

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER LA Grande Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interview and record review it was determined the facility failed to ensure kitchen equipment was clean and sanitary, and dishes were adequately cleaned for 1 of 1 kitchen reviewed. This placed residents at risk of illness and contaminated food. Findings include: The facility's Sanitation Policy dated 10/2008 indicated the following:- Utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas. The facility's Dishwashing Policy dated 10/2/20 indicated the following:- The person assigned to dishwashing should allow all items to air dry prior to storage.1. Observations of the facility's dishwashing process on 7/20/26 from 10:42 AM through 1:11 PM, revealed Staff 9 (Dietary Aide) complete the following:- Put away multiple, visibly wet, serving utensils, cooking pans, and steam table pans away with visible drips of water.- Rinse a steam table pan, which had residual food scraps after being run through the dish washer, and put it away without rewashing or allowing the pan to dry.On 7/20/26 at 1:11 PM Staff 9 confirmed she put the dishes away wet and had not rewashed the pan with food debris. Staff 9 stated she should have rewashed the pan and allowed the dishes to dry before putting them away.On 7/20/26 at 1:23 PM Staff 5 (Dietary Manager) stated the expectation was to rewash dishes that come out of the dishwasher with food debris or was visibly dirty and allow dishes to dry before they were put away due to the risk of developing bacteria.On 7/22/26 at 8:45 AM Staff 18 (Registered Dietician) stated dishes put away wet pose a risk of bacteria development. 2. Observation of the facility's kitchen on 7/19/26 and 7/20/26 between the hours of 10:42 AM and 1:30 PM, revealed the following:- The stainless steel, three-compartment sink had white calcification coating approximately 75% of the sinks' surface, including the sides and faucets. Meat (ground) was observed thawing in a container placed in the sink with cold water running into the container.- The countertops were observed with multiple missing portions of the surface material, one approximately fourteen by one inch and another approximately three by one inch, both of which revealed a wood material with a coating of dark colored, and scrapable material. The area was sticky upon touching.- A slotted steam table pan was observed in the steam table with opaque white stains and two small, slivered, light brown colored stick-like material in the upper left corner. Insulated plate warmer bases were stacked in this pan.- Multiple counter surfaces in and around the kitchen were covered with dust and debris.- Behind the steam table was dust particles and food on the floor and adjacent to the steam table there were dust particles and food splatters on the cabinet and floors?On 7/20/26 at 1:11 PM Staff 9 stated a cleaning list was posted, and she followed the instructions which included daily cleaning of wiping down surfaces and the sink. On 7/20/26 at 1:23 PM Staff 5 (Dietary Manager) and on 7/22/26 at 8:45 AM Staff 18 (Registered Dietician) with Staff 5 were shown the areas of observed concerns. Staff 5 confirmed the areas were unclean but should have been cleaned daily. Staff 5 and Staff 18 stated the white calcification in the sink and damage to the countertops (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to have a process in place to ensure resident rights to execute an advance directive and periodically follow up on preferences for 2 of 2 sampled residents (#s 7 and 19) reviewed for advance directives. Findings include: The facility's advance directive policy dated 1/2025 included the following:- During the admission process, if it is determined that the resident does not have an advance directive and wishes to formulate one, assistance is provided using state specific advance directive forms.- During the development of the initial comprehensive assessment and care plan, quarterly, annually, when significant changes in condition occur, or at the resident's request, discussion and documentation of the resident's choices regarding future health care occurs. A review of the advance directive is included in the discussion. 1. Resident 7 was admitted to the facility 2/2026 with a diagnosis of end stage renal disease. Resident 7's 5/18/26 5-Day Medicare MDS revealed the resident was cognitively intact.A review of Resident 7's clinical record revealed no evidence of an advance directive being discussed or offered to the resident.On 7/19/26 at 4:08 PM, Resident 7 stated she/he didn't know what an advance directive was and was uncertain if staff had ever talked to her/him about one. Resident 7 stated she/he was interested in completing an advance directive to ensure her/his choices and preferences were known and would be honored.On 7/22/26 at 9:43 AM, Staff 4 (Social Services Director) stated he did not offer, explain, or assist residents with completing an advance directive. Staff 4 stated it was the responsibility of Staff 3 (RNCM) to assist residents with advance directives. On 7/22/26 at 10:04 AM, Staff 3 (RNCM) stated she did not do anything with advance directives, but encouraged residents to go over an advance directive with their physicians.On 7/22/26 at 2:22 PM, Staff 1 (Administrator) acknowledged advance directives were not being offered or discussed with residents. Staff 1 stated he expected Staff 4 (Social Services Director) to discuss advance directives upon admission and during quarterly care conferences. 