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	03/28/2025

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

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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. 34324 Based on interview and record review it was determined the facility failed to inform residents and/or resident's responsible party of the risks and benefits, and to ensure consent was obtained, for the use of psychotropic medications for 2 of 5 sampled residents (#s 22 and 30) reviewed for unnecessary medications. This placed residents at risk for lack of informed consent of psychotropic medications. Findings include: 1. Resident 22 admitted to the facility in 2024 with diagnoses including anxiety. A 3/15/25 physician order indicated the use of trazodone for sleep disorder. Review of Resident 22's medical record revealed no indication the resident was informed of the risks and benefits of the medication. On 3/26/25 Staff 37 (Regional RN) acknowledged Resident 22 was not informed of the risks and benefits of the use of trazodone. 50928 2. Resident 30 was admitted to the facility in 2/2025 with diagnoses including anxiety and post-traumatic stress disorder. Resident 30's 2/2025 MAR revealed the resident received Quetiapine fumarate (an antipyschotic medication) one time a day for anxiety. Review of Resident 30's health record revealed no documentation to indicate the resident, or her/his representative, was informed of the risks and benefits of quetiapine fumarate and the resident did not consent to receiving the medication. On 3/26/25 at 3:03 PM Staff 2 (DNS) stated it was her expectation nursing staff reviewed the risks and benefits of psychotropic medications with residents and confirmed Resident 30 received quetiapine fumarate without giving consent.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 34702 Based on interview and record review it was determined the facility failed to ensure privacy was provided during care and resident records were kept private for 2 of 2 sampled residents (#s 37 and 45) and 1 of 1 sampled facility record system reviewed for privacy. This placed residents at risk for lack of privacy. Findings include: 1. On 11/4/24 a public complaint was received that alleged the facility did not keep resident records private by sending confidential resident information to Staff 26 (RN) via a phone application (app) after she was terminated from the facility . The 10/28/24 Termination Letter indicated Staff 26 was terminated from the facility as of 10/28/24. On 3/25/25 at 11:55 AM Staff 26 stated she worked at the facility in 2024 and was terminated on 10/28/24. Staff 25 stated after her termination she still continued to receive resident private data through a phone app which included information such as admissions, discharges and anything going on with residents. On 3/28/25 at 9:00 AM Staff 2 (DNS) acknowledged Staff 25 was terminated on 10/28/24 and continued to receive private resident data through a phone app until 11/27/24. Staff 2 stated the app was used for staff to communicate falls, change of condition, and resident condition. Staff 2 stated the expectation was for staff to be removed from communications the last date of employment. 47005 2. On 1/22/25 a public complaint stated the flooring was replaced in the entire facility which displaced all residents from their rooms. Residents were placed in the main dining room, therapy room and front open area of the facility known as the living room. The complaint stated there was inadequate privacy between residents while personal care was provided, and there was a makeshift divider curtain between the genders but not between each resident. a. Resident 37 was admitted to the facility in 1/2023 with diagnoses including stroke and hypertension. A 1/20/25 Annual MDS indicated Resident 37 was cognitively intact. On 3/19/25 at 10:25 AM Resident 37 stated she/he stayed in the therapy room for a couple days during the flooring replacement. Resident 37 stated she/he did not recall having a curtain or divider between her/him and Resident 45 when personal care was provided. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 9:55 PM Staff 25 (CNA) stated Resident 37 and Resident 45 were in the therapy room for several days during the flooring replacement. Staff 25 stated there were dividers created using IV poles and blankets but there was not enough to go between each resident. The dividers were used to separate the genders in the dining room and around the commodes. Staff 25 stated Resident 37 was provided personal care without a divider while Resident 45 laid in the next bed less than two feet away. On 3/21/25 at 10:24 Staff 12 (CMA) stated there were makeshift dividers using two IV poles and bed sheets and staff were expected to move the dividers between the residents when providing personal care. Staff 12 stated there were not enough dividers to provide each resident with privacy and the dividers were cumbersome and difficult to move. On 3/21/25 at 1:36 PM Staff 23 (LPN, Resident Care Coordinator) stated CNAs reported concerns regarding resident privacy during the constructions, and the concerns were brought to Staff 1 (Administrator). Staff 23 stated staff were instructed to move the IV dividers between the residents when providing personal care for privacy, but there was not always enough time or dividers to use. On 3/21/25 at 2:16 PM Staff 2 (DNS) stated she was out of the office for the beginning portion of the construction but expected nursing staff to provide privacy when any personal care was provided. On 3/21/25 at 2:28 PM Staff 1 acknowledged there were several family and resident concerns regarding the floor construction. Staff 1 stated he attempted to address the concerns brought to his attention. Staff 1 stated he had 15 IV poles to create privacy curtains for the residents while in the dining room, therapy room and living room area. Staff 1 stated he expected nursing staff to provide privacy with personal care at all times. b. Resident 45 was admitted to the facility 10/2023 with diagnoses including a stroke. A 1/18/25 Quarterly MDS indicated Resident 45 was cognitively intact. On 3/21/25 at 10:52 AM Resident 45 stated she/he stayed in the therapy room during the floor replacement project. Resident 45 stated there was a sheet covering the bedside commode but did not recall having a sheet between her/him and Resident 37. Resident 45 stated she/he was exposed when using the bedside commode. On 3/20/25 at 9:55 PM Staff 25 (CNA) stated Resident 45 and Resident 37 were in the therapy room for several days during the flooring replacement project. Staff 25 stated there were dividers created using IV poles and blankets but there was not enough to go between each resident. The dividers were used to either separate the genders in the dining room and around the commodes. Staff 25 stated Resident 45 laid in bed next to Resident 37 while personal care was provided without a divider. On 3/21/25 at 10:24 Staff 12 (CMA) stated there were makeshift dividers using two IV poles and bed sheets and staff were expected to move the dividers between the residents when providing personal care. Staff 12 stated there were not enough dividers to provide each resident with privacy and the dividers were cumbersome and difficult to move. