STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385201	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Terrace	707 SW 37th Street Pendleton, OR 97801

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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 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. 38140 Based on observation, interview and record review the facility failed to implement the plan of care for 2 of 6 sampled residents (#s 32 and 139) who were reviewed for ADLs. This placed residents at risk for unmet needs and injury. Findings include: 1. Resident 139 admitted to the facility in 2023 with diagnoses including the left and right femur (upper leg bone) fractures. Resident 139's 1/15/23 Admission MDS indicated a BIMS a 15 (cognitively intact). Resident 139's 3/1/23 plan of care direct staff to provide extensive assistance by two staff members with bed mobility. On 3/1/23 the facility submitted a FRI to the State Agency. The facility received information of an incident on 3/1/23 which occurred on 2/24/23. Staff 25 (CNA) was placed on administrative leave pending an investigation of the incident. Review of a 3/1/23 written statement by Staff 25 revealed Staff 25 stated she independently completed bed mobility and ADL care for Resident 139 on 2/24/23. Review of a 3/1/23 written statement by Staff 30 (Former DNS) revealed Resident 139 described an incident on 2/24/23 when Staff 25 turned her/him in bed, pressed on her/his knees, caused pain during the movement and no additional staff were present to assist with the bed mobility. Review of a 3/6/23 incident investigation revealed Staff 25 completed Resident 139's bed mobility and ADL care independently and did not follow the resident's plan of care for the need of assistance by two staff members. On 5/16/24 at 10:07 AM Staff 25 stated she did not recall the incident with Resident 139 in 2/2023. On 5/16/24 at 10:15 AM Staff 1 (Administrator) stated he was aware of the 2/24/23 incident and he expected all staff to follow resident's plan of care. 2. Resident 32 was admitted to the facility in 3/2024 with diagnoses including Rhabdomyolysis (breakdown of muscle tissue which releases protein into blood system). (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 32's 5/3/24 Significant Change of Condition MDS indicated a BIMS score of 07 (severe cognitive impairment). On 5/13/24 at 3:07 PM Witness 2 (Spouse) stated Resident 32 would normally like to have her/his dentures in her/his mouth, especially when she/he ate meals. Review of Resident 32's current care plan indicated the resident wore upper and lower dentures and required assistance from staff to wear. Resident 32 was observed with no dentures in her/his mouth on the following dates: - 5/13/24 at 2:27 PM; - 5/14/24 at 12:40 PM and 2:28 PM; - 5/15/24 at 9:36 AM, 11:09 AM and 1:15 PM. On 5/16/24 at 10:58 AM Staff 25 (CNA) confirmed Resident 32 did not have dentures in her/his mouth. Staff 25 found Resident 32's dentures in a soaking cup in her/his drawer. On 5/16/24 at 11:01 AM Staff 26 (CNA) stated this was not her normal section of residents where she provided care. Staff 26 stated she obtained her information to care for a resident from the plan of care. Staff 26 stated she asked other staff about Resident 32's teeth and she was told she/he did not have any dentures at the facility. Staff 26 acknowledged she did not assist Resident 32 with her/his dentures for that morning breakfast meal. On 5/16/24 at 11:10 AM Staff 3 (LPN/Resident Care Manager) confirmed Resident 32 was care planned for assistance with her/his upper and lower dentures. Staff 3 stated she expected Resident 32 to wear her/his dentures as care planned. On 5/16/24 at 11:12 AM Staff 2 (Regional RN) acknowledged she expected staff to follow Resident 32's care plan to assist with her/his dentures.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services to maintain personal hygiene for 1 of 6 sampled residents (#15) reviewed for ADLs. This placed residents at risk for poor personal hygiene. Findings include: Resident 140 was admitted to the facility on ,d+[DATE] with diagnoses including a fractured femur (upper leg bone). Resident 140's 5/4/24 Admission MDS indicated a BIMS score of 12 (moderately impaired cognition). On 5/13/24 at 2:36 PM Resident 140 stated she/he had not been offered a shower since admission and had just given her/himself a bed bath and would love a shower. A wet washcloth was observed on the resident's bedside table. There was no wash bin with soap and water observed at the resident's bedside. Review of Resident 140's care plan revealed she/he had an ADL self-care performance deficit and needed extensive assistance for bathing. Staff were to assist with bathing by preference of a shower every Monday and Thursday evening. Resident 140's 5/2024 Task record documented the resident received no showers, bed baths or attempts to bathe on 5/2/24 and 5/13/24. On 5/14/24 at 1:57 PM Staff 15 (CNA) stated resident showers were scheduled and if a resident refused a shower or bed bath, he was to tell the charge nurse and reapproach the resident to offer the resident another time to shower or receive a bed bath. Staff 15 stated all attempts were expected to be documented in the resident's task record. On 5/14/24 at 3:09 PM Staff 18 (CNA) stated some of the resident's