2. Resident 19 was admitted to the facility in 8/2023 with a diagnosis of chronic obstructive pulmonary disease.Resident 19's 5/10/26 Quarterly MDS revealed the resident had moderate cognitive impairment. On 7/20/26 at 8:18 AM, Resident 19 stated she/he didn't know what an advance directive was and was uncertain if staff had ever talked to her/him about one. Resident 19 stated it would be beneficial to have an advance directive and expressed a desire to complete one to ensure treatment preferences were known. On 7/22/26 at 9:43 AM, Staff 4 (Social Services Director) stated he did not offer, explain, or assist residents with completing an advance directive. Staff 4 stated it was the responsibility of Staff 3 (RNCM) to assist residents with advance directives.On 7/22/26 at 10:04 AM, Staff 3 (RNCM) stated she did not do anything with advance directives, but encouraged residents to go over an advance directive with their physicians.On 7/22/26 at 2:22 PM, Staff 1 (Administrator) acknowledged advance directives were not being offered or discussed with residents. Staff 1 stated he expected Staff 4 (Social Services Director) to discuss advance directives upon admission and during quarterly care conferences.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review it was determined the facility failed to ensure residents with Serious Mental Illness (SMI) diagnoses had PASRR (pre-admission screening/resident review) level II referrals for 1 of 1 resident (# 5) reviewed for PASRR level II screening. This placed residents at risk for unmet mental health needs. Findings include: Resident 5 was admitted to the facility in 5/2024 with diagnoses including anxiety. The diagnosis of PTSD (Post-Traumatic Stress Disorder) was added in 1/2025. The 5/24/26 Annual MDS indicated Resident 5 was cognitively intact and had current active diagnoses of depression, anxiety and PTSD, and PASRR level II screening was marked as not needed. Review of Resident 5's clinical records revealed the following:- The 1/6/25 PASRR level I screening was completed prior to Resident 5's 1/6/25 readmission to the facility and was marked 'no SMI'. Resident 5 was diagnosed with PTSD on 1/8/25, major depressive disorder on 2/11/25, and adjustment disorder on 11/10/25. No evidence was found that a PASRR level II referral had been submitted after these diagnoses were added. A progress note dated 1/8/26 indicated Resident 5 had a verbal altercation with another resident, where Resident 5 chased the other resident down the hallway, threatening to harm the other resident, because the other resident had given her/him the finger. Review of Resident 5's 6/3/26 care plan revealed the resident had behaviors requiring intervention and psychotropic medication use. The behaviors listed included accusing others, expressing frustration and anger towards others, agitation, and cursing others. On 7/21/26 at 9:56 AM Staff 28 (CNA), 10:21 AM Staff 17 (CNA), 7:00 PM Staff 7 (CNA), 7:29 PM Staff 27 (Agency RN), and on 7/22/26 at 9:47 AM Staff 19 (RN) stated Resident 5 demonstrated behaviors such as verbal aggression towards others, targeting timid individuals especially those of the same gender, and becoming agitated with change or when things did not go her/his way. Staff 7 stated she also observed Resident 5 exhibiting trauma responses to loud noises and nightmares about war. On 7/21/26 at 1:51 PM Staff 4 (Social Services Director) stated he was unaware of what diagnoses were considered SMI and stated his understanding was a PASRR level II was required for a resident with developmental delays or significant cognitive decline. Staff 4 was not aware residents exhibiting SMI in the nursing home setting required PASRR II referrals. Staff 4 confirmed Resident 5 had a PTSD diagnosis and exhibited behaviors, including verbal aggression, perseveration, possessiveness over specific spaces. He confirmed Resident 5 did not have a PASRR level II referral or screening. Staff 4 stated he was still new to the SSD position, and required more training regarding SMI and PASRR level II referrals. On 7/23/26 at 2:00 PM Staff 1 (Administrator) indicated if the PASRR level 1 screen did not indicate SMI, the resident did not need a PASRR level II screen. After review of diagnoses that were considered SMI, potential for the PASRR level 1 to be marked incorrectly, and the PASRR level II requirements, Staff 1 acknowledged if Resident 5 had PTSD and was exhibiting behaviors and trauma responses a PASRR level II referral may be needed.		