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/25 at 1:36 PM Staff 23 (LPN, Resident Care Coordinator) stated CNAs reported concerns regarding resident privacy during the constructions, and the concerns were brought to Staff 1 (Administrator). Staff 23 stated staff were instructed to move the IV dividers between the residents when providing personal care for privacy, but there was not always enough time or dividers to use. On 3/21/25 at 2:16 PM Staff 2 (DNS) stated she was out of the office for the beginning portion of the construction but expected nursing staff to provide privacy when any personal care was provided. On 3/21/25 at 2:28 PM Staff 1 acknowledged there were several family and resident concerns regarding the floor construction. Staff 1 stated he attempted to address the concerns brought to his attention. Staff 1 stated he had 15 IV poles to create privacy curtains for the residents while in the dining room, therapy room and living room area. Staff 1 stated he expected nursing staff to provide privacy with personal care at all times.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34324 Based on observation, interview, and record review it was determined the facility failed to ensure resident rooms were clean and in good repair for 2 of 3 sampled residents (#s 37 and 54) reviewed for environment. This placed residents at risk for lack of a homelike environment. Findings include: 1. Resident 37 admitted to the facility in 2023 with diagnoses including hemiplegia. a. On 3/19/25 at 10:22 AM Resident 37's shared bathroom was observed to have dried feces inside and outside the toilet bowl. The toilet also was observed to have splattered layers of caked on old feces between the seam of the bowl and tank. Splatters of feces were observed on the floor. Review of Resident Council notes revealed the following: - 1/2025 residents indicated issues with the bathrooms not being cleaned daily. - 2/2025 residents indicated confusion on which staff cleaned the bathrooms and toilets. On 3/19/25 at 10:22 AM Witness 4 (Family) stated the bathroom toilet was in the observed condition for about a day or two. Resident 37 stated she/he used the toilet that morning. On 3/19/25 at 11:08 AM Staff 38 (Housekeeping) stated he was assigned to Resident 37's room. Staff 38 stated the resident's bathroom was last cleaned the previous day. Staff 38 was shown the old feces on the back of the toilet and provided no further information. On 3/19/25 at 10:50 AM Staff 1 (Administrator) was shown Resident 37's bathroom and acknowledged the toilet and floor were unclean and did not appear as if they were recently cleaned. b. On 3/19/25 at 10:24 AM half of an electric outlet was observed to be off of the wall with exposed wires. Resident 37's bed was in front of the outlet with a device plug in from the outlet to the resident's bed. Witness 4 stated the outlet was pulled off the wall for a while. On 3/28/25 at 8:25 AM Staff 37 (Maintenance) stated he was aware of the electric outlet being pulled away from the wall in Resident 37's room. Staff 37 stated the outlet was pulled from the wall at least two months. 2. Resident 54 was admitted to the facility in 2024 with diagnoses including depression. On 3/19/25 at 1:36 PM Resident 54's window was observed to have a large piece of the bottom trim missing with exposed jagged edges. On 3/28/25 at 8:30 AM Staff 37 (Maintenance) acknowledged Resident 54's window trim was missing and had exposed jagged edges.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34324 Based on interview and record review it was determined the facility failed to implement their policies and procedures for screening potential employees to prevent abuse for 3 of 3 sampled new employees (#s 8, 9 and 10) reviewed for employee screening. This placed residents at risk for abuse. Findings include: The facility's Abuse Policy dated 9/2024 indicated the screening process for potential employees included contacting previous employers to request employment history which included: dates of services, position held, performance history and history of abuse/neglect. On 3/26/25 a random sample of three newly hired staff members was reviewed for reference checks with Staff 36 (Human Resources). On 3/26/25 at 10:00 AM Staff 36 stated the facility did not complete reference checks for newly hired staff since the change in ownership in 2024. Staff 36 acknowledged no reference checks were completed for Staff 8 (LPN), Staff 9 (CNA) and Staff 10 (CNA). On 3/26/25 at 10:10 AM and 3/27/25 at 8:21 AM Staff 1 (Administrator) acknowledged reference checks were not completed for newly hired staff and the facility's abuse policy indicated previous employers were to be contacted.

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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. 34324 Based on interview and record review it was determined the facility failed to develop a person-centered comprehensive care plan related to bowel care for 1 of 1 sampled resident (#16) reviewed for constipation. This placed residents at risk for lack of personal preferences being honored. Findings include: Resident 16 admitted to the facility in 2018 with diagnoses including quadriplegia. Resident 16's revised 11/12/23 Care Plan indicated Resident 16 was incontinent of bowel related to quadriplegia and was at risk for constipation. Resident 16 received a bowel regimen that included medications and a suppository. Interventions included a bowel regimen including digital stimulation and suppository. On 3/19/25 at 11:51 AM Resident 16 stated nursing staff, mostly consisting of agency staff, tried to tell her/him when she/he could and coud not have a suppository and she/he was upset about it. On 3/25/25 at 9:31 AM Staff 22 (LPN) stated she was an agency nurse. Staff 22 stated when she worked with Resident 16 she was unaware the resident preferred a suppository instead of oral medications. Staff 22 stated Resident 16 became upset when oral medications were given instead of the suppository. On 3/25/25 at 10:10 AM Staff 12 (CMA) stated Resident 16 had a history of requesting a suppository instead of oral bowel medications. Staff 12 stated if staff offered oral bowel medications before a suppository Resident 26 got upset and started cussing. On 3/25/25 at 3:08 PM Staff 23 (LPN Resident Care Manager) stated Resident 16 had a history of refusing oral bowel medications and preferred to have a suppository first. Staff 23 stated Resident 16 requested suppositories first for the past few years. Staff 23 stated Resident 16 had issues with agency staff not honoring her/his bowel medication preferences. Staff 23 acknowleged Resident 16's Care Plan did not indicate her/his bowel care preferences.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34702 Based on interview and record review it was determined the facility failed to ensure Staff 32 (LPN) adhered to professional standards for medication management. This placed residents at risk for adverse side effects of medication. Findings include: Resident 39 admitted to the facility in 2023 with diagnoses including schizophrenia and major depressive disorder. The 2/2024 MAR indicated Resident 39 received escitalopram, also known as Lexapro (antidepressant) 20 mg once daily. The 3/4/24 provider note indicated I will half the dose of Celexa [also known as citalopram]. A review of the prior physician orders and 2/2024 MARs indicated Resident 39 did not receive Celexa prior to 3/4/24. The 3/4/24 Celexa order was transcribed by Staff 24 (LPN) and indicated 10 mg daily was set to start on 3/5/24 at 7:00 AM. The escitalopram was discontinued, and the reason documented was decrease to 10 mg. On 3/24/25 at 8:46 AM Staff 24 stated she often worked with Resident 39 and the resident often went back and forth with meds. Staff 24 stated she did not remember the 3/4/24 incident with Resident 39's Celexa and escitalopram orders. On 3/28/25 at 12:18 PM Staff 2 (DNS) acknowledged Resident 39 received Celexa 10 mg from 3/5/24 through 3/29/24 (25 days) in error due to the discrepancy between the provider order for Celexa and escitalopram. Staff 2 acknowledged nursing staff failed to clarify the physician order and the error was not identified until 3/29/24 during a psychotropic drug review.

