STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure residents were treated with dignity for 1 of 10 sampled residents (#29) reviewed for dining. This placed residents at risk for lack of dignity. Finding include: Resident 29 admitted to the facility in 11/2023 with diagnoses including kidney disease. On 11/18/24 at 12:24 PM during the lunch meal on the third floor Resident 29 and Resident 7 were observed seated at a dining table together. Staff delivered Resident 7's lunch but not Resident 29's. Staff then proceeded to deliver lunch to other residents in the dining room. Resident 7 was observed to stop and ask multiple staff multiple times where Resident 29's lunch was. Staff acknowledged Resident 29 waited for a long time for lunch since Resident 7's lunch was served. Staff's response to Resident 7 was Resident 29's meal was getting dished up. Resident 29 began asking staff were her/his meal was and staff stated her/his lunch was being dished up. Staff 7 stopped eating and stated she/he did not want to eat in front of Resident 29, so she/he would wait for Resident 29 to receive her/his lunch. On 11/18/24 at 12:42 PM Resident 29 was served her/his lunch, which was 18 minutes after Resident 7 was served her/his lunch. On 11/18/24 at 1:10 PM Staff 1 (Administrator) stated she expected staff to serve meals one table at a time, and make sure each resident at the table had their meal served before moving to another table to serve.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 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. 42270 Based on interview and record review it was determined the facility failed to timely inform the resident representative of the risks and benefits of psychotropic medication use for 1 of 5 sampled residents (#18) reviewed for medications. This placed residents at risk for the lack of informed consent. Findings include: Resident 18 admitted to the facility in 10/2024 with diagnoses including dementia. An 10/24/24 Admission MDS revealed Resident 18's cognition was severely impaired. A review of Resident 18's 11/2024 MAR revealed she/he had an 10/18/24 order to for lorazapam (an anti-anxiety medication) as needed, and received the medication on 11/1/24, 11/3/24, and 11/10/24. A Consent for Treatment for Anti-Anxiety to administer lorazapam was completed on 11/12/24 by Resident 18's representative. In an interview on 11/20/24 at 10:42 AM Staff 3 (LPN Resident Care Manager) stated Resident 18 did not have a consent for lorazapam, so she completed one on 11/12/24 after the medication was administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 42270 Based on interview and record review it was determined the facility failed to complete a comprehensive assessment within the required timeframe for 1 of 2 sampled residents (#2) reviewed for resident assessment. This placed residents at risk for unassessed needs. Findings include: Resident 2 admitted to the facility in 6/2018 with diagnoses including respiratory failure. The Assessment Lookup for Resident 2 revealed the following MDS assessments were completed: 9/7/23 Annual MDS, 12/8/23 Quarterly MDS, 3/9/24 Quarterly MDS, and 6/10/24 Quarterly MDS. A 11/15/24 Annual MDS was open and in progress. On 11/18/24 at 10:50 AM Staff 1 (Administrator) confirmed the facility did not complete the Annual MDS due in 9/2024 for Resident 2 within the required timeframe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50926 Based on observation, interview, and record review it was determined the facility failed to ensure accurate assessments for 1 of 1 sampled resident (#31) reviewed for limited range of motion. This placed residents at risk for unassessed needs. Findings include: Resident 31 admitted to the facility in 10/2024 with diagnoses including Alzheimer's disease and Type 2 Diabetes The Admission MDS dated [DATE] revealed Resident 31 had no limitations of her/his upper extremities (shoulder, elbow, wrist, hand). Review of Resident 31's Active Care Plan dated 10/3/24 revealed the resident had impaired functional status in bed mobility, transfers, walking, toileting, dressing, locomotion, eating, grooming, hygiene, and bathing. Interventions included to insert a rolled ace wrap or washcloth in her/his hands daily to prevent progression of her/his bilateral hand contractures (fingers bent toward the palm of the hand, the affected fingers could not straighten completely). On 11/18/24 Resident 31 was observed to have contractures to both hands. No splinting was observed. On 11/20/24 at 1:14 PM Witness 1 (Family Member) stated they were aware of the hand contractures present on admission and brought cloth covered intervention devices from the previous facility. On 11/20/24 at 12:36 PM Staff 3 (LPN Resident Care Manager) confirmed the hand contractures were present on admission and were not coded on the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for 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. 