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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** Based on interview and record review it was determined the facility failed to provide care and service related to hospice and comfort care and follow physician orders for 2 of 6 sampled residents (#s17 and 33) reviewed for change of condition and medications. This placed residents at risk for unmanaged symptoms, decreased comfort during end-of-life care and adverse side effects. Findings include: 1. Resident 33 was admitted to the facility in 5/2024 with diagnoses including bladder neck obstruction (a blockage or narrowing where the bladder empties into the tube that carries urine out of the body), dementia and palliative care (care focused on relieving symptoms and improving comfort rather than curing illness) and was admitted to hospice services on 10/20/25. Record review indicated the resident had an indwelling urinary catheter for urinary retention and documentation revealed the following: On 5/10/26 night shift (10:00 PM to 6:00 AM) the resident's medical record documented no urinary output. On 5/11/26 day shift (6:00 AM to 2:00 PM) the resident's medical record documented no urinary output. On 5/11/26 evening shift (2:00 PM to 10:00 PM) there was no documentation of the resident's urinary output. There was no documentation found in the resident's medical record of any assessment or interventions, including bladder scan, catheter evaluation, or replacement despite the absence of urinary output. Review of Resident 33's medical record indicated medical transport to the hospital was requested by the family on 5/11/26 at 11:07 PM. Resident 33 was admitted to the hospital on [DATE] with urinary retention. The resident's hospital admission records stated the resident's catheter was found out of place, and 1250 ml of concentrated and odorous urine was drained from the resident's bladder. The catheter was removed and replaced with a new indwelling urinary catheter. On 7/20/26 at 10:35 AM Witness 1 (Family Member) stated they visited Resident 33 several times on 5/11/26 and consistently observed no urine in the collection bag. They reported the resident appeared uncomfortable throughout the day, staff noted earlier vomiting, and hospice was contacted. Witness 1 stated the resident's discomfort persisted, and by approximately 10:30 PM, with continued absence of urinary output they requested the resident be sent to the hospital. On 7/23/26 at 8:34 AM Staff 24 (CNA) stated they cared for the resident on the 5/11/26 day shift, noted little to no urinary output, did not recall the resident being uncomfortable. Staff 24 stated they left early and did not document or report the concern. On 7/23/26 at 1:40 PM Staff 10 (CNA) stated they observed little to no urinary output during multiple rounds on the 5/10/26 night shift, reported it to the charge nurse each time, and documented it in the medical record. Staff 10 indicated they did not recall the resident being uncomfortable or having discomfort. On 7/20/26 at 4:12 PM Staff 16 (LPN) described the facility process requiring CNAs to report and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document no urinary output, which generated an electronic alert. Nurses were expected to assess bladder status, catheter patency, and notify hospice if applicable. On 7/21/26 at 1:58 PM Staff 13 (Hospice RN) stated they saw Resident 33 on 5/11/26 for a hospice visit due to the resident's vomiting. Staff 13 stated Resident 33 was sick and Witness 1 was concerned. Staff 13 stated they believed they asked facility staff when the resident's urinary collection bag was last emptied but did not remember the response. Staff 13 stated they observed scant urine in the resident's urinary collection bag but did not have concerns regarding the catheter's function and did not examine or palpate Resident 33's bladder. On 7/22/26 and 7/23/26 attempts were made to reach Staff 11 (LPN) and Staff 25 (RN), both night shift nurses but were unsuccessful. On 7/23/26 at 12:47 PM Staff 14 (Nurse Practitioner) stated if a resident had no urinary output for over eight to 16 hours, should receive a bladder scan and likely straight catheterization should be performed. Staff 14 stated that while every bladder is different, a volume of 350-400 ml would cause pressure and discomfort, and 1250 ml of urine in the bladder would be uncomfortable. On 7/23/26 at 9:27 AM, Staff 3 (RNCM) stated they expected CNAs to report absent urinary output but were unaware nurses received electronic alerts. Staff 3, who worked the 5/11/26 day shift and requested a hospice nurse due to vomiting, stated they were unaware the resident had no urinary output. Staff 3 acknowledged there was no documentation of urinary output or bladder/catheter assessments on 5/10/26 or 5/11/26 and stated the assessments should have been completed. On 7/23/26 at 9:50 AM, Staff 2 (DNS) stated CNAs were expected to document and report absent urinary output, which also generated an electronic alert to the nurse. Staff 2 said nurses should then assess the bladder, perform a bladder scan, and check catheter patency. Staff 2 acknowledged these assessments were not documented for Resident 33 and stated they should have been completed. 