experienced a mix-up with shower schedules. Staff 18 acknowledged Resident 140's shower schedule was available and if the resident received or refused it should be documented in the tasks section in the health record. On 5/15/24 at 10:04 AM Staff 14 (LPN) stated all residents were expected to receive a shower on their scheduled days. Staff 14 stated when a CNA reported to her a resident refused a shower then she would talk with the resident and document in the resident's heath record if the resident refused. On 5/15/24 at 10:22 AM Staff 4 (LPN/Resident Care Manager) confirmed there was no documentation Resident 140 received a shower, was offered a shower, or had refused a shower or a bath. Staff 4 stated she was unaware of any reason as of why Resident 140 had not been bathed. On 5/15/24 at 10:45 Am Staff 2 (Regional RN) acknowledged she expected Resident 140 to be bathed on her/his scheduled days and as requested.

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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. 47000 Based on observation, interview and record review it was determined the facility failed to monitor skin conditions for 1 of 1 sampled resident (#28) reviewed for skin conditions. This placed residents at risk for unmet care needs. Findings include: The facility's 9/2020 Skin At Risk/Skin Breakdown Policy and Procedure indicated the following: -Updates of current non-pressure areas coincide with the weekly full body skin audit performed by the licensed nurse. The licensed nurse monitors bruises, skin tears and abrasions on the resident TAR. All other non-pressure skin concerns should be documented on the Skin-Wound Form. -Upon discovery of a newly identified skin impairment (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the licensed nurse would document the skin impairment, including measurements of size, color, presence of odor and exudates, document identified bruises and skin tears on the resident TAR with monitoring completed with weekly and record on the TAR until deemed appropriate for discontinuance. Resident 28 was admitted to the facility in 4/2024 with diagnoses including acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Resident 28's 4/10/24 SNF Admission Nursing Database revealed the resident had multiple bruises and dry, discolored skin to her/his bilateral (both) upper extremities. Resident 28's 4/16/24 Admission MDS revealed the resident was cognitively intact, experienced moisture associated skin damage and indicated the resident was at risk for skin impairments secondary to incontinence, oxygen use, impaired mobility and balance, obesity and the need for assistance with bed mobility. Resident 28's 4/20/24 Skin Impairment Care Plan revealed the following interventions: -Notify the licensed nurse of any new skin issues. -See MAR/TAR for current medical interventions. Resident 28's 4/2024 and 5/2024 TAR revealed the resident received weekly skin checks and no new skin impairments were noted. The TAR did not indicate the presence of any bruises or specific skin impairments being monitored or treated outside of the wound to the resident's coccyx (the small bone at the bottom of the spine) in 4/2024 and a rash under the resident's breasts in 5/2024. No evidence was found in Resident 28's clinical record to indicate the resident's bilateral upper extremity bruises from 4/10/24 were assessed, treated or monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 1:09 PM Resident 28 was observed in her/his room in her/his wheelchair. The resident had a dark purple bruise across the top of her/his right hand that was approximately three and a half inches wide and another dark purple bruise approximately one inch in diameter located between her/his pointer and middle finger. The resident had a dark purple bruise approximately two inches long and three inches wide on the top of her his left hand and scattered bruises were observed on both of the resident's forearms. Resident 28 stated she/he always had bruises because she/he got banged up all of the time as a result of people grabbing and handling me. On 5/15/24 at 10:52 AM Staff 27 (CNA) stated he was not sure when he first noticed the bruises on Resident 28's hands and forearms. Staff 27 further stated he had not been instructed on any specific ways to handle the resident's skin and the resident had complained staff were rough when rolling [her/him]. On 5/15/24 at 12:01 PM Staff 15 (CNA) stated he noticed the bruises on Resident 28's hands and forearms a week ago and he was not sure what they were from. Staff 15 stated he reported the bruises to the treatment nurse when he noticed them a week ago but could not remember which nurse he told. On 5/16/24 at 10:44 AM Staff 13 (RN) stated nurses were responsible for completing a daily check of resident bruises in order to make sure they were not getting bigger or worsening and documenting their check on the resident's TAR. Staff 13 stated if a resident's bruise got worse or a new bruise was observed, nurses were to complete a risk management form, adjust the resident's care plan and possibly contact the resident's provider. Staff 13 stated Resident 28 had bruises on her/his bilateral hands and forearms for as long as she could remember and thought they were maybe a little worse, darker in color. Staff 13 reviewed the resident's TAR