STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385199	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chehalem Post Acute	1900 E. Fulton Street Newberg, OR 97132

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41453 Based on interview and record review it was determined the facility failed to provide advance written notice to a resident or their responsible party prior to a room change for 1 of 4 sampled residents (#10) reviewed for resident rights. This placed residents at risk for potential adjustment difficulties related to room changes. Findings include: Resident 10 was admitted to the facility in 8/2024, with diagnoses including dementia and visual disturbances. Resident 10 was also receiving hospice services. Resident 10's Admission Record revealed Witness 4 (Family Member) was Resident 10's spouse and signed the consent to treat upon admission. Resident 10's census record revealed Resident 10 was moved from room [ROOM NUMBER]-2 to 21-2 on 10/30/24. On 12/26/24 at 9:10 AM, Witness 4 (family member) stated they entered the facility and were disturbed when Resident 10 was not in her/his room (17-2), there was just an empty bed. Witness 4 stated Resident 10's behavior and demeanor were more anxious and aggressive after the room change. No documentation was found in Resident 10's clinical record regarding notification of a room move on 10/30/24. On 1/6/25 at 12:29 PM, Staff 1 (Administrator) stated he recalled Resident 10 was moved and her/his demeanor and mood were different after the move. Staff 1 confirmed there was no notification made to the resident or family prior to Resident 10 being moved.

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41453 42271 Based on observation, interview, and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 3 sampled residents (#14) reviewed for abuse. This failure resulted in Resident 13 deliberately kicking Resident 14's walker which resulted in Resident 14 losing her/his balance. Resident 14 fell to the floor and received a head laceration with contusion (bruise) and a fractured hip which required surgery. This placed residents at risk for physical harm. Findings include: The facility's 8/2024 Abuse-Screening, Training, Identification, Investigation, Reporting and Protection policy and procedure stated Abuse is the willful infliction of injury resulting in physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident 13 readmitted to the facility in 10/2024, with diagnoses including Alzheimer's and paranoid schizophrenia. Resident 13's 10/26/24 Quarterly MDS indicated the resident had a BIMS score of ten (moderate cognitive impairment). Resident 13's 10/19/24 Care Plan revealed the following focused behaviors: -Calling out/yelling/shouting; -Agitation; -Suspicious or paranoid behaviors. Behavior interventions for Resident 13 included the following: -Have tactile objects around for resident to manipulate and touch. The resident is visual and likes to do art, particularly diamond painting. -Use activity as a distraction from repetitive thoughts. -Assist to quiet area. A 11/12/24 Abnormal Involuntary Movement Scale (AIMS) indicated Resident 13 did not have any involuntary movements. Resident 14 admitted to the facility in 10/2024, with diagnoses including dementia, with other behavioral disturbances and surgical amputation of left great toe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 14's 11/6/24 MDS indicated the resident had a BIMS score of six, (severe cognitive impairment). Resident 14's 11/2024 Care Plan revealed the following focused behaviors: -Agitation; and -Physical and Verbal aggression. Behavior interventions for Resident 14 included the following: -Attempt to redirect; -Provide 1:1 reassurance and support; and -Set boundaries. On 10/22/24 at 9:30 PM, the facility submitted a report to the State Survey Agency, which revealed Resident 14 entered Resident 13's room. There was a verbal altercation which escalated to a physical altercation when Resident 14 physically hit Resident 13 and Resident 13 yelled and pushed Resident 14. The residents were separated, and an intervention was put into place. The nursing assessment revealed no injuries noted. On 12/29/24 the facility submitted a report to the State Survey Agency, which revealed on 12/29/24 another physical altercation occurred between Resident 13 and Resident 14. Resident 13 was visiting with her/his family member in the hallway. Resident 14 was ambulating with her/his walker and was in close proximity to Resident 13. Resident 13 became agitated and kicked Resident 14's walker. Resident 14 lost her/his balance, fell back, and struck her/his head on the wall and then fell to the floor. No staff were present during the altercation. Resident 13's family member called out for help and Staff 7 (LPN) responded. Resident 13's family member removed Resident 13 from the vicinity. Staff 7 assessed Resident 14. Resident 14 was transferred to the hospital where she/he suffered a head laceration with contusion (bruising) and a fractured hip requiring surgery. On 1/2/25 at 9:48 AM, observations in Expressions (locked memory care unit) noted Resident 14 to be out of the facility. Shadow box outside Resident 14's door included Resident 14's name. On 1/2/25 at 9:56 AM, Resident 13 was observed to be working on crafts in her/his room. Resident 13 stated she/he felt badly she/he kicked somebody's walker the other day. Resident 13 stated she/he was talking with a family member and Resident 14 kept coming around and Resident 14 stated she/he told her/him several times to leave her/him alone. Resident 13 stated she/he was scared and frustrated at the time. Resident 13 stated she/he stayed in her/his room now because of Resident 14. On 1/2/25 at 10:15 AM, Staff 8 (CNA) stated she was providing care to a resident in another room, heard a scream, ran out to the hall and found Resident 14 on the floor being assessed by Staff 7. Staff 8 stated she was not aware of any previous incidences between Resident 13 and Resident 14. Staff 8 stated Resident 14 wanders into other residents' rooms and staff were to watch her/him and approach her/him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/2/25 at 10:33 AM, Resident 13 ambulated with the physical therapist using a walker and a gait belt. Resident 13 appeared calm. On 1/2/25 at 10:39 AM, Staff 6 (Activities Assistant) stated Resident 13 gets frustrated really quickly and was less patient recently. Staff 6 stated she was not aware of any concerns with Resident 13 and other residents. Staff 6 stated she had not discussed with the nurse about Resident 13 and was not aware to watch Resident 13 and to keep her/him apart from other residents. Staff 6 stated staff would let her know if there were resident's who needed to be separated. Staff 6 stated she often saw Resident 14 walk into other resident's rooms. On 1/2/25 at 10:57 AM, Staff 9 (CNA) stated he was told to keep Resident 14 away from all residents and to keep an eye out for Resident 13. On 1/2/25 at 1:16 PM, Staff 7 (LPN) stated she did not see the incident happen. Staff 7 stated she heard Resident 13's family member scream: Stop, Mom, Stop! Staff 7 stated when she walked by, she saw Resident 14 on the floor. Staff 7 stated Resident 13 was agitated and wanted to go home. Staff 7 stated Resident 14 wanders a lot in the area. Staff 7 stated staff separated the two residents and Resident 14 was sent to the hospital later diagnosed with a hip fracture requiring surgery. On 1/2/25 at 1:41 PM, Staff 3 (LPN RCM) stated Resident 14 was originally in the room occupied by Resident 13. Staff 3 stated Resident 13 thinks it is her/his room. Staff 3 stated Resident 14 had a fixation with that room. Staff 3 stated on 12/22/24 Resident 14 entered Resident 13's room and there was a physical altercation between the two residents. The residents were separated. The facility intervention was to place a shadow box outside Resident 14's room to help her/him identify their room. Staff 3 stated she was not at work on 12/29/24. Staff 3 stated she read Resident 13 made Resident 14 trip and fall and Resident 13 sustained injuries and was sent to the hospital. Staff 3 acknowledged no staff were present during the altercation. Staff 3 stated Resident 13 usually spends time in front of the tv and had not directed anything physically towards another resident. On 1/6/25 at 3:02 PM, Staff 2 (DNS) stated it is the facility's job to supervise the residents and acknowledged the facility did not monitor Resident 13 or Resident 14.