2. Resident 17 was admitted to the facility in 3/2024 with diagnoses including a stroke with right side weakness/paralysis and hypertension (high blood pressure). Resident 17's 5/27/26 physician order instructed staff to administer lisinopril (a medication to treat high blood pressure) in the morning due to hypertension. A review of Resident 17's 6/1/26 through 7/1/26 MARs indicated the resident's lisinopril was not administered on the following dates: -6/3/26, -6/4/26, -6/9/26, -6/13/26 and -7/1/26. On 7/21/26 at 10:36 AM, Staff 20 (CMA) stated she did not administer Resident 17's lisinopril on 6/3/26, 6/4/26, 6/9/26 and 7/1/26 because she thought the lisinopril was supposed to be held when the resident's systolic blood pressure (top number in a blood pressure reading) was less than 100. Staff 20 reviewed Resident 17's physician order and confirmed there were no instructions to hold the resident's lisinopril for systolic blood pressure less than 100. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/26 at 2:43 PM, Staff 3 (RNCM) reviewed Resident 17's physician order for lisinopril and confirmed there were no instructions to hold the resident's lisinopril if systolic blood pressure was less than 100. Staff 3 stated she expected the resident's lisinopril to be administered per physician orders and if there were concerns with low blood pressure, the physician should have been contacted to determine if parameters were needed.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review it was determined the facility failed to provide adequate catheter care for 1 of 1 sampled residents (#33) reviewed for catheter care. This placed residents at risk for inadequate catheter management and related complications. Findings include: Resident 33 was admitted to the facility in 5/2024 with diagnoses including chronic kidney disease, bladder neck obstruction (a blockage or narrowing where the bladder empties into the tube that carries urine out of the body). Resident 33's 10/30/25 care plan indicated the resident's indwelling urinary catheter was to be replaced every four to six weeks and as needed. Resident 33's 3/24/26 Physician Orders specified the resident's indwelling urinary catheter was to be replaced every four to six weeks and as needed by hospice or the facility for urinary retention. Review of Resident 33's medical record indicated the following: -The 3/25/26 hospice visit note indicated the resident's catheter was changed. -The resident was due to have a catheter change no later than 5/6/26. -There was no documentation in Resident 33's medical record her/his catheter was changed after 3/25/26. On 5/11/2026 Resident 33 was hospitalized with urinary retention. The resident's indwelling catheter was found to be displaced and was replaced by hospital staff. The resident had 1250 ml of retained urine drained from the bladder at the time of hospitalization. On 7/23/26 at 9:37 AM Staff 3 (RNCM) stated they expected nursing staff to follow physician orders. Staff 3 acknowledged Resident 33's physician orders and care plan for indwelling urinary catheter change frequency had not been followed and should have been followed.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review it was determined the facility failed to ensure recommendations from dialysis were followed up on and ensure residents' medications were scheduled to avoid missed doses for 1 of 1 sampled resident (#7) reviewed for dialysis. This placed residents at risk for delayed treatment. Findings include: Resident 7 was admitted to the facility in 3/2026 with diagnoses including End-Stage Renal Disease (ESRD) and dependence on renal dialysis. The 5/18/26 5-Day MDS indicated Resident 7 was cognitively intact and received dialysis treatments. a. Resident 7's 7/2026 physician's order revealed the following orders:- The resident left the facility at 11:00 AM three days per week (Monday, Wednesday, and Friday) for dialysis treatments.- Four capsules of Zenpep Oral Capsule Delayed Release Particles 5000-24000 UNIT were ordered to be given to the resident three times a day with meals for the resident's Exocrine Pancreatic Insufficiency (a lack of digestive enzymes to break down food and nutrient absorption).