STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385225	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evan Terrace Post Acute	421 SE Evans Street McMinnville, OR 97128

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on observation, interview and record review it was determined the facility failed to thoroughly and timely investigate an allegation of abuse and neglect for 3 of 3 sampled residents (#s 1, 5 and 13) reviewed for abuse. This placed residents at risk for abuse. Finding include: 1. Resident 1 admitted to the facility in 9/2024, with diagnoses including stroke and dementia. An observation on 11/18/24 at 4:50 AM, revealed the front doors could be opened by entering a code on the keypad. No facility staff were present near the front doors and the surveyor entered the building unnoticed. The undated Event Summary Report revealed on 10/22/24 Resident 1 stated a male entered her/his room between 11:00 PM and 1:00 AM, approached her/him from behind and attempted to remove her/his brief but was unsuccessful. The Administrator, DNS and local law enforcement were notified. The facility interviewed two male staff members who worked the previous evening shift and two LPNs who worked the night shift. The LPNs stated no male strangers were in the facility at the time of the alleged incident. Four residents were interviewed and two indicated there were no strangers in the facility at the time. The summary concluded there were no males present in the facility at the time of the alleged incident and interviews indicated there were no unknown people at the time of the incident so the allegation of abuse and neglect was unsubstantiated. The investigation did not include who completed the investigation, when the investigation was completed and if the Administrator or DNS reviewed the investigation. Most resident interviews did not include the resident name and the interviews were not dated or timed. No night shift CNAs were interviewed. On 11/18/24 at 11:35 AM, Staff 1 (Administrator) stated he completed the investigation on 10/29/24, verified anyone who knew the door code could enter the building when the doors were locked and acknowledged the investigation was not thorough or timely. 2. Resident 5 admitted to the facility on [DATE] with diagnoses including diabetes. On 10/11/24, a Facility Reported Incident (FRI) was received by the State Survey Agency, which alleged potential neglect of Resident 5. The report revealed Resident 5 was discharged home on 9/30/24 with an indwelling urinary catheter and Wound Vac (Vacuum-Assisted Closure of a Wound) without a primary care physician or home health services. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/30/24 Progress Note revealed Resident 5 was discharged home without an outside provider, home health services and wound care assistance. The resident had a Wound Vac and indwelling urinary catheter in place. The resident was instructed to obtain a provider as soon as possible and to go to either urgent care or the emergency department for any care needs. The 10/2/24 Social Service Note revealed the resident had not been able to locate a provider and was concerned with the lack of follow-up care. Resident 5 further reported the urinary bag leaked so she/he put tape on the bag. Staff encouraged the resident to go to urgent care or the emergency room if she/he required further assistance. The 10/4/24 Hospital Records revealed Resident 5 presented to the emergency room to report the Wound Vac had malfunctioned so she/he turned it off and requested a dressing change. Review of the facility's 10/11/24 investigation revealed Resident 5 had an unsafe discharge due to being discharged without a provider, home health services and wound care assistance. The investigation was not thorough and did not include witness or staff interviews of what happened and why, if there was any outcome to the resident, who conducted the investigation, and no evidence the Administrator or DNS reviewed the investigation. On 11/18/24 at 11:35 AM, Staff 1 (Administrator) verified the facility investigation was not thorough. 42271 3. Resident 13 admitted to the facility in 9/2024 with diagnoses including fracture of unspecified part of neck of right femur (large leg bone) and cirrhosis of the liver. On 11/20/24 at 5:15 PM, Witness 9 (Complainant) stated Resident 13 was admitted to a room with a roommate who had dementia and hallucinations. Resident 13 did not feel comfortable. Witness 9 stated Resident 13 did not receive two doses of her/his medications upon admission for 18 hours. Resident 13 was discharged on [DATE]. A 10/7/24 Facility Reported Incident (FRI) was received by the State Survey Agency which alleged potential abuse and neglect of Resident 13. The FRI indicated the family was concerned regarding Resident 13's roommate the resident missed her/his Lactulose medication on 9/16/24 at 7:00 PM and on 9/17/24 at 7:00 AM. The FRI submitted was incomplete and did not include observations of the alleged victim, interviews with staff, residents, alleged victim and alleged perpetrator, review of clinical records, and there was no investigation completed after the facility was made aware of the roommate concern. On 11/26/24 at 1:45 PM, Staff 1 (Administrator) stated he did not interview other residents or staff for the FRI and submitted the FRI late.