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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** 34324 Based on interview and record review it was determined the facility failed to clarify insulin orders with the physician, monitor and provide bowel medications as ordered and failed to identify medication discrepancies for 3 of 7 sampled residents (#s 22, 39 and 114) reviewed for medications. This placed residents at risk for not receiving medications. Findings include: 1. Resident 22 admitted to the facility in 2018 with diagnoses including congestive heart failure. The 9/2/24 care plan indicated Resident 22 was continent of bowel. Interventions included to record bowel movement patterns each day and to monitor for signs or symptoms of constipation related to opioid use. The care plan did not indicate any history of Resident 22 refusing bowel medication. A 10/2/24 physician order indicated the use of Milk of Magnesia as needed for no bowel movement after three days. Review of Resident 22's bowel record indicated no bowel movement from 2/26/25 to 3/1/25 (four days) and from 3/3/25 to 3/6/25 (four days). Review of the 2/2025 and 3/2025 MARs revealed no indication Resident 22 received bowel medication after three days of no bowel movement during the two identified instances. Review of Resident 22's medical record revealed no documentation of monitoring of bowel movement after three days of no bowel movement or an indication of bowel medications being offered, accepted or refused. On 3/28/25 at 9:12 AM Resident 22 stated she/he was independent with toileting. Resident 22 stated staff did not ask her/him very often when she/he had a bowel movement. Resident 22 stated staff asked her/him maybe a couple times a week if she/he had a bowel movement. On 3/27/25 9:04 AM and 10:49 AM Staff 16 (RN) stated staff were to monitor when a resident did not have a bowel movement after three days and were to document when bowel medications were offered/accepted or refused. Staff 16 stated Resident 22 had a history of refusing bowel medications and acknowledged bowel medication refusals and monitoring of the resident's bowel movements were not documented. On 3/27/25 at 11:26 AM Staff 2 (DNS) acknowledged staff lacked documentation of monitoring of Resident 22's bowel movements. Staff 2 stated if no bowel movements were documented after three days then bowel medications were to be given as ordered. Staff 2 stated the expectation was for staff to monitor Resident 22's bowel movements daily even though she/he was independent with toileting. Staff 2 further stated Resident 22 had a history of refusing bowel medication and that needed to be reflect in the care plan. 2. Resident 114 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/18/24 progress note by Staff 44 (LPN) indicated a new order for sliding scale insulin including 14 units of insulin to be given and the physician to be contacted for a CBG greater than 300. The progress noted indicated Resident 144 had a CBG of 327 and staff would continue to monitor. Review of Resident 114's medical record revealed no indication Resident 144 was given insulin or Staff 44 contacted the physician to clarify the order for frequency of the insulin, or to report the CBG above 300. On 10/1/24 a concern was reported to the State Agency indicating Resident 114's CBG was above 300 on the resident's first night at the facility and the resident was not administered insulin. On 3/26/25 at 8:18 AM and 4:12 PM attempts to contact Staff 44 were unsuccessful. On 3/27/25 at 11:12 PM Staff 2 (DNS) acknowledged the order for sliding scale insulin was not clarified by the physician for frequency, the physician was not contacted regarding the CBG over 300, and there was no indication Resident 144 was given insulin for a CBG of 327. 34702 3. Resident 39 admitted to the facility in 2023 with diagnoses including schizophrenia and major depressive disorder. The 2/2024 MAR indicated Resident 39 received escitalopram, also known as Lexapro (antidepressant) 20 mg once daily. The 3/4/24 provider note indicated the following: -The past few days-week Resident 39 had an increase in manic episodes and behaviors; -Omeprazole could potentiate the effects of citalopram [antidepressant medication] which in turn could result in mania; -I will half the dose of Celexa [also known as citalopram]. A review of the prior physician orders and 2/2024 MARs indicated Resident 39 did not receive Celexa prior to 3/4/24. The 3/4/24 Celexa order was transcribed by Staff 24 (LPN) and indicated citalopram 10 mg daily was set to start on 3/5/24 at 7:00 AM. The escitalopram was discontinued, and the reason documented was decrease to 10 mg. The 3/2024 MAR indicated Resident 39 received the following medications: -escitalopram 20 mg every morning from 3/1/24 through 3/4/24. -Celexa 10 mg every morning from 3/5/24 through 3/29/24. -escitalopram 10 mg every morning on 3/30/24 and 3/31/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacy review was completed on 3/7/24 and there was no indication the discrepancy between the Celexa order and escitalopram order was noted. The 3/29/24 progress note indicated an order was received to discontinue citalopram and start escitalopram 10 mg daily. The resident was placed on alert charting for continued monitoring. There was no indication in the clinical record to indicate Resident 39 had side effects from the citalopram. On 3/24/25 at 8:46 AM Staff 24 stated she often worked with Resident 39 and the resident often went back and forth with meds. Staff 24 stated she did not remember the 3/4/24 incident with Resident 39's Celexa and escitalopram orders. On 3/24/25 at 1:41 PM a message was left for Staff 39 (Former Medical Director). A call back was not received. On 3/28/25 at 12:18 PM Staff 2 (DNS) acknowledged Resident 39 received Celexa 10 mg from 3/5/24 through 3/29/24 (25 days) in error due to the discrepancy between the provider order for Celexa and escitalopram. Staff 2 acknowledged nursing staff failed to clarify the physician order and the error was not identified until 3/29/24 during a psychotropic drug review.