- Two tablets of Sevelamer Carbonate Oral Tablet 800 MG were ordered to be given to the resident three times a day with meals for high phosphorus. Review of Resident 7's 7/2026 MAR revealed the ordered Zenpep and Sevelamer Carbonate were not administered due to the resident being out of the facility on the following days and time:- 7/1/26 12:00 PM - 7/6/26 12:00 PM- 7/8/26 12:00 PM- 7/13/26 12:00 PM Review of Resident 7's clinical record revealed no evidence the facility attempted to augment the medication administration or dialysis time or send the medication with the resident to ensure the medication was administered as ordered. Staff 20 (CMA) stated Resident 7 had not been given the ordered lunchtime Zenpep and Sevelamer Carbonate on days she/he went to dialysis because the two medications were scheduled to be given at 12:00 PM but the resident left for dialysis at 11:00 AM. Staff 3 (RNCM) acknowledged Resident 7's Zenpep and Sevelamer Carbonate were ordered to be administered at 12:00 PM and the resident left for dialysis three days per week at 11:00 AM. Staff 3 confirmed the two medications had not been administered to the resident on dialysis days because the medications would have been washed out during the dialysis process and confirmed no attempts had not been made to change the administration schedules or dialysis times, and the facility did not obtain an order to hold the medications but should have. b. Resident 7's clinical records revealed the following recommendations from dialysis:- The 6/29/26 Dialysis Transfer form revealed a recommendation of a fluid restriction of two liters or less.- The 7/15/26 Dialysis Transfer form revealed a recommendation to maintain fluid restriction at two liters per 24 hours due to gains and fluid pulled had exceeded what they could safely pull.- A 7/15/26 progress note revealed the dialysis clinic called the facility and requested an order change from the primary provider to increase Sevelamer Carbonate from two tablets to three tablets with meals, and an additional two tablets PRN with a large snack.- The 7/17/26 Dialysis Transfer form revealed a change in medical or mental status that included fluid restrictions of 2000 cc per day. Review of Resident 7's physician orders on 7/21/26 revealed there were no current or past orders for fluid restrictions or a requested change to the Sevelamer Carbonate order was made. Resident 7's clinical records revealed no evidence the requested changes were followed up on. On 7/22/26 at 8:47 AM Staff 19 (LPN) confirmed she received the call from the dialysis clinic on 7/15/26 and reviewed the dialysis transfer form the same day. Staff 19 stated she notified Staff 3 (RNCM) and Staff 14 (Nurse Practitioner) by secure messaging on 7/15/26 but had not seen a response back and confirmed no changes were made to the Sevelamer Carbonate order and fluid restrictions were not in the orders. On 7/22/26 at 10:24 AM Staff 3 stated nurses were responsible for reviewing the dialysis transfer forms and then enter the recommendations into the resident's physician's orders. She confirmed she was the nurse who (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. F699: Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 1 sampled resident (#5) reviewed for trauma-informed care. This placed residents at risk for re-traumatization and a decrease in their quality of life. Findings include: The facility's Social Services admission and History policy dated 11/2016 instructed the facility to develop a plan of care to mitigate triggers that may increase potential re-traumatization of residents with a history of trauma. Resident 5 was first admitted to the facility in 5/2024 with diagnoses including anxiety. The diagnosis of PTSD (Post-Traumatic Stress Disorder, mental condition with intense emotional and/or physical reaction after a traumatic event or experience) was added in 1/2025. The 5/24/26 Annual MDS indicated Resident 5 was cognitively intact and had current active diagnoses of depression, anxiety and PTSD. No behaviors or mood concerns were marked as occurring during the assessment review period. Review of Resident 5's clinical records revealed the following:- The resident was diagnosed with the following diagnoses during her/his stay: PTSD on 1/8/25, major depressive disorder on 2/11/25, and adjustment disorder on 11/10/25.- The Social Service admission and History dated 6/15/24 revealed the resident worked as a paramedic, as well as in an emergency department, and was a military veteran. - The 1/6/25 Trauma Informed Care form indicated Resident 5 reported she/he was abused by a stepparent and had a friend who threw things around.