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to complete a baseline care plan within the required timeframe for 2 of 4 sampled residents (#s 1 and 3) reviewed for care plans. This placed residents at risk for unmet care needs. Findings include: 1. Resident 3 admitted to the facility on [DATE], with diagnoses including liver transplant and diabetes. Per record review, Resident 3's Baseline Care Plan was not completed until 10/14/24; 32 days after admission. On 11/13/24 at 11:20 AM, Staff 2 (DNS) verified Resident 3's Baseline Care Plan was not completed in the required timeframe. 2. Resident 1 admitted to the facility on [DATE], with diagnoses including dementia, stroke, and chronic obstructive pulmonary disease. Per record review, Resident 1's Baseline Care Plan was not completed until 10/14/24; 21 days after admission. On 11/13/24 at 11:20 AM, Staff 2 (DNS) verified Resident 1's Baseline Care Plan was not completed in the required timeframe.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 33179 Based on interview and record review it was determined the facility failed to ensure discharge needs were in place for 2 of 3 sampled residents (#s 4 and 5) reviewed for discharge. This placed residents at risk for a decline in abilities and unmet care needs after discharge. Findings include: 1. Resident 5 admitted to the facility in 9/2024 with diagnoses including diabetes and heart failure. Resident 5 discharged home on 9/30/24. The 9/18/24 SLUMS (cognitive assessment) score was 13/30 which revealed Resident 5 had dementia. The 9/18/24 Care Plan revealed Resident 5 had an open wound to the right buttock and two surgical wounds to the left buttock. Resident 5's 9/27/24 Discharge Orders included wound care orders for a wound vac (Vacuum-Assisted Closure of a wound.) Resident 5's 9/30/24 Progress Note revealed the resident's previous outside provider no longer accepted her/his insurance and would not accept Resident 5 as a patient. The note indicated the resident would not have a primary care provider, home health (HH) services or durable medical equipment which included a Wound Vac upon discharge. The Administrator and RCM were notified and they confirmed the resident would still discharge but with a facility Wound Vac. Resident 5 would need to obtain a provider ASAP and go to an urgent care or emergency department (ED) to have the Wound Vac serviced. The 9/30/24 Discharge Summary revealed the resident was discharged home. A 10/2/24 Social Service Note revealed the resident was called to follow-up on her/his status and the resident reported being concerned of lack of home health, getting a new Wound Vac and not being able to find a provider. Staff reminded the resident she/he had to obtain a new provider for those services and to go to urgent care or ED for help. The resident also reported a leak to the urine bag which she/he had put tape over. Staff again encouraged the resident to go to an urgent care or ED. Resident 5's 10/4/24 Hospital Records revealed she/he went to the ED and stated the Wound Vac needed to be serviced because it had malfunctioned and she/he needed a new dressing applied to the wound. On 11/18/24 at 11:35 AM, Staff 1 (Administrator) verified the resident was discharged home without a provider, home health or wound care supplies. Staff 1 verified it was an unsafe discharge. 2. Resident 4 admitted to the facility in 10/2024, with diagnoses including acute respiratory failure. Resident 4 discharged home on 11/3/24. Resident 4's Progress Notes from 10/2024 to 11/2024 revealed the following: -10/30/24: The SSD (Social Service Director) sent a referral for Home Health (HH) therapy services. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/3/24: Resident 4 discharged home with family. -11/5/24: The SSD called HH to confirm the start date. -11/6/24: SSD called HH to confirm start date and was informed HH services could not be initiated until Resident 4 re-established care with her/his provider as the appointment was longer than one week post discharge. -11/6/24: SSD followed up with Resident 4 related to the discharge. On 11/20/24 8:08 AM, Staff 6 (SSD) stated prior to a resident's discharge home she would send a referral for HH and DME (durable medical equipment) and schedule a follow-up appointment with the resident's provider. Staff 6 stated she did not confirm HH services for Resident 4 prior to her/his discharge, did not follow-up until 11/5/24 and HH did not initiate service until 11/18/24 which was 15 days after Resident 4's discharge home.