and stated her/his bruises were currently not being monitored and should be. On 5/16/24 at 11:41 AM Staff 4 (LPN Resident Care Manager) reviewed Resident 28's electronic record and confirmed no assessment was completed to indicate the specific location, size or number of bruises the resident admitted to the facility with and no ongoing monitoring of the bruises was in place. Staff 4 stated at this point she would have expected the bruises to be healed. At 11:57 AM Staff 4 observed Resident 28's hands and forearms and stated she was unsure of how or when the deep purple bruise on the resident's right hand between the pointer and middle finger or the bruise on her/his left hand which was currently covered with a band aid developed. Staff 4 further stated an incident report should have been completed for these bruises and monitoring should have been in place and was not.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47000 Based on observation, interview and record review it was determined the facility failed to prevent loss of range of motion and development of contractures for 1 of 1 sampled resident (#23) reviewed for contractures. This failure resulted in Resident 23 developing bilateral (both) hand contractures and experiencing significant pain in her/his hands. Findings include: The facility's 2/2018 Restorative Nursing Policy and Procedure revealed the following: -Based on a comprehensive assessment of the resident's current functional status related to communication, mobility, range of motion, performance of ADLs, eating and toileting, the RCM (Resident Care Manager) will determine appropriateness for participation in restorative nursing programs. -Ongoing assessment of each resident's functional status occurs no less often than quarterly with the completion of the MDS. -If the resident expresses a desire to improve in one or more area of communication, mobility, range of motion, ADL performance, eating or toileting, a therapy referral or restorative nursing referral will be initiated. -If the RCM or licensed staff determines the resident has a need to maintain current function in communication, mobility, range of motion, ADL performance, eating or toileting, a restorative nursing referral will be initiated. -Residents with the need to improve functional status will be re-evaluated monthly to determine effectiveness of the current interventions and need to revise goals or interventions. -Residents with the need to maintain current functional status will be re-evaluated at least quarterly to determine effectiveness of the current interventions and need to revise goals or interventions. Resident 23 was admitted to the facility in 6/2023 with diagnoses including spinal stenosis (narrowing of the spinal column that can cause pressure on the spinal cord). Resident 23's 6/8/23 Admission and 9/8/23 Quarterly MDS revealed the resident was severely cognitively impaired and she/he had no upper extremity (shoulder, elbow, wrist or hand) impairment. Resident 23's 10/23/23 Neurology Clinic Note indicated the resident developed weakness of her/his arms since she/he admitted to the facility. Resident 23's 12/9/23 Quarterly MDS revealed the resident was severely cognitively impaired and she/he experienced upper extremity impairment on both sides. Resident 23's 12/22/23 Neurosurgery Clinic Evaluation Note indicated the resident's arm strength was progressively worsening. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Resident 23's 12/28/23 OT Evaluation and Plan of Treatment revealed the following: -The resident experienced problems with immobility and weakness in all extremities. -The resident's right and left upper extremity strength and range of motion was impaired. -No pain was present per resident verbal and nonverbal communication. -The resident's goal for therapy was to return home. -The resident could benefit from skilled therapy to return home. Resident 23's 1/2/24 Potential for Harm due to Substance Use Care Plan indicated the resident was to utilize a carrot (an alternative nonsurgical solution for management of contractures of the hand) in the right hand and an edema glove (used to push excess fluid out of the hand) on the left hand during the day. Resident 23's 3/10/24 Quarterly MDS indicated the resident was moderately cognitively impaired and she/he experienced upper extremity impairment on both sides. Resident 23's 5/2024 Physician Orders directed the following: -The resident was to wear an edema glove to her/his left hand during the day and it was to be removed at night PRN. -PT and OT evaluation and treatment as indicated. No evidence was found in Resident 23's clinical record to indicate the resident's upper extremity impairments were comprehensively assessed, ongoing monitoring of her/his upper extremity impairments was being provided or exercises were being completed to maintain or improve the resident's range of motion/mobility or to prevent further declines. No rationale was found as to why range of motion services were not being provided. Additionally, no evidence was found to indicate care plan interventions were implemented as directed or that the care plan was reviewed or revised to determine if interventions were effective. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 5/13/24 at 1:53 PM Resident 23 was observed in her/his room in bed visiting with Witness 1 (Spouse). Resident 23's middle, ring and little fingers on both of her/his hands curled into the palm of her/his hands. No carrot was observed in either of the resident's hands. Resident 23 stated she/he was unable to extend any of those fingers on either hand, her/his hands were not too good and they caused her/him a great deal of pain. Witness 1 stated she was at the facility three times daily to assist Resident 23 at meal times. Witness 1 stated Resident 23 was supposed to use a carrot in her/his right hand to prevent her/his contracture from worsening but stated staff had not offered it to Resident 23 in months. Witness 1 stated Resident 23 rarely received any restorative therapy for either of her/his hand contractures as there was only one CNA in the building who provided any sort of stretching or range of motion exercises and Resident 23 was often not assigned to that particular CNA. Witness 1 further stated Resident 23 did not have a carrot for her/his left hand or anything else to prevent further decreases in her/his range of motion in that hand. Resident 23 stated she/he was interested in receiving restorative therapy for her/his hands. Witness 1 stated she thought staff were aware of the resident's interest. On 5/15/24 at 10:10 AM Staff 21 (CNA) stated Resident 23 was not care planned to receive any type of restorative therapy or stretching exercises for her/his hands. Staff 21 stated the resident had a carrot for one of her/his hands but he only offered it to the resident when he remembered. Staff 21 stated Resident 23 regularly complained of pain in her/his hands and stated the resident would scream in pain when he barely brushed her/his finger. On 5/15/24 at 11:53 AM Staff 15 (CNA) stated Resident 23 did not receive any restorative therapy. Staff 15 stated Resident 23 did not have hand contractures when [she/he] first came here and her/his hand contractures have gotten worse. Staff 15 further stated Resident 23 regularly complained about pain in her/his hands. On 5/15/24 at 1:12 PM Staff 22 (CNA) stated Resident 23 had contractures in both of her/his hands, and she was unsure if anything was being done to prevent the contractures from worsening. Staff 22 stated Resident 23 was cooperative with care, she had not seen the resident ever use a carrot in either of her/his hands and the resident frequently complained about pain in her/his hands. On 5/15/24 at 1:35 PM Staff 14 (LPN) stated Resident 23 should have restorative stuff for [her/his] upper body and hands because of [her/his] contractures. Staff 14 reviewed Resident 23's electronic record and stated the resident did not have a restorative plan in place. Staff 14 further stated she had never seen the resident use a carrot in either of her/his hands, and she was not aware of anything being done to prevent her/his contractures from worsening. On 5/16/24 at 12:51 PM Staff 3 (RNCM) stated residents with contractures required assessments and monitoring, and she would initiate an RA program for any resident who experienced a functional decline. Staff 3 stated she was unsure of when Resident 23's contractures started and could not explain the change in MDS coding that occurred in 12/2023 which indicated the resident had bilateral upper extremity impairments. Staff 3 stated the resident's bilateral hand contractures were not being monitored, had not been assessed and she was unsure if her/his current care plan for contractures was appropriate. Staff 3 further stated she was unsure if the carrot for the resident's right hand was effective or being utilized, nothing was in place for contracture prevention for her/his left hand and the resident was appropriate for an RA program but she had not initiated such a program for the resident. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 5/16/24 at 1:46 PM Staff 2 (Regional RN) acknowledged the lack of assessing and monitoring of Resident 23's contractures to ensure they didn't worsen, and expected this in place for the resident. Staff 2 stated she was surprised they don't have a restorative program in place for [her/him].

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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. 47000 Based on observation, interview and record review it was determined the facility failed to implement fall prevention interventions and evaluate and analyze resident falls for 2 of 5 sampled residents (#s 23 and 32) reviewed for position and mobility and accidents. This placed residents at risk for injury. Findings include: 1. Resident 23 was admitted to the facility in 6/2023 with diagnoses including spinal stenosis (narrowing of the spinal column that can cause pressure on the spinal cord). Resident 23's 9/8/23 Quarterly MDS revealed the resident was severely cognitively impaired and had experienced two or more falls with injury and two or more falls without injury since her/his prior assessment. Resident 23's 12/27/23 SNF Morse Fall Scale indicated the resident was considered at moderate risk for falling. Resident 23's 3/11/24 At Risk for Falls Care Plan revealed the following: -The resident was considered a high fall risk. -The resident had a history of self-transferring out of bed and falling on the floor. -A bedside fall mat was to be placed next to the resident's bed to reduce risk for injury. -The resident's