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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. 41453 Based on interview and record review it was determined the facility failed to follow care plan interventions when transferring for 1 of 4 sampled residents (#7) reviewed for accidents. This failure put residents at risk for injury. Findings include: Resident 7 admitted to the facility in 3/2019, with diagnoses including spinal fusion and anxiety. Resident 7's 5/1/24 care plan revealed Resident 7 required two-person assistance with a gait belt for transfers. The resident's care plan also revealed she/he frequently falsely accused staff. Resident 7's 5/10/24 Quarterly MDS indicated she/he was cognitively intact with a BIMs of 15. The facility's Fall Investigation initiated on 8/3/24 revealed the following: -On 8/3/24 Staff 10 (Agency CNA) attempted to transfer Resident 7 without a second staff member. -Staff 10 stated Resident 7 had told her/him that they were a one-person stand and pivot transfer. -Staff 10 attempted to transfer Resident 7, was unsuccessful, and returned Resident 7 to her/his bed and went to find help. - Resident 7 stated Staff 10 had dropped her/him on the floor. - Resident 7 complained of pain and an inability to lay flat, their legs were elevated. -The resident was transferred to the hospital for further evaluation and was diagnosed with a distal femur fracture. A review of hospital records did not indicate a cause of the distal femur fracture. Attempts to contact Staff 10 were made on 1/3/25 and 1/6/25, but no response was received. There were no other witnesses to this incident. On 1/6/25 at 10:58 AM, Staff 3 (LPN/RCM) stated she/he was working the day of the incident. Staff 3 recalled resident was laying perpendicular to the direction of the bed and was upset and in pain. Staff 3 confirmed the resident was not transferred correctly but did not confirm the cause of the fracture.