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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. 34702 Based on observation, interview and record review it was determined the facility failed to assess a resident's fall for 1 of 2 sampled residents (#53) reviewed for falls. This placed residents at increased risk for injury from falls. Findings include: Resident 53 admitted to the facility in 2024 with diagnoses including dementia. The 10/12/24 9:14 AM progress note indicated Resident 53 had an unwitnessed fall, and included, the CNA reported the fall to the nurse, vital signs were taken and within normal limits, Assessed the resident for injuries, skin intact and no signs of immediate bruising or injuries. Resident appeared to be confused. Neuro checks were started immediately. The resident was assisted by the nurse and CNA from the floor to [her/his] wheelchair. On 3/27/25 a request was made for the fall assessment for the 10/12/24 fall. On 3/28/25 at 12:28 PM Staff 2 (DNS) acknowledged a fall assessment was not completed for the 10/12/2 fall.

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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. 34702 Based on interview, and record review it was determined the facility failed to ensure sufficient staffing to meet resident care needs for 1 of 1 resident council and 4 of 4 sampled residents (#s 13, 16, 37 and 38) reviewed for concerns with staffing. This placed residents at risk for delayed and unmet care needs. Findings include: On 3/26/25 the facility provided a list of residents who: -Required assistance with dressing: 55 -Required assistance with bathing: 58 -Required assistance with toileting: 49 -Required assistance with incontinence care: 44 -Required assistance with two-person transfers: 23 -Required two person assistance with mechanical lifts: 10 -Required assistance with incontinence care: 44 -Received mental health services: 24 -Had wandering behaviors: 8 a. Resident Council Notes indicated the following: -1/20/25: Nursing: not responding to call lights in a timely manner. -2/24/25 Nursing: call light times exceeded one hour after 6:00 PM on most days. Grievances indicated the following resident concerns: -1/15/25: long call light times at night, 60 plus minutes. -1/20/25: call light pushed once resident was finished on the toilet, staff responded 17 minutes later. -1/30/25: call light times of 60 plus minutes, staff put residents on the toilet and they were left for extended periods of time. -2/25/25: concerns with call light times of 60 plus minutes. (continued on next page)

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Chehalem Post Acute	1900 E. Fulton Street Newberg, OR 97132

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2/27/25: concerns about not getting pain medications timely. A review of the facility's Direct Care Staff Daily Reports from 1/1/25 through 3/18/25 revealed the facility had insufficient CNA staff, according to state minimum staffing requirements, for one or more shifts on the following dates: -1/24/25 -1/25/25 -1/26/25 -1/28/25 -2/16/25 -2/17/25 -3/9/25 A review of the Direct Care Staff Daily Reports from 1/1/25 through 3/18/25 revealed the following dates with no RN coverage: - 1/4/25 -1/5/25 -2/15/25 b. Interviews with residents revealed the following concerns: -On 3/19/25 at 10:22 AM Resident 37 stated it took up to an hour for the call light to be answered and shift change was even worse. -On 3/19/25 at 12:12 PM Resident 16 stated she/he waited over an hour for call lights to be answered at nighttime. -On 3/19/25 at 1:38 PM Resident 38 stated it took up to an hour for call lights to be answered and call lights were sometimes not answered at all. -On 3/20/25 at 9:38 AM Resident 13 stated there were staffing issues and she/he did not get checked on by staff. c. Interviews with staff revealed the following concerns: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/21/25 at 8:18 AM Staff 11 (CMA) stated the facility had residents with high acuity needs and was consistently short staffed for CNA and CMA staff. Staff 11 stated it was hectic at times, especially evening shift, and staff were not always able to take breaks. Staff 11 stated when it was busy, medications were given late. -On 3/24/25 at 6:19 AM Staff 6 (CNA) stated staff were not always able to get resident care completed due to being short staffed. -On 3/24/25 at 8:46 AM Staff 24 (LPN) stated the facility was consistently short staffed and she had to assist with dining due to not having enough CNA staff. Staff 24 further stated if a nurse did not show up for a shift there were only two nurses working the floor which was not safe because she did not have time to check on the residents. Staff 24 stated two or three times per week staff were late for work or did not arrive to work. Staff 24 stated management knew about the staffing issues and concerns and say they were working on it. -On 3/24/25 at 10:09 AM Staff 8 (LPN) stated the low staffing was overwhelming especially when there was a resident emergency or resident discharge. Staff 8 stated the facility had residents with high acuity needs and there were not enough nursing staff to complete treatments and assessments. Staff 8 stated the staffing concerns were brought to Staff 1 (Administrator) and Staff 2 (DNS) and the concerns were ignored. -On 3/25/25 at 8:50 AM Staff 12 (CMA) stated staff were not able to administer medications on time if there was only one CMA, and that happened twice in the past two weeks. Staff 12 stated she was unable to do it by herself. Staff 12 stated the management staff were aware of the staffing concerns and responded by telling staff when the facility census increased then the facility would then increase staff on the floor. Staff 12 stated it was stressful and it was not always possible to take breaks. -On 3/25/25 at 9:18 AM Staff 46 (CNA) stated acuity was higher in the memory care unit and it was difficult to see and answer the lights because she was responsible for residents inside and outside the memory care unit. Staff 46 stated the administrator was aware of the staffing concerns. -On 3/25/25 at 2:51 PM Staff 47 (CNA) stated the facility was short staffed most of the time and it was difficult to find another staff to assist residents who required two-person assistance. Staff 47 stated when one staff stayed in the dining room there was often no staff to cover that CNA in the hallway. Staff 47 stated they were not always able to get to incontinence care on time and had to stay late to complete resident care. Staff 47 further stated it was difficult when being assigned to memory care and the back hall because staff were not able to see call lights in each hall, and the memory care residents required more care and more frequent checks which was difficult to do when assigned both halls. -On 3/26/25 at 11:38 AM Staff 48 (LPN) stated resident acuity was high and the facility needed another nurse to help out with resident care. Staff 48 stated the facility had a large number of residents that required wound care, tube feeding and diabetic care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/26/25 at 5:41 PM Staff 27 (RN) stated she worked on 1/27/25 and arrived to work at 10:00 AM. She stated there was no CMA working that day; there were only two nurses working the floor and they were down one nurse. Staff 27 stated the 6:00 AM medications were due and she started passing morning medications at 11:30 AM and almost all residents' medications were late by then. On 3/26/25 08:19 AM and 12:00 PM Staff 1 (Administrator) stated the facility measured acuity based off the facility assessment. Staff 1 stated staff were encouraged to communicate if they were short staffed and we are more than happy to supply more help. Staff 1 stated CNAs knew they had to see their residents every two hours and double check on them; if the necessary teamwork was done the CNAs were able to split the work between the memory care and general population. On 3/28/25 at 12:47 PM the staffing concerns were reviewed with Staff 2 (DNS). Staff 2 stated if the facility could make a strong case to justify the need for additional staff, then the facility could get the extra help approved. Staff 2 stated it was difficult to get involved with staffing due to her other work.