bed was to be in the lowest position when she/he was in bed to help prevent injuries related to multiple falls out of bed. On 5/14/24 at 2:01 PM Resident 23 was observed in her/his room in bed. The resident's eyes were open and she/he was talking to her/himself. The resident's bed was elevated to waist height. At 2:10 PM Staff 23 (CNA) entered the resident's room and moved her/his bed to the low position. On 5/14/24 at 2:11 PM Staff 23 stated Resident 23 often kicked her/his legs off of the side of her/his bed and would try to get up on her/his own when she/he was restless. Staff 23 stated Resident 23's bed was to be kept in a low position when she/he was in bed and stated the bed height was too high when she just went in and if she had been paying close enough attention she would have gotten that taken care of. On 5/15/24 at 9:44 AM Resident 23 was observed in her/his room in bed. The resident's eyes were open, she/he moved her/his upper body around in bed and made loud, nonsensical verbalizations that could be heard from the hallway. The resident's bed was elevated to waist height and no fall mat was in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 10:10 AM Staff 21 (CNA) stated Resident 23 was considered at risk to fall and the resident was supposed to have a fall mat in place and the bed was to be in the low position when she/he was in bed. Staff 21 confirmed the resident's bed at this time was too high and a fall mat should have been in place. On 5/16/24 at 1:46 PM Staff 2 (Regional RN) acknowledged Resident 23's care plan was not being implemented and expected staff to follow the resident's fall care plan. 38140 2. Resident 32 was admitted to the facility in 3/2024 with diagnoses including Rhabdomyolysis (breakdown of muscle tissue which releases protein into blood system). Resident 32's 5/3/24 Significant Change of Condition MDS indicated a BIMS score of 07 (severe cognitive impairment). Review of Resident 32's 5/5/24 at 2:35 AM Progress Note revealed she/he was found lying on the floor to the left side of her/his bed. The Progress Note indicated Resident 32 stated she/he hit her/his left forehead on the floor during the fall. Resident 32's 5/5/24 at 2:35 AM Fall incident report was initiated and was not completed as of 5/16/24. There was no indication the facility identified risks or hazards to the fall, evaluated or analyzed the fall risks or hazards, establish a root cause for the fall or implemented interventions to reduce risks or hazards for the 5/5/24 at 2:34 AM fall. Review of Resident 32's 5/5/24 at 7:35 PM Progress Note revealed she/he was found lying on the floor next to her/his bed. Resident 32 hit her/his head on the bed side oxygen concentrator, obtained a contusion (bruise) to her/his left eyebrow. Resident 32's 5/5/24 at 10:35 PM fall did not have a Fall Incident Report initiated by 5/16/24. There was no indication the facility identified risks or hazards to the fall, evaluated or analyzed the fall risks or hazards, establish a root cause for the fall or implemented interventions to reduce risks or hazards for the 5/5/24 fall at 7:35 PM. On 5/16/24 at 11:22 AM Staff 4 (LPN) stated when a resident experienced a fall the licensed nurse was expected to complete an initial assessment of the resident and initiate a Fall incident report in the resident's health record. On 5/16/24 at 11:31 AM Staff 2 (Regional RN) and Staff 14 (LPN/Resident Care Manager) acknowledged Resident 32 experienced two falls on 5/5/24. Staff 2 and Staff 14 confirmed there was no Fall Incident Reports completed for the resident's falls on the 5/5/24 at 2:35 AM and 5/5/24 at 7:35 PM. Staff 2 stated for every fall she expected a completed Fall Incident Report, full investigation which included a root cause analysis, care plan interventions assessed, and the fall analyzed for risks and potential hazards.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 38140 Based on observation, interview and record review it was determined the facility failed to obtain physician orders, ensure respiratory equipment was properly maintained and administer oxygen as ordered for 2 of 3 sampled residents (#s 28 and 32) reviewed for respiratory care. This placed residents at risk for adverse respiratory effects and discomfort. Findings include: The facility's 6/2022 Respiratory Treatment Policy and Procedure indicated the following: - The amount, method and duration of oxygen usage and diagnosis were identified on the resident's treatment record per the physician orders and care plan. - Oxygen concentrator filters were cleaned weekly and documented. 1. Resident 32 was admitted to the facility in 3/2024 with diagnoses including Rhabdomyolysis (breakdown of muscle tissue which releases protein into blood system). Resident 32's 5/3/24 Significant Change of Condition MDS indicated she/he received oxygen therapy. Resident 32 was observed on multiple occasions with oxygen administered through a nasal cannula (device which gives oxygen through nose) on 5/13/24 to 5/15/24 between the hours of 7:38 AM to 2:38 PM. Record review of Resident 32's health record revealed no evidence of a physician order which directed the facility to administer oxygen. No plan of care directed staff how to monitor or administer oxygen for Resident 32. On 5/15/24 at 11:21 AM Staff 24 (CNA) confirmed Resident 32 wore oxygen daily. Staff 24 stated she knew to assist her/him to wear the oxygen by the Kardex (plan of care). On 5/15/24 at 11:30 AM Staff 2 (Regional RN) confirmed Resident 32's health record did not include a physician order to administer oxygen and the plan of care did not direct staff to administer oxygen. Staff 2 stated she would expect a resident to have a physician order for oxygen therapy. 