he did not call the DNS, Resident Care Manager, or Administrator for assistance. On 5/6/25 at 2:55 PM Staff 37 (Staffing coordinator) stated when CNAs call in or were sent home the staff member who had the work phone would be notified in order to help call staff to cover the shift. Staff 37 stated Staff 1 (Administrator) had the work phone on the morning of 5/5/25 and she did not come to work until 9:30 AM. On 5/6/25 at 4:44 PM Staff 2 (DNS) stated she was not notified of the CNA staffing issue on 5/5/25 until approximately 9:00 AM. Staff 2 stated the short staffing affected the [NAME] wing. On 5/6/25 at 4:47 PM Staff 1 stated he had the work phone on the morning of 5/5/25 but no one called him and he was not aware of the CNA shortage until approximately 9:30 AM. 4. Resident 54 was admitted to the facility in 10/2024 with a diagnosis of a stroke. Resident 54's 5/2025 ADL report revealed she/he refused a shower on 5/5/25. On 5/7/25 at 9:02 AM Staff 27 (CNA) stated Resident 54 did not get a shower on 5/5/25 due to staffing but she provided her/him a shower on 5/6/25. On 5/6/25 at 2:55 PM Staff 37 (Staffing coordinator) stated when CNAs call in or were sent home the staff member who had the work phone would be notified in order to help call staff to cover the shift. Staff 37 stated Staff 1 (Administrator) had the work phone on the morning of 5/5/25. Staff 37 stated she did not come to work until 9:30 AM. On 5/6/25 at 4:44 PM Staff 2 (DNS) stated she was not notified of the CNA staffing issue on 5/5/25 until approximately 9:00 AM. Staff 2 stated the short staffing affected the [NAME] wing. (continued on next page)

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	385197	A. Building B. Wing	05/09/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/25 at 4:47 PM Staff 1 stated he had the work phone on the morning of 5/5/25 but no one called him and he was not aware of the CNA shortage until approximately 9:30 AM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26991 Based on interview and record review it was determined the facility failed to ensure a resident's medication was available to administer for 1 of 1 sampled resident (#17) reviewed for pharmacy services. This placed residents at risk for pain. Resident 17 was admitted to the facility in 6/2021 with a diagnosis of arthritis. Resident 17's Encounter Note revealed a Nurse Practitioner visit for her/his medication review and to refill her/his Norco (narcotic medication) prescription. Resident 17's 1/2025 MAR revealed Resident 17 was to be administered Norco every four hours for pain. The MAR revealed it was not administered on 1/30/25 at 4:00 AM, 1/30/25 at 8:00 AM, 1/30/25 at 12:00 PM or 1/30/25 at 4:00 PM. Progress notes revealed the following: -1/30/25 at 5:40 AM waiting for Norco delivery. Physician notified of missed dose. -1/30/25 at 8:39 AM physician was faxed for a new prescription for Norco. -1/30/25 at 3:45 PM Norco-not applicable, nurse notified. Resident 17's 4/4/25 Quarterly MDS revealed she/he was cognitively intact. On 5/8/25 at 8:09 AM Staff 38 (CMA) stated if a resident was on a scheduled narcotic the narcotic packaging will indicate if a new prescription was needed. If a new prescription was needed the nurse was notified and the nurse requested a new prescription from the physician. Staff 38 stated the physician was in the facility four days a week and it was easy to receive new prescriptions if needed. On 5/8/25 at 8:59 AM Staff 2 (DNS) stated she was not aware Resident 17 did not have her/his Norco due to a prescription issue and was unclear the reason the prescription was not sent to the pharmacy from the 1/29/25 physician visit. On 5/7/25 at 7:53 PM Witness 7 (Pharmacy) stated the pharmacy did not receive Resident 17's prescription until 1/30/25 and as soon as the new prescription was received it was filled.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 34703 Based on interview and record review it was determined the facility failed to provide dental services for 1 of 1 sampled resident (#24) reviewed for dental services. This placed residents at risk for unmet dental needs. Findings include: Resident 24 was admitted to the facility in 12/2023 with diagnoses including heart failure and kidney disease. The 3/26/25 Care Conference notes indicated Resident 24 requested a dental appointment. The 4/15/25 care plan revealed Resident 24 had oral/dental health problems and staff were to coordinate arrangements for dental care and transportation as needed. On 5/7/25 at 3:47 PM Resident 24 stated she/he asked staff to schedule her/him a dental appointment for a while but staff had not scheduled one. On 5/9/25 at 12:32 PM Staff 5 (Social Services) stated she was in charge of making dental appointments for residents. Staff 5 acknowledged Resident 24 asked during the 3/26/25 Care Conference for a dental appointment and the appointment was not scheduled. On 5/9/25 at 1:41 PM Staff 3 (Regional Nurse) stated her expectation was for staff to follow-up with a dental appointment right away when residents request an appointment.