50926 Based on observation, interview, and record review it was determined the facility failed to ensure a resident with limited ROM received appropriate treatment and services to prevent further decline for 1 of 1 sampled resident (#31) reviewed for ROM. This placed residents at risk for worsening contractures. Findings include: Resident 31 admitted to the facility in 10/2024 with diagnoses including Alzheimer's disease and Type 2 Diabetes. Review of Resident 31's Active Care Plan dated 10/3/2024 revealed the resident had impaired functional status in bed mobility, transfers, walking, toileting, dressing, locomotion, eating, grooming, hygiene, and bathing. Interventions included to insert a rolled ace wrap or washcloth into her/his hands daily to prevent progression of her/his bilateral hand contractures (fingers bent toward the palm of the hand, the affected fingers cannot straighten completely). On 11/18/24 Resident 31 was observed to have contractures to both hands. No contracture interventions were observed. On 11/21/24 at 7:27 AM Staff 15 CNA stated care of Resident 31's hands included cleaning hands and nails. Staff 15 was not aware of any care related to the resident's contractures. On 11/20/24 at 1:14 PM Witness 1 (Family Member) stated they were aware of the hand contractures and brought cloth-covered intervention devices from the previous facility. Additionally she stated the devices were now difficult to get into the resident's hands because her/his fingers were more tight, and staff did not use the devices much. On 11/20/24 at 12:36 PM Staff 3 (LPN resident Care Manager) confirmed the hand contractures were present on admission, and a care plan intervention was put in place. She confirmed staff should have followed the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 34703 Based on observation, interview, and record review it was determined the facility failed to serve food in a sanitary manner for 2 of 2 dining rooms. This placed residents at risk for foodborne illness. Findings include: On 11/18/24 at 12:14 PM the lunch meal service was observed on the third floor dining room. Staff 7 (CNA) donned gloves and touched multiple surfaces including cupboards, clean cups, clean plates, a refrigerator and serving utensils multiple times throughout the meal and did not change her gloves. On 11/18/24 Staff 7 stated gloves were to be worn in the kitchen, and staff should change gloves after touching multiple surfaces in the kitchen before touching clean plates, cups, or food items. On 11/19/24 at 8:42 AM the breakfast meal service was observed in the second floor dining room. Staff 11 (Cook) served multiple food item and touched plates and serving utensils, but did not wear gloves throughout the meal service. On 11/19/24 at 11:58 AM the lunch meal service was observed on the third floor dining room. Staff 6 (RNCM) donned gloves and touched multiple surfaces including cupboards, clean cups, clean plates, a refrigerator and serving utensils multiple times throughout the meal and did not change her gloves On 11/19/24 at 12:25 PM Staff 6 stated she wore the same gloves while assisting in the kitchen during lunch. Staff 6 confirmed she touched cupboards, clean cups, clean utensils, a refrigerator, and juice containers. Staff 6 stated she always wore the same gloves while assisting in the kitchen. On 11/19/24 at 12:28 PM Staff 11 was observed serving lunch in the second floor dining room without wearing any gloves. Staff 11 used utensils to serve food and directly touched the residents' plates. On 11/19/24 at 12:23 PM Staff 18 (Server) assisted with meal service. She removed her gloves and with ungloved hands touched multiple meal trays to be delivered. Staff 18 then then sanitized her hands. On 11/19/24 at 12:46 PM Staff 19 (Infection Preventionist) stated staff should change their gloves and sanitize their hands after touching any equipment before they touch clean cups, dishes, silverware, and food items. 42270 2. On 11/19/24 at 12:31 PM Staff 12 (CMA) was observed in the second floor dining room. Staff 12 picked up a chair and moved it next to Resident 30's table, after which no hand hygiene was completed. Staff 12 sat down next to Resident 30 and assisted Resident 30 with the meal by picking up her/his fork, encouraging her/him to eat, then placing the fork down, looked through a newspaper on the table, and then picked up the resident's fork again and assisted her/him to eat. No hand hygiene was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/19/24 at 12:42 PM Staff 12 acknowledged she did not do hand hygiene after moving a chair to Resident 30's table, and did not do hand hygiene before assisting Resident 30 with her/his meal when she should have.