- Staff 4 (Social Services) completed Resident 5's 1/7/26 Trauma Informed Care form which revealed Resident 5 did not want to talk about her/his trauma with Staff 4. Resident 5's 6/3/26 care plan revealed there was no observed trauma specific focus. PTSD was observed as a contributing diagnosis for being at risk for nutrition/hydration deficits, ADL self-care performance deficits, and impaired psychosocial well-being, but not what the trauma response was, how PTSD impacted these care areas or interventions to prevent or address trauma responses. On 7/19/26 at 1:25 PM Resident 5 acknowledge she/he had PTSD and other mood related diagnoses but declined to discuss them or his trauma. On 7/21/26 at 9:56 AM Staff 28 (CNA) stated she would know about and how to address a resident's trauma through the care plan and word of mouth. Resident 5 but did not like to talk about the time she/he served in the military. Staff 28 suspected the resident had trauma associated with the military but did not recall seeing anything in the care plan. On 7/21/25 at 10:21 AM Staff 17 (CNA) stated she used the care plan and reports from others to know about a resident's trauma but did not recall seeing anything in Resident 5's care plan specific to trauma. Staff 17 stated she suspected Resident 5 had experienced trauma due to the resident not wanting to talk about being a military veteran and her/his experience as a paramedic but was unsure of the specific trauma or specific trauma related triggers. On 7/21/26 at 7:00 PM Staff 7 (CNA) stated she did not recall specific trauma but had observed possible trauma response. She stated Resident 5 had told her she/he had nightmares about being in the army after the resident had awoken a few times sweating and startled. Staff 7 stated she once saw Resident 5 jump out of her/his wheelchair when someone dropped something that created an explosion-like sound. Staff 7 stated Resident 5 told her that noises that sound like explosions sometimes caused her/him to startle. Staff 7 stated she reported sharing her observations with other nursing staff. She stated she would use the care plan and report from nurses to guide her with trauma care. On 7/21/26 at 1:51 PM Staff 4 stated Resident 5 had PTSD but was unaware of the resident's trauma or known trauma related triggers. He confirmed he had not reviewed the 1/6/25 trauma informed care assessment. Staff 4 stated the resident declined to talk about trauma but suspected the resident had past traumas associated with her/his military experience and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER LA Grande Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 91 Aries Lane LA Grande, OR 97850	
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	losing her/his spouse. Staff 4 stated he was unaware of the reported loud noise trigger and nightmares. He stated he had not added a trauma care plan because he was assuming the resident's traumas but acknowledged he should have care planned the resident's PTSD diagnosis and desire not to discuss the trauma.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary hypoglycemic medications for 1 of 5 sampled residents (#3) reviewed for unnecessary medications. This placed residents at risk for complications related to low blood sugars. Findings include: Resident 3 was admitted to the facility in 10/2021 with diagnoses including diabetes, chronic kidney disease and Alzheimer's/dementia. Resident 3's 5/22/26 physician orders indicated the resident received insulin glargine (long-acting insulin) one time a day. The insulin glargine was to be held if Resident 3's blood sugar readings were less than 100. Resident 3's 7/1/2026 through 7/20/26 MAR indicated the resident received insulin glargine when her/his blood sugar readings were less than 100 on the following days: -7/1/26 with blood sugar reading of 97, -7/8/26 with blood sugar reading of 89 and -7/16/26 with blood sugar reading of 86. On 7/22/26 at 9:24 AM, Staff 19 (LPN) reviewed Resident 3's 7/2026 MAR and confirmed she administered the resident's insulin glargine when her/his blood sugars were less than 100 on 7/8/26 and 7/16/26. Staff 19 stated Resident 3's blood sugars were on the low side for a while and was unsure why she administered the resident's insulin glargine when her/his blood sugars were less than 100. On 7/22/26 at 2:14 PM, Staff 3 (RNCM) stated Resident 3's blood sugars were running low, even after adjusting her/his night-time insulin and the resident should not have received insulin glargine on 7/1/26, 7/8/26 and 7/16/26 when her/his blood sugars were that low.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined the facility failed to ensure resident records were complete and accurately documented for 1 of 5 sampled residents (#17) reviewed for unnecessary medications. This placed residents at risk for inaccurate health records. Findings include: Resident 17 was admitted to the facility in 3/2024 with diagnoses including a stroke with right side weakness/paralysis and hypertension (high blood pressure). Physician orders dated 5/7/26, 5/8/26 and 6/2/26 indicated Resident 17 was prescribed the following medications: -Cholecalciferol (vitamin D3 supplement) one time a day. -Cranberry oral tablet (supplement) one time a day. -Spironolactone (diuretic) one time a day. -Ascorbic Acid (vitamin C supplement) one time a day. -Multivitamins (supplement) one time a day. -Senna (bowel care) two times a day. -Phenazopyridine (bladder numbing medication) three times a day. A