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41455 Based on observation, interview, and record review it was determined the facility failed to ensure food was served at palatable temperatures for 1 of 5 sampled residents (#56) and 1 of 1 kitchen. This placed residents at risk for food that was not palatable, safe, or appetizing. Findings include: 1. Resident 56 was admitted to the facility in 12/2024 with diagnoses including stroke and heart disease. The 12/23/24 Admission MDS indicated Resident 56 was assessed with a BIMS score of 13 (cognitively intact) and required supervision for eating. A 3/26/25 Nutritional Risk Assessment indicated Resident 56 was at risk for decreased food intake because she/he was unable to feed herself/himself. A 4/22/25 revised care plan indicated Resident 56 required one person to assist her/him with meals. A 5/8/25 Diet Slip for Resident 56 indicated no information related to her/his need for dining assistance. On 5/5/25 at 8:29 AM Resident 56 was observed in bed with a meal in front of her/him on the bedside table. Resident 56 stated she/he was waiting for a CNA to return and her/his food was getting cold. On 5/5/25 at 8:38 AM and 5/8/25 at 5:54 PM Staff 12 (CNA) was observed to assist Resident 56 with eating. Staff 12 stated she was new to Resident 56's care and knew Resident 56 needed assistance with her/his meal because the resident vocalized the request. On 5/5/25 at 12:30 PM Resident 56 stated staff often delivered meals to her/his bedside and did not return to provide timely meal assistance. On 5/5/25 at 1:19 PM Staff 12 stated Resident 56 was the only resident who did not get lunch timely because Staff 12 neglected to check all the trays in the food cart. Resident 56 was assisted with her/his meal and acknowledged the food was not warm. On 5/6/25 at 3:49 PM Staff 11 (RN) stated there was an early food cart for those residents who needed assistance including Resident 56. Staff 11 stated all CNAs and nurses were responsible to ensure Resident 56 received her/his meals timely. On 5/7/25 at 3:40 PM Staff 6 (Dietary Manager) stated the meal tray for residents who required meal assistance, including Resident 56, were delivered to the halls first. Staff 6 stated staff were able to request hot meal alternatives until 7:30 PM every day if they came to the kitchen and asked. Staff 6 acknowledged he did not update meal needs or preferences for Resident 56 on her/his ticket because there was no request from nursing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 10:02 AM Staff 26 (CNA) stated staff were known to help with Resident 56's meal delivery and neglect to communicate when they left her/his tray in the room. Staff 26 acknowledged it was easy for Resident 56's food to get cold without improved communication. On 5/9/25 at 11:33 AM Staff 7 (Resident Care Manager) acknowledged the facility struggled to get meals to residents effectively, including Resident 56, and an improved system was needed. Staff 7 expected information related to a resident's dining assistance should be on Resident 56's ticket to assist with communication. On 5/9/25 at 1:05 PM Staff 2 (DNS) and Staff 3 (Regional Nurse) stated they expected Resident 56's tray ticket to be updated to include the need for meal assistance in order to ensure more timely and warmer meals. 2. On 5/8/25 at 12:55 PM Staff 9 (RN) was observed to sit at the nurse station. A food cart was observed within eight feet of the nurse station with the door open and no staff present to pass out meals. Staff 9 stated she was not asked to assist with meals and continued to sit at the nurse station. On 5/8/25 at 1:03 PM staff were observed to pass out trays from the observed food cart. On 5/8/25 at 1:05 PM a sample test tray was completed by Staff 22 (Cook) and placed in the last food cart sent to the residents' hall. On 5/8/25 at 1:27 PM the test tray was retrieved by a CNA (22 minutes after the meal was completed) from the food cart and provided to surveyors. The broccoli was cold and the potatoes and meat were lukewarm. On 5/8/25 at 1:37 PM Staff 2 (DNS) and Staff 3 (Regional Nurse) stated the expectation was for nurses to assist with the distribution of meals and an all hands on deck mindset to ensure meals were passed out timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41455 Based on observation, interview, and record review it was determined the facility failed to properly follow dish sanitation practices for 1 of 1 kitchen. This placed residents at risk for food borne illnesses. Findings include: The American Dish Service Installation Instructions for the facility's low temperature dish machine revealed to set and maintain the sanitizer (chlorine) concentration at 50 parts per million. A 12/19/2024 training note by Staff 19 (Maintenance Director) indicated Staff 6 (Dietary Manager)and general dietary staff were present when the new dishwasher was installed. Staff were instructed on how to operate the dishwasher and what chemicals were required. A 4/9/25 report (most recent) completed by Witness 5 (Dishwasher Technician) verified the facility's dishwasher sanitizer level was at 50 parts per million. On 5/8/25 at 10:27 AM Staff 23 (Cook) was observed to wash and sanitize dishes using the facility's low temperature dishwasher. Staff 23 stated she ensured the dishwasher operated correctly each shift by looking at the temperature gauges on the machine. Staff 23 stated she monitored the beginning of the cycle to ensure the temperature reached 120 degrees and the end of the cycle to ensure it reached 50 degrees. Staff 23 verified she did not test the chemical levels of the dishwasher because the task was completed routinely by an outside company who verified the chemical levels were accurate. On 5/8/25 at 11:00 AM Staff 22 (Cook) stated she worked five days each week and was instructed to only check temperatures and soap levels of the dishwasher. The dishwasher sanitizer solution container connected to the dishwasher was observed empty. On 5/8/25 at 11:09 AM Staff 1 (Administrator) was observed to test the chemical sanitizer levels of the dish machine which measured below 50 parts per million. Staff 1 stated staff were expected to ensure chemical sanitizer levels for the dish machine were monitored and maintained and on 5/8/25 there was no sanitizer connected to the dish machine. Staff 1 acknowledged the chemical sanitizer levels of the dish machine were not maintained.