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34702 Based on interview and record review it was determined the facility failed to ensure a registered nurse was available for at least eight consecutive hours for 6 of 79 days reviewed for RN coverage. This placed residents at risk for delayed nursing assessments. Findings include: A review of the Direct Care Staff Daily Reports revealed the following dates with no RN coverage: -7/20/24 -9/16/24 -9/28/24 - 1/4/25 -1/5/25 -2/15/25 On 3/26/25 at 8:19 AM and 12:00 PM Staff 1 (Administrator) acknowledged the identified dates without the required RN coverage.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 34702 Based on interview and record review it was determined the facility failed to ensure performance reviews were completed at least once every 12 months for 3 of 3 CNAs (#s 29, 30 and 31) reviewed for staffing. This placed residents at risk for a lack of care by competent staff. Findings include: Annual performance reviews and hire dates were requested on 3/25/25 and 3/28/25 from Staff 2 (DNS) for the following staff: -Staff 29 (CNA),hired on 6/12/23. -Staff 30 (CNA), hired on 9/12/22. -Staff 31 (CNA), hired on 4/10/84. No annual performance reviews were submitted to the survey team. On 3/25/25 at 1:47 PM and 3/28/25 at 9:00 AM Staff 2 acknowledged Staff 29, Staff 30 and Staff 31 worked at the facility for over one year and did not receive an annual performance reviews in the past 12 months.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34702 Based on interview and record review it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for required staff postings. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include: A review of the Direct Care Staff Daily Reports from 1/1/25 through 3/18/25 revealed 5 of 76 days when portions of the form were left blank or were inaccurate. The incomplete or inaccurate information included daily census, and the number of working staff. The dates included: -1/14/25 -1/20/25 -1/29/25 -2/19/25 -3/5/25 On 3/26/25 at 8:57 AM Staff 1 (Administrator) acknowledged the Direct Care Staff Daily Reports were incomplete and inaccurate for the identified dates.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34324 Based on interview and record review it was determined the facility failed to obtain and administer medication to residents timely to ensure the provision of routine medications for 10 of 17 sampled residents (#s 15, 22, 33, 34, 35, 44, 53, 62, 166, 167) reviewed for medications. This placed residents at risk for adverse medication side effects. Findings include: 1. Resident 22 admitted to the facility in 2018 with diagnoses including alcohol dependence and osteoarthritis. a. A 3/15/25 physician order indicated the use of trazodone for sleep related to alcohol dependence. A 3/18/25 progress note by Staff 12 (CMA) indicated trazodone was ordered and would arrive in the pharmacy delivery. Review of the 3/2025 MAR revealed Resident 22 was not administered trazodone until 3/20/25 (five days after the order date). On 3/21/25 at 8:23 AM Staff 11 (CMA) stated Resident 22 did not have trazodone for three or four days. Staff 11 stated the resident received the medication only after contacting the pharmacy. On 3/25/25 at 10:07 AM Staff 12 (CMA) stated she contacted the pharmacy on 3/18/25 and 3/19/25 regarding not having Resident 22's trazodone. Staff 12 stated she was told by pharmacy they did not have the order for the trazodone. Staff 12 stated she notified nursing staff of the resident missing the trazodone. Staff 12 stated it was nursing staff's responsibility to verify orders and contact the physician when a resident missed a medication. Staff 12 stated medications arriving late, and residents missing medication administrations, happened frequently due to orders sitting in the system and not being reviewed by nursing staff. On 3/25/25 at 1:37 PM Staff 13 (CMA) stated Resident 22's trazodone was not filled until 3/19/25 and the resident did not receive it until 3/20/25. On 3/27/25 at 11:26 AM Staff 2 (DNS) stated Resident 22's order for trazodone was not verified by nursing staff and was not requested from the pharmacy until 3/18/25. Staff 2 acknowledged Resident 22 did not receive trazodone until five days after the 3/15/25 physician order. b. A 10/4/24 physician order indicated the use of oxycodone every six hours as needed for pain for a pain level of 6 to 10. Review of the 3/2025 MAR indicated Resident 22 received oxycodone at least twice daily. The MAR indicated oxycodone was administered on 3/14/25 at 7:52 PM with a pain level of six. Resident 22 was not administered oxycodone again until 3/16/25 at 4:38 AM. Review of the 3/2025 Narcotic Log indicated Resident 22 had no remaining oxycodone on 3/15/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/14/25 email from Staff 2 (DNS) to the pharmacy indicated Resident 22 waited all day for the oxycodone due to the pull code not being authorized. Staff 2 was told the medication was to be delivered at 5:10 PM but it did not arrive until after 6:30 PM. On 3/19/25 at 1:55 PM Resident 22 stated there were issues with the facility running out of her/his oxycodone and she/he was upset about it. On 3/25/25 at 10:07 AM Staff 12 (CMA) stated she heard Resident 22 previously ran out of her/his oxycodone. Staff 12 stated Resident 22 asked for oxycodone twice a day. Staff 12 stated oxycodone was available in the emergency medication system but it was challenging for nursing staff to get access due to pharmacy issues with getting the pull code. On 3/25/25 at 1:37 PM Staff 13 (CMA) stated Resident 22 asked for oxycodone twice a day and the resident was out of the medication for a day. On 3/27/25 at 11:26 AM Staff 2 (DNS) stated Resident 22 asked for oxycodone daily. Staff 2 acknowledged Resident 22 ran out of oxycodone and did not receive the medication as ordered. 34702 2. On 2/10/25 a public complaint was received that alleged multiple residents received late medication during the end of January 2025 due to being displaced during a flooring renovation project. Facility records indicated the flooring project was completed for one hall on 1/27/25. A review of resident progress notes from 1/27/25 revealed the following: -Resident 44 received morning medication including metoprolol (blood pressure medication; Norvasc (blood pressure medication); finasteride (urinary retention medication) lisinopril (blood pressure medication); and sertraline (antidepressant medication) at 2:46 PM. The morning dose of acetaminophen was held because it was too late to administer per the physician. -Resident 33 received morning medications including methadone (pain medication); empaglifozin (diabetic medication); metoprolol (blood pressure medication); duloxetine (antidepressant medication); spironolactone (diuretic medication); and finasteride (urinary retention medication) at 2:12 PM. The morning dose of apixaban (anticoagulant medication) was held because it was too late to administer per the physician. -Resident 34's morning dose of aspirin was held because it was too late to administer per the physician at 12:58 PM. -Resident 166's morning dose of furosemide (diuretic medication); allopurinol (gout medication) were administered at 12:50 PM. The morning dose of losartan (blood pressure medication) and