47000 2. Resident 28 was admitted to the facility in 4/2024 with diagnoses including acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Resident 28's 4/16/24 Admission MDS revealed the resident was cognitively intact and received continuous oxygen therapy. Resident 28's 5/2024 Physician Orders directed the resident to receive continuous oxygen at two liters per minute via nasal cannula (a device used to deliver supplemental oxygen to a person in need of respiratory help) as needed for shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 1:12 PM Resident 28 was observed in her/his room and sat in her/his wheelchair with the nasal cannula attached to the oxygen concentrator around her/his neck. The oxygen concentrator was set to deliver 2.5 liters of oxygen per minute and the filter at the back of the concentrator was observed to have a thick layer of whitish dust covering the entire filter. Resident 28 stated she/he did not think her/his concentrator had been cleaned since she/he admitted to the facility, and she/he was able to independently remove the cannula from her/his nose when she/he felt she/he did not need the supplemental oxygen. On 5/15/24 at 10:45 AM Staff 27 (CNA) stated nurses were responsible for setting and adjusting the oxygen liter flow on a resident's concentrator. Staff 27 stated CNAs were supposed to check the filter on a resident's concentrator once a shift in order to ensure it was clean. Staff 27 further stated he checked the filter on Resident 28's concentrator this morning and made sure it was clean and clear and not dirty by any means. The surveyor and Staff 27 then observed Resident 28's concentrator. Staff 27 stated the concentrator was set to deliver 2.5 liters of oxygen and the filter had a lot of build up. Staff 27 removed and cleaned the filter. On 5/15/24 at 12:01 PM Staff 15 (CNA) stated nurses were responsible for setting and adjusting the oxygen liter flow on a resident's concentrator. Staff 15 further stated CNAs were responsible for the general cleaning of concentrators and maintenance was responsible for cleaning the filters. On 5/15/24 at 1:01 PM Staff 25 (CNA) stated she thought CNAs were allowed to set and adjust the oxygen liter flow on a resident's concentrator but half the time it was where it needed to be. Staff 25 stated CNAs wiped down concentrators but had never been told who was responsible for cleaning the filter on the back of the concentrator. On 5/15/24 at 1:30 PM Staff 7 (Environmental Services) stated the facility utilized a rental company who maintained and cleaned the concentrators on a monthly basis. Staff 7 also stated maintenance staff looked at concentrator filters on a weekly basis but they typically didn't need changed because filters don't typically get that bad. Staff 7 stated in a week hardly any build up would be noticeable on a concentrator filter. On 5/15/24 at 2:44 PM Staff 2 (Regional RN) and Staff 28 (RN) acknowledged staff were unclear on who was responsible for cleaning the filters on the concentrators. Staff 2 confirmed Resident 28 was to receive two and not 2.5 liters of oxygen per minute when she/he used her/his concentrator. At 2:59 PM Resident 28 was observed in bed with her/his concentrator on and nasal cannula in place. Staff 28 adjusted the resident's concentrator at this time from 2.5 to two liters.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34702 Based on interview and record review it was determined the facility failed to document a clinical rationale for pharmacy recommendations for 2 of 5 sampled residents (#s 3 and 24) reviewed for unnecessary medications. This placed residents at risk for unnecessary medication administration. Findings include: 1. Resident 24 admitted to the facility in 2023 with diagnoses including dementia and mood disorder. The 4/26/24 pharmacist recommendation indicated the following: -Resident 24 received Abilify (an antipsychotic medication) 10 mg daily since 5/13/23. -Centers for Medicare and Medicaid Services (CMS) guidelines require that gradual dose reductions be attempted in two separate quarters (with at least one month between the attempts) during the first year; then annually thereafter, unless clinically contraindicated. Please assess if resident is a candidate for GDR for the medications. -CMS requires written rationale when declining pharmacist recommendations. Resident 24's pharmacy recommendation was signed by the physician on 5/15/24 and indicated no change to the medication. No clinical rationale was provided to continue to the medication. On 5/16/24 at 2:03 PM Staff 2 (Regional RN) acknowledged no clinical rationale was provided for Resident 24's continued use of Abilify. 