STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385211	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Grande Post Acute Rehabilitation	91 Aries Lane LA Grande, OR 97850

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on interview and record review it was determined the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 3 (#1) sampled residents reviewed for abuse. This placed residents at risk for abuse. Findings include: The facility's Investigation of Alleged Sexual Abuse policy, updated 10/2022, defined sexual abuse as non consensual sexual contact of any type with a resident, which included unwanted intimate touching of any kind, especially the breast or perineal area. Resident 1 was admitted to the facility in 8/2024, with diagnoses including multiple sclerosis. Resident 1's Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated she/he was cognitively intact. Resident 2 was admitted to the facility in 5/2024 with diagnoses including stroke. Resident 2's Quarterly MDS dated [DATE] revealed a BIMS score of 13 which indicated she/he was cognitively intact. On 2/25/25, the facility submitted a FRI to the State Survey Agency which revealed Resident 2 was observed with her/his hand in the genital area of Resident 1, who was seated in her/his wheelchair in the facility's dining hall. Resident 2 was immediately taken to her/his room and Staff 1 (Administrator) initiated an investigation. On 4/2/25 at 2:12 PM, Resident 1 stated she/he recalled the incident from 3/25/25. She/he revealed Resident 2 had touched her/his genital area over the clothing on that date. Resident 1 stated Resident 2 was taken away from the dining room by a nurse immediately after the incident. She/he denied that she/he was afraid of Resident 2, confirmed she/he had seen Resident 2 since the incident and there was always staff present with Resident 2 in the dining room or hallways. Resident 1 confirmed she/he felt safe and wanted to remain living in the facility. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:17 PM, Staff 5 (CNA) was observed to provide 1:1 supervision for Resident 2. She stated she was Resident 2's assigned CNA on 3/25/25 and was aware Resident 2 had a history of touching other residents inappropriately. Staff 5 stated she was assigned to the dining room for lunch duty and had left the dining room to return another resident to their room. When she came back to the dining room, Resident 2 had already been taken out of the dining room. Staff 5 stated she was gone only for a minute but acknowledged Resident 2 moved very quickly in her/his wheelchair, stating she/he was 20 feet away (from Resident 1), it was that quick. On 4/2/25 at 2:56 PM, Staff 3 (Dietary Manager) stated he was working in the kitchen on 3/25/25 and was told by the cook something was going on in the dining room. Staff 3 walked into the dining room and observed Resident 2 sitting in her/his wheelchair next to Resident 1, who was seated in her/his wheelchair facing the kitchen. Staff 3 stated Witness 3 (facility resident) was yelling and told him Resident 2 had her/his hand all the way up Resident 1's thigh. Staff 4 (LPN) had entered the room the same time as Staff 3 and removed Resident 2 from the dining room. Staff 3 then spoke to Resident 1, who stated she/he was okay. Staff 3 stated there were no other CNA or staff in the dining room when the incident occurred. On 4/2/25 at 3:22 PM, Witness 3 (facility resident) stated she was in the dining room on 3/25/25 and it was just her, Resident 1 and Resident 2. She decided to stay in the dining room with Resident 1 and was seated at a different table. Witness 3 observed Resident 2 go to Resident 1's table and talked to her/him, then leaned toward Resident 1, who told Resident 2 to leave her/him alone. Resident 2 then moved closer in to Resident 1 and Witness 3 observed her/him put her/his hand up Resident 1's pants leg. Witness 3 stated Resident 1 then said no, no, go away to Resident 2, who still had her/his hand on Resident 1's upper leg area. Witness 3 started yelling at Resident 2 to stop and for help and stated staff immediately came to the dining room. Witness 3 stated a CNA had been assisting Resident 1 with eating but had left to take someone to their room when the incident occurred. On 4/2/25 at 3:52 PM, Staff 4 (LPN) stated she worked on 3/25/25 day shift, was at the nurse's station and heard yelling from the dining room. She ran down to the dining room and observed Resident 2 facing the kitchen doors seated right next to Resident 1. Staff 4 did not observe any physical contact and stated she could tell Resident 1 was distressed by her/his voice and facial expression. She stated another resident in the dining room was yelling. She noted Resident 2 was cognitively intact and had a smirk on her/his face when she came into the dining room. She stated she told Resident 2 she was going to take her/him to their room and the resident was agreeable. Resident 2 was observed in her/his room on 4/2/25 at 2:08 PM and 3:45 PM. Resident 2 was unavailable for an interview. On 4/2/25 at 5:00 PM, Staff 1 (Administrator) was advised of the investigative findings. He stated Resident 2 would remain on one to one supervision during waking hours until a more appropriate placement was found.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on interview and record review it was determined the facility failed to implement the plan of care for 1 of 3 sampled residents (#2) reviewed for care plans. This placed residents at risk of abuse. Findings include: Resident 2 was admitted to the facility in 5/2024, with diagnoses including stroke. Resident 2's Quarterly MDS dated [DATE] revealed a BIMS score of 13 which indicated she/he was cognitively intact. Resident 2's care plan, revised 2/3/25, indicated she/he had disinhibited sexual behaviors related to touching residents of the opposite gender. Interventions included Resident 2 was to be in line of sight of staff and was not to dine with opposite gender residents. On 4/2/25 at 2:12 PM, Resident 1 stated she/he recalled the incident from 3/25/25. She/he revealed Resident 2 had touched her/his genital area over the clothing on that date. Resident 1 stated Resident 2 was taken away from the dining room by a nurse immediately after the incident. On 4/2/25 at 2:17 PM, Staff 5 (CNA) stated she was Resident 2's assigned CNA on 3/25/25 and was aware Resident 2 had a history of touching other residents inappropriately. Staff 5 stated she was assigned to the dining room for lunch duty and had left the dining room to return another resident to their room and left Resident 2 alone with other residents in the dining room. Staff 5 stated she was gone only for a minute but acknowledged Resident 2 moved very quickly in her/his wheelchair, stating she/he was 20 feet away (from Resident 1), it was that quick. On 4/2/25 at 5:00 PM, Staff 1 (Administrator) acknowledged the facility did not follow Resident 2's care plan related to supervision in the dining room and Resident 2 would be on one to one supervision during waking hours until a more appropriate placement was found.