apixaban (anticoagulant medication) was held because it was too late to administer per the physician. -Resident 62's morning dose of morphine (pain medication) was held due to past time to administer at 12:47 PM. The 3:01 PM dose was unable to be administered due to the nurse being unable to access the resident's room due to the construction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 15's morning dose of Cymbalta (antidepressant medication); Lasix (diuretic medication); and bupropion (antidepressant medication) were administered at 2:18 PM. -Resident 167's morning dose of acetaminophen was held because it was too late to administer per the physician at 3:30 PM. -Resident 35's morning dose of lisinoprol (blood pressure medication); finasteride (urinary retention medication); Norvasc (blood pressure medication); chlorthalidone (blood pressure medication); allopurinol (gout medication) were administered at 2:29 PM. The morning dose of Eliquis (anticoagulant medication) and Coreg (blood pressure medication) was held because it was too late to administer per the physician. On 3/26/25 at 5:41 PM Staff 27 (RN) stated she worked on 1/27/25 and arrived to work at 10:00 AM. She stated there were no CMAs working that day; there were only two nurses working the floor and they were down one nurse. Staff 27 stated the 6:00 AM medications were due and she was unable to find a working computer until 11:30 AM; and almost all medications were late by then. Staff 27 stated the residents were moved out of their rooms and displaced throughout the facility. Staff 27 stated she had to contact the physician and notify him that morning medications were all past due by the time she was able to start morning medication pass, and she received orders to either give or hold the medications. Staff 27 further stated there were no serious outcomes to the residents. On 3/28/25 at 12:47 PM Staff 2 (DNS) acknowledged the identified findings on 1/27/25 when residents either received their medications late or not at all depending on the physician response to morning medications being passed after 2:00 PM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48830 Based on observation, interview and record review it was determined the facility failed to ensure medications and biologicals were secured for 1 of 3 medication carts and 1 of 3 treatment carts reviewed for safe medication storage. This placed residents at risk for unauthorized access to medications. Findings include: The facility's 1/2023 Storage of Medications Policy specified the following: -The medication supply shall be accessible only to licensed nurses, pharmacy staff, and those lawfully authorized to administer medications such as medication aides. Medication carts, rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. 1. On 3/24/25 at 12:12 PM a treatment cart was observed to be unlocked and unattended in the hallway near the nurses station. On 3/24/25 at 12:15 PM Staff 8 (LPN) returned to the treatment cart and stated she left the cart unlocked and unattended and the cart contained resident insulin, creams and other treatment supplies. On 3/24/25 at 1:09 PM Staff 2 (DNS) stated the expectation was for the treatment carts to be locked when unattended. 34702 2. On 3/25/25 at 2:39 PM medication cart one was observed to be unlocked and unattended in the hallway near the nurses station. On 3/25/25 at 2:40 PM Staff 35 (LPN) returned to the medication cart and stated he used the restroom and left the cart unlocked and unattended and the cart contained resident medications. On 3/25/25 at 2:50 PM Staff 2 (DNS) stated the expectation was for the medication carts to be locked when unattended.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 34702 Based on interview and record review it was determined the facility failed to provide timely diagnostic services for 1 of 2 sampled residents (#164) reviewed for lab services. This placed residents at risk for undiagnosed care needs. Findings include: Resident 164 admitted to the facility in 2024 with diagnoses including diabetes. The 10/3/24 physician order indicated staff were to obtain a stool sample from the resident to rule out Clostridium Difficile (c-diff, a bacterial infection that can cause severe diarrhea). The 10/9/24 1:20 PM progress note by Staff 25 (RN) indicated Resident 164's stool sample was collected and picked up by the lab. On 3/25/25 at 11:55 AM Staff 25 stated Resident 164's stool sample was obtained initially after the 10/3/24 order was received and staff accidentally put another resident's name on it. Staff 25 stated due to the error, staff had to obtain another sample on 10/9/24, delaying the lab results. On 3/28/25 at 12:41 PM Staff 2 (DNS) acknowledged the physician order to obtain Resident 164's stool sample was received on 10/3/24 and the facility did not complete it until 10/9/24.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 34702 Based on interview and record review it was determined the facility failed to notify the ordering physician of the results of a critical lab value for 1 of 2 sampled residents (#53) reviewed for accidents. This placed residents at risk for delayed treatment. Findings include: Resident 53 admitted to the facility in 2024 with diagnoses including dementia. On 10/9/24 labs were obtained, and the results were completed and reported to the facility the same day. The results indicated Resident 53 had a critical hemoglobin level of 5.8 g/DL (grams per deciliter) (normal reference range was 12.5-14.9 g/DL). It was noted on the lab report that a critical value was identified, and the facility was contacted, but there was no one available to take critical value. The 10/16/24 progress note indicated Resident 53 had abdominal pain and later had vomiting and absent bowel tones. The resident was transported to the hospital. The 10/16/24 4:57 PM progress note by Staff 2 (DNS) indicated a chart review was completed, and a critical lab value was in an unreviewed state. A call was placed to Staff 39 (Former Medical Director) to inform him of the critical low hemoglobin level from 10/9/24 and the resident was sent out to the hospital that morning for possible concerns for bowel obstruction per nurse report. The DNS also informed the other provider of lab values. On 3/28/25 at 12:18 PM Staff 2 stated Resident 53's 10/9/24 critical hemoglobin level was not noted by the facility until she discovered it on 10/16/24 at 4:25 PM and called Staff 39 and the other provider to notify them of the results, and that the resident was hospitalized as of that morning. Staff 2 stated due to a technical issue in the electronic health record and a change in the phone system, the critical lab value was received by the facility but not noted by staff until 10/16/24.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 34324 Based on interview and record review, it was determined the facility failed to conduct and complete a comprehensive facility wide assessment to care for its residents competently during day to day operations. This placed residents at risk for unidentified and unmet needs. Findings include: The 3/19/25 Facility Assessment was reviewed. The assessment was not comprehensive and failed to accurately include information on the following: - How the facility assessment was used to address staffing needs and competencies. - The percentage of transmission based precautions in the facility. - The number of ADL assistance based on the average census. - The ethnic, cultural and religious makeup of the facility resident population. - The high usage of agency staff. On 3/28/25 at 3:00 PM, Staff 1 (Administrator) reviewed the Facility Assessment and acknowledged the assessment was not comprehensive and did not have accurate information related to the areas indicated. No further information was provided.