review of Resident 17's 6/1/26 through 7/20/26 MAR indicated medications were not consistently being administered; the MAR was marked 5 indicating medications were being held and to see progress note for details. Medications were not administered and no progress notes were found in Resident 17's health record for the following medications, on the following days: -Cholecalciferol 6/10/26, 7/1/26 and 7/3/26. -Cranberry oral tablet 6/5/26, 6/6/26, 6/10/26, 6/11/26, 6/12/26, 6/24/26, 7/1/26, 7/2/26 and 7/3/26. -Spironolactone 6/3/26, 6/4/26 and 6/5/26. -Ascorbic Acid 6/10/26, 6/11/26, 6/12/26, 6/24/26, 7/1/26 and 7/3/26. -Multivitamins 6/10/26, 6/11/26, 6/24/26, 7/1/26, 7/2/26 and 7/3/26. -Senna 7/3/26 and 7/17/26. -Phenazopyridine 7/17/26. On 7/21/26 at 10:36 AM and 7/23/26 at 8:47 AM, Staff 20 (CMA) stated she held Resident 17's medications on various days for different reasons including the resident being tired, medications drooling from her/his mouth or the resident choking on medications. She reported at times she held some medications so more important medications could be given. Staff 20 reviewed Resident 17's 6/1/26 through 7/20/26 MAR and confirmed she held several of the resident's medications on multiple days. Staff 20 stated she always communicated to the charge nurse any time Resident 17's medications were held and either her or the charge nurse was supposed to write a progress note to explain the reason the resident's medications were held. Staff 20 confirmed there were no progress notes written on the days reviewed. On 7/23/26 at 9:35 AM, Staff 19 (LPN) stated Staff 20 routinely communicated with her when Resident 17's medications were not administered. Staff 19 confirmed there were no progress notes written to explain the reason why Resident 17 was not administered medications on multiple days. Staff 19 stated either she or Staff 20 should write a progress note with a rationale as to why a resident's medication was not administered. On 7/23/26 at 1:42 PM, Staff 2 (DNS) stated she reviewed Resident 17's 6/1/26 through 7/20/26 MAR and health record and confirmed there were many days when medications were not administered and no progress note to explain why. Staff 2 stated in order for Resident 17's health record to be complete and accurate, a progress note needed to be written to provide a rationale as to why Resident 17's medications were not administered.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review it was determined the facility failed to implement antibiotic stewardship practices for 1 of 1 sampled resident (#5) reviewed for antibiotics. This placed residents at risk for adverse medication effects, inappropriate antibiotic use and potential for development of antibiotic resistance. Findings include: The facility's Antibiotic Stewardship Policy dated 3/2018 instructs the facility to collaborate with providers regarding resident clinical status and current treatment and document clinical rationale to support the use of antibiotics. Resident 5 was readmitted to the facility in 1/2025 with diagnoses including UTI. The 5/24/26 Annual MDS indicated Resident 5 was cognitively intact and was taking an antibiotic. The hospital clinical records dated 1/6/25 revealed Resident 5 was discharged from the hospital with a low dose chronic suppressive therapy using Bactrim (an antibiotic) daily due to four UTIs in four months. A pharmacy recommendation dated 4/27/26 indicated the pharmacist advised the prescriber of the requirement for periodic assessment of prophylactic antimicrobial therapy to minimize the development of potential resistance to the prescribed daily use of Bactrim (an antibiotic). The pharmacist requested the prescriber to verify if the antibiotic order needed to be continued indefinitely and for the provider to provide a brief risk versus benefit assessment to justify the continuation. The prescriber marked yes to continuing the antibiotic but did not include a written justification for the continuance of the medication. Review of the 7/2026 physician orders revealed an order for Bactrim DS Oral Tablet 800-160 MG 0.5 tablet daily. Review of the 7/2026 MAR revealed the antibiotic had been administered daily as ordered. On 7/23/26 at 12:30 PM Staff 14 (Nurse Practitioner) stated he had not been the original prescriber of the antibiotic but continued the medication because the hospital felt it was necessary. Staff 14 stated he had not evaluated the ongoing use and had not documented any justification for continuing the antibiotic. On 7/23/26 at 1:45 PM Staff 3 (Infection Preventionist/RNCM) stated she was unsure why the antibiotic was ordered prophylactically (a preventative measure). She stated she had not reviewed the need to continue the daily Bactrim and acknowledged she should have. On 7/23/26 at 2:00 PM Staff 2 (DNS) stated she thought Staff 14 had provided justification for the ongoing use of the Bactrim however no additional information was provided.		