2. Resident 3 admitted to the facility in 2012 with diagnoses including anxiety disorder. The 4/26/24 pharmacist recommendation indicated the following: -Resident 3 received Celexa (an antidepressant medication) 20 mg daily since 6/9/23 and clonazepam (medication used for anxiety) 0.5 mg twice daily since 4/29/23. -Centers for Medicare and Medicaid Services (CMS) guidelines require that gradual dose reductions be attempted in two separate quarters (with at least one month between the attempts) during the first year; then annually thereafter, unless clinically contraindicated. Please assess if resident is a candidate for GDR for the medications. -CMS requires written rationale when declining pharmacist recommendations. Resident 3's pharmacy recommendation was signed by the physician on 5/15/24 and indicated no change to the medication. No clinical rationale was provided to continue to the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 2:03 PM Staff 2 (Regional RN) acknowledged no clinical rationale was provided for Resident 3's continued use of Celexa and clonazepam.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34702 Based on interview and record review it was determined the facility failed to attempt gradual dose reductions (GDRs) for 1 of 5 sampled residents (#3) reviewed for medications. This placed residents at risk for unnecessary psychotropic medications. Findings include: Resident 3 admitted to the facility in 2012 with diagnoses including anxiety disorder. The 4/12/24 physician order indicated Resident 3 received clonazepam (medication used for anxiety) 0.5 mg BID for anxiety disorder. On 5/15/24 the clinical record was reviewed and indicated Resident 3 received clonazepam 0.5 mg twice daily since 4/29/23. The 4/26/24 pharmacist recommendation indicated the following: -Resident 3 received clonazepam 0.5 mg twice daily since 4/29/23. -Centers for Medicare and Medicaid Services (CMS) guidelines require that gradual dose reductions be attempted in two separate quarters (with at least one month between the attempts) during the first year; then annually thereafter, unless clinically contraindicated. Please assess if resident is a candidate for GDR for the medications. -CMS requires written rationale when declining pharmacist recommendations. On 5/15/24 at 10:00 AM Resident 3's clinical record revealed no dose changes or GDRs were completed and there was no clinical rationale to continue the medications. Behavior Monitoring records were reviewed from 4/15/24 through 5/15/24 and revealed no behaviors were documented for Resident 3. On 5/16/24 at 2:03 PM Staff 2 (Corporate RN) acknowledged no behaviors were documented from 4/15/24 through 5/15/24 for Resident 3. Staff 2 acknowledged Resident 3 received clonazepam 0.5 mg BID since 4/29/23, a GDR was not attempted and there was no clinical rationale to support the continued use of clonazepam.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34702 Based on observation, interview and record review it was determined the facility failed to maintain a medication error rate of less than 5 percent. There were seven errors out of 28 opportunities resulting in a 25 percent error rate. This placed residents at risk for adverse medication side effects and pain. Findings include: 1. Resident 6 admitted to the facility in 2018 with diagnoses including chronic pain and osteoarthritis. The 4/12/24 physician order indicated Resident 6 was to receive: -gabapentin (pain medication) 300 mg TID; -Voltaren gel (pain gel used for osteoarthritis) apply to bilateral hands topically three times a day. a. On 5/14/24 at 12:06 PM Staff 12 (RN) was observed to administer the morning doses of gabapentin and Voltaren gel to Resident 6. The 5/14/24 time stamped MAR indicated gabapentin and Voltaren gel were due at 7:00 AM and not administered until 12:06 PM On 5/14/24 at 12:06 PM Staff 12 acknowledged the late medication administration of gabapentin and Voltaren gel. On 5/17/24 at 9:43 AM Staff 2 (Corporate RN) acknowledged the identified medication errors due to the late administration of gabapentin and Voltaren gel for Resident 6 on 5/14/24. b. On 5/16/24 at 10:34 AM Staff 13 (RN) was observed to administer morning doses of gabapentin and Voltaren gel to Resident 6. The 5/16/24 time stamped MAR indicated gabapentin was due at 7:00 AM and not administered until 10:35 AM and Voltaren gel was due at 7:00 AM and not administered until 10:38 AM. On 5/16/24 at 10:34 AM Staff 13 acknowledged the late medication administration of gabapentin and Voltaren gel. On 5/17/24 at 9:43 AM Staff 2 (Corporate RN) acknowledged the identified medication errors due to the late administration of gabapentin and Voltaren gel for Resident 6 on 5/16/24. 2. Resident 32 admitted to the facility in 2024 with diagnoses including hypertension. The 5/3/24 physician order indicated Resident 32 was to receive Ipratropium Bromide nasal solution two sprays in nostrils TID for dry nostrils. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 10:25 AM Staff 13 (RN) was observed to administer Ipratropium Bromide nasal solution one spray in Resident 32's nostrils. On 5/16/24 at 11:26 AM Staff 13 reviewed the physician order and acknowledged the order was for Ipratropium Bromide nasal solution two sprays in nostrils and she only administered one spray in Resident 32's nostrils. On 5/17/24 at 9:43 AM Staff 2 (Corporate RN) acknowledged the identified errors for Resident 32. 