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Chehalem Post Acute	1900 E. Fulton Street Newberg, OR 97132

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 34324 Based on interview and record review it was determined the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program that implemented action plans to correct identified quality deficiencies. This failed practice placed all residents at risk for not receiving the care and services for optimal resident outcomes. Findings include: The facility's undated Quality Assurance/Performance Improvement (QAPI) policy indicated it used a systematic, comprehensive and data driven approach to maintain and improve safety and quality. A 3/15/25 statement of guiding principles were indicated as the following: - The mission of doing more than just enough to provide quality care because of the quality of staff. - The purpose of a better process and systems to make resident lives better and staff's lives better. - Guiding principles of: every resident your resident, accountability, love/compassion and fun. On 3/28/25 at 3:00 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the QAPI program did not recognize or address the following identified concerns: - Lack of sufficient staffing based on acuity. - Addressing resident grievances related to staffing. - The regulatory requirements of the memory care unit. - Residents not receiving medications timely. - Pharmacy services not provided. - Facility construction causing displacement of residents resulting in issues of receiving medications late and lack of privacy. - Lack of apppropriate infection control practices related to following CDC guidelines. - Lack of timely lab services. - Lack of an Infection Control Preventionist in the facility for a period of time. Refert to F583, F684, F725, F727, F755, F776, F880 and F882.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005 1. Based on observation, interview and record review it was determined the facility failed to ensure proper hand hygiene was completed during meals for 2 of 3 halls reviewed for dining. This placed residents at risk for cross contamination. Findings include: The 8/1/24 Hand Hygiene Policy and Procedure indicates effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team will comply with current Centers of Disease Control and Prevention hand hygiene guidelines. The procedure included: 3. Hand hygiene is the primary means of preventing the transmission of infection and should be performed as soon as possible after hands become contaminated and frequently during the working day. The following is list of some situations that require hand hygiene: c. Before and after direct resident contact; f. Before and after eating or handling food; g. Before and after assisting a resident with meals; s. After handling soiled equipment or utensils; On 3/19/25 between the hours of 12:11 PM and 12:29 PM, during the lunch meal in the west and east hall the following observations were made: -12:15 PM Staff 3 (CNA) was observed retrieving a meal tray from a delivery cart located in the west hall and entered room [ROOM NUMBER]. Staff 3 retrieved another tray from the delivery cart and entered room [ROOM NUMBER] without sanitizing her hands after exiting the resident's room and before retrieving another meal tray. -12:19 PM Staff 3 was observed delivering a meal tray to room [ROOM NUMBER]. Staff 3 retrieved used coffee cups from the resident's bedside table and threw away the cups. Staff 3 made coffee for room [ROOM NUMBER] and did not sanitize her hands after retrieving the dirty cups and making coffee for another resident. -12:25 PM Staff 3 was observed pushing the meal delivery cart from the west hall to the east hall. Staff 3 retrieved a meal tray and delivered the tray to room [ROOM NUMBER]. Staff 3 retrieved another tray from the delivery cart and entered room [ROOM NUMBER] without sanitizing hands after moving the cart or before retrieving or delivering the meal tray. On 3/19/25 at 12:29 PM Staff 3 stated she was supposed to sanitize her hands before touching each meal tray and before and after exiting a resident rooms. Staff 3 acknowledged she did not complete hand hygiene between resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 1:02 PM Staff 2 (DNS) stated staff were to complete hand hygiene each time they went in and out of a resident's room and passed each meal tray. 48830 2. Based on interview and record review it was determined the facility failed to develop and implement a water management program and conduct a risk analysis assessment for potential areas of growth and spread of water-borne pathogens and illness. This placed all residents at risk for exposure to water-borne pathogens. Findings include: The Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality/Safety and Oversight Group letter 17-30, revised on 7/6/18, on Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease stated, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. A review of the facility 9/2024 Legionnaire's Disease Policy revealed the following: -The center completes Legionella Risk Assessment to determine risk for Legionella outbreaks annually. -The center develops and reviews their Water Management Program annually. -During routine inspections of control areas, the center mitigates areas of concern via developed center specific plans. A review of the 3/19/25 Facility Assessment revealed no evidence a risk assessment was completed to prevent the growth and spread of water-borne pathogens in the facility's main water system. On 3/28/25 at 8:29 AM Staff 37 (Maintenance Director) stated the facility did not have a water management program in place. On 3/28/25 at 12:11 PM Staff 1 (Administrator) stated he was not aware of the requirement for the facility to have a water management program. Staff 1 confirmed the facility did not have a prevention plan or system in place for the prevention of a spread of water-borne pathogens, such as Legionella, in the facility's main water system. 3. Based on observation, interview and record review it was determined the facility failed to follow CDC (Centers for Disease Control and Prevention) Infection Control Guidelines related to Enhanced Barrier Precautions for 2 of 10 sampled residents (#s 2 and 10) reviewed for infection control. This placed residents at risk for exposure and cross contamination. Findings include: The CDC's 4/2/24 implementation of Nursing Home PPE guidelines for prevention of spread of Multidrug-Resistant Organisms (MDROs) included a trash bin was to be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Resident 10 was admitted to the facility in 9/2024 with diagnoses including Multiple Sclerosis and use of a colostomy. A 3/14/25 care plan indicated Resident 10 was on enhanced barrier precautions related to an indwelling catheter and a colostomy. Staff were to follow the guidelines posted next to the door. On 3/25/25 at 9:25 AM Resident 10's room was observed to have signage posted on the resident's door that stated the resident was on enhanced barrier precautions. A plastic storage bin with PPE in the drawers was observed outside of the resident's room along with a garbage bin located next to it which contained a used PPE gown. On 3/25/25 at 9:30 AM Staff 4 (CNA) stated used PPE was either thrown away in the garbage bin inside Resident 10's bathroom or the garbage bin right outside of the room in the hallway. On 3/25/25 at 9:32 AM Staff 5 (CNA) stated Resident 10 was on enhanced barrier precautions due to a catheter and a colostomy. Staff 5 stated after direct care was provided for Resident 10, used PPE was always placed in the garbage bin located outside of the resident's room. On 3/25/25 at 9:37 AM Staff 6 (CNA) stated Resident 10 was on enhanced barrier precautions and when direct care was provided, PPE was to be worn. Staff 6 stated used PPE was placed in the garbage bin located outside of the resident's room and that was okay since the resident did not have covid. b. Resident 2 was admitted to the facility in 9/2024 with diagnoses including neurogenic bladder (when nerves that control bladder function are damaged or impaired, leading to a loss of normal bladder control) and dementia. A 3/14/25 care plan indicated Resident 2 was on enhanced barrier precautions related to an indwelling catheter. Staff were to follow the guidelines posted next to the door. On 3/25/25 at 9:43 AM Resident 2's room was observed to have signage posted on the resident's door that stated the resident was on enhanced barrier precautions. A plastic storage bin with PPE in the drawers was observed outside of the resident's room along with a garbage bin located next to it that contained a used PPE gown. On 3/25/25 at 9:47 AM Staff 8 (LPN) stated all used PPE was placed in the garbage bin outside of the resident's room. On 3/25/25 at 9:54 AM Staff 7 (Infection Preventionist) observed the used PPE gowns inside the garbage bins. Staff 7 acknowledged staff were to place used PPE in the garbage bin located inside the resident's room.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 34702 Based on interview and record review it was determined the facility failed to have a qualified and trained infection preventionist in place for 1 of 1 facility reviewed for infection prevention and control. This placed residents at risk for inadequate infection control. Findings include: On 3/28/25 surveyors requested documentation to indicate the facility had an infection preventionist in place. On 3/28/25 at 10:56 AM Staff 2 (DNS) provided documentation to indicate Staff 51 (Former Infection Preventionist) was employed until 1/5/24 and Staff 7 (Infection Preventionist) started on 10/29/24. On 3/25/25 at 11:55 AM Staff 25 (RN) stated she worked at the facility in 2024 and was asked by Staff 2 to be the infection prevention nurse, but did not receive education or training and was terminated from the facility on 10/28/24. Staff 25 stated there was no infection preventionist working at the facility since January 2024. On 3/28/25 at 10:56 AM Staff 2 acknowledged the facility did not have a certified infection preventionist from 1/5/24 through 10/29/24 (298 days).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48830 Based on interview and record review it was determined the facility failed to administer a pneumococcal vaccine for 1 of 5 sampled residents (#24) reviewed for immunizations. This placed residents at risk for contracting communicable illnesses. Findings include: A review of the facility 9/1/2024 Influenza and Pneumococcal Immunizations policy indicated it was the policy of the center to offer the Influenza and Pneumococcal immunizations to residents in accordance with federal regulations and current CDC (Centers for Disease Control and Prevention) guidelines. Resident 24 was admitted to the facility in 6/2024 with diagnoses including diabetes and heart failure. A review of the 1/18/25 Quarterly MDS indicated Resident 24 was cognitively intact. A review of Resident 24's clinical record revealed an undated pending consent for Prevnar 20 (a type of Pneumococcal vaccination). On 3/26/25 at 1:33 PM and on 3/28/25 at 10:12 AM Staff 7 (Infection Preventionist) stated she recalled talking with Resident 24 in October or November 2024 to educate and offer a pneumococcal vaccination that the resident was eligible for. Staff 7 stated Resident 24 provided verbal consent, however Staff 7 never followed up and Resident 24 was not administered the vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 48830 Based on interview and record review it was determined the facility failed to obtain resident representative consent for a Covid-19 vaccine for 1 of 5 sampled residents (#40) reviewed for immunizations. This placed residents at risk for a lack of informed education and consent and at risk for contracting communicable illnesses. Findings include: A review of the facility's 9/1/24 Covid-19 Vaccination policy and procedure indicated residents were offered recommended Covid-19 vaccinations upon admission and as eligible per CDC (Centers for Disease Control and Prevention) recommendations. Consent for approved vaccines were obtained prior to or at the time of vaccination. Resident 40 was admitted to the facility in 4/2023 with diagnoses including dementia and adult failure to thrive. A review of the 8/5/24 Quarterly MDS indicated Resident 40's cognition was severely impaired. A review of Resident 40's clinical record revealed Witness 5 (Family Member) was Resident 40's Power of Attorney and Healthcare Decision maker. A review of Resident 40's immunization list revealed on 10/16/24 the resident was educated, offered and refused a Covid-19 vaccination. There was no indication Witness 5 was contacted for education and consent. On 3/26/25 at 1:24 PM Staff 7 (Infection Preventionist) acknowledged Resident 40's cognition was impaired, and Resident 40's resident representative was not contacted for education or consent for a Covid-19 vaccination.