3. Resident 14 admitted to the facility in 2022 with diagnoses including Parkinson's disease and psychotic disorder. The 5/13/24 physician order indicated Resident 14 was to receive carbidopa levodopa 25-100 mg TID for Parkinson's disease and Seroquel 50 mg in the evening for psychotic disorder. On 5/16/24 at 2:24 PM Staff 16 (CMA) was observed to administer carbidopa levodopa 25-100 mg and Seroquel 50 mg to Resident 14. On 5/16/24 at 2:24 PM Staff 16 reviewed the chart and stated the last dose of carbidopa levodopa was administered on 5/16/24 at 11:08 AM and acknowledged the short duration of time between doses. Staff 16 acknowledged she administered the evening dose of Seroquel at 2:24 PM. On 5/17/24 at 9:43 AM Staff 2 (Corporate RN) acknowledged the identified errors for Resident 14 and stated evenings medications should not be administered in the afternoon.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053 Based on observation, interview and record review it was determined the facility failed to ensure foods were labeled and stored in a way to minimize food spoilage and cross contamination, failed to maintain a clean and sanitary environment for food preparation and failed to prevent potential contamination of the ice machine in 1 of 1 kitchen reviewed for sanitation. This placed residents at risk for potential infections related to foodborne pathogens. Findings include: 1. On 5/13/24 at 11:24 AM in the facility's kitchen, the following items were observed in the middle refrigerator: -A partially-consumed one-gallon plastic container of [NAME] Salad Dressing (labeled 8/1); -A partially-consumed one-gallon plastic container of pickle spears (labeled 11/16); -A partially-consumed one-gallon plastic container of dijon mustard (labeled 8/1); -A partially-consumed one-gallon plastic container of Ranch dressing (labeled 3/20); -A partially-consumed one-gallon plastic container of black olives (labeled 3/15); -A partially-consumed one-gallon plastic container of jalapenos peppers (labeled 3/15); -A stainless steel bin of individually-bagged ham and cheese sandwiches (none of the sandwiches were labeled or dated); and -An individually-bagged ham and cheese sandwich (unlabled and undated) on a tray with a package of string cheese. On 5/13/24 at 11:24 AM Staff 29 (Cook) commented on the sandwiches and stated, I think they were probably made yesterday. Should I write yesterday's date on it? On 5/13/24 at 11:48 AM Staff 11 (Dietary Manager) stated she did not know if the dates on the gallon containers of condiments were the open dates and she was unable to know when to discard them based on the way they were labeled. She stated the way they were labeled made it impossible to know if they were opened during the current year or a previous year. She stated, They should be labeled more clearly and the dates should include the year. I think it's better to have the open date and discard date just to be safe. On 5/13/24 11:58 AM Staff 11 stated dietary staff made a supply of sandwiches daily and she expected them to be individually labeled and dated. 2. On 5/13/24 at 11:24 AM a pork loin was observed to be thawing on a rack positioned directly above portions of thawing chicken in the thawing refrigerator located adjacent to the end of the food prep area and cook top. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/13/24 at 11:48 AM Staff 11 (Dietary Manager) stated she expected the meats to be positioned to thaw at the bottom of the refrigerator so they would not drip on other items. 3. On 5/15/24 at 12:07 PM the following unsanitary conditions were observed in the facility's kitchen: -Dust and grit on the supply shelves over the main food prep area; -Accumulated fuzz and dust on the ceiling support beam and shelving over the main food prep area and on the pipes over the steam table. Air circulated from the vents in the kitchen caused the fuzz to circulate over food trays and the steam table. On 5/15/24 at 12:07 PM Staff 11 (Dietary Manager) stated she expected these items to be clean so the dust did not land on the residents' food. 4. On 5/15/24 at 12:21 PM a test tray containing lunch was observed to have a weathered, oxidized and pitted dome covering the plate of food. The dome appeared grey despite its original color being maroon. The dome appeared unclean due to its worn nature. On 5/15/24 at 12:36 PM Staff 1 (Administrator) observed the test tray and stated the dome appeared weathered. He stated he expected the domes to be in better repair for the residents. 5. The Federal Food Sanitation Rules code 5-402.11 Backflow Prevention directed facilities to ensure a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 5/15/24 at 1:59 PM the facility's ice machine in the 200 hall was observed to drain directly into the floor plumbing without an air gap. The machine was also observed to have an ice scoop in a holster on the right side of the machine. There was standing water inside the holster and black dust particles floated on the surface of the water. Used PPE, black grime and debris were observed in a puddle of water under the ice machine. On 5/15/24 at 2:10 PM Staff 1 (Administrator) observed the ice machine and stated he understood the need for an airgap in the ice machine's drain plumbing to protect the ice from potential back flow from the sewar line. He also observed the unsanitary conditions in the ice scoop holster and under the ice machine. He stated he expected the ice machine and the area around it to be clean to protect the residents.