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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. 33179 Based on interview and record review it was determined the facility failed to follow physician orders and notify the physician of omitted medications for 3 of 10 sampled residents (#s 2, 3 and 13) reviewed for medications and pressure ulcers. This placed residents at risk for unmet medication and treatment needs. Findings include: 1. Resident 2 admitted to the facility in 9/2024, with diagnoses including diabetes and sepsis (blood stream infection). Resident 2's 9/30/24 Admission Orders included the following orders: -Amoxicillin (an antibiotic medication) 1000 mg TID with meals to start 10/1/24. -Gabapentin (a nerve pain medication) 100 mg TID. -CBG (capillary blood glucose test) checked TID before meals. -Insulin lispro 100 units/ml sliding scale. -Insulin glargine 8 units daily. -Quetiapine fumarate (an antipsychotic medication) 100 mg every evening. Resident 2's October MARs revealed the following medications and checks were not administered: -10/1/24 3:00 PM: amoxicillin and gabapentin -10/1/24 5:00 PM: queitapine fumarate -10/2/24 7:00 AM: insulin glargine subcutaneous -10/2/24 3:00 PM: amoxicillin and gabapentin -10/2/24 8:00 AM, 12:00 PM and 5:00 PM: CBG checks and insulin lispro On 11/21/24 at 12:10 PM, Staff 2 (DNS) verified the above medications were not administered as ordered. 2. Resident 3 admitted to the facility in 9/2024 with diagnoses including liver transplant and diabetes. a. Resident 3's 9/12/24 Admission Orders included the following orders: -Apixaban (an anticoagulant medication) 2.5 mg tab BID to prevent embolisms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Chlorhexidine (an antiseptic) 0.12% mouthwash. Swish 15 ml every six hours. -Methocarbamol (a muscle relaxant medication) 500 mg, two tabs four times daily. -Metoprolol tartrate (a medication to lower blood pressure) 25 mg tab; 1/2 tab BID. -Midodrine (a medication to lower blood pressure) 10 mg tab, give three tabs daily. -Simethicone (a gas relief medication) 40 mg every six hours. Resident 3's October 2024 MARS revealed the following medications were not administered: -10/1/24 and 10/2/24 at 1:30 PM and 5:30 PM: methocarbamol -10/1/24 and 10/2/24 at 3:30 PM: simethicone -10/1/24 and 10/2/24 at 5:00 PM: chlorhexidine throat solution Resident 3's October 2024 MARS revealed the following medications were not administered at the correct time: -10/9/24 9:30 AM dose administered at 10:49 AM: midodrine -10/10/24 9:30 AM dose administered at 11:39 AM: midodrine -10/9/24 9:30 dose administered at 10:47 AM: methocarbamol -10/9/24 9:30 AM dose administered at 10:51 AM: metoprolol -10/10/24 9:30 AM dose administered at 12:39 PM: metoprolol -10/9/24 9:30 dose administered at 10:47 AM: apixaban -10/10/24 9:30 AM dose administered at 12:39 AM: apixaban On 11/21/24 at 9:10 AM, Staff 2 (DNS) acknowledged the above medications were not administered or administered late. b. Resident 3's 9/12/24 Admission Orders revealed an order for insulin lispro sliding scale every six hours for CBGs as follows: -141-200 - 2 units; -210-250 - 4 units; -251-300 - 6 units; -301-350 - 8 units; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-351-400 - 10 units; and -Over 400 - notify physician. Resident 3's October 2024 Diabetic Administration Records revealed the resident's CBG was not checked and insulin lispro was not given on 10/5/24 at 6:00 PM, 10/26/24 at 5:00 PM and 10/28/24 at 5:00 PM. On 11/18/24 at 12:18 PM, Staff 2 (DNS) verified Resident 3's CBGs were not checked and insulin was not administered per physician orders on 10/5/24, 10/26/24 and 10/28/24. c. Resident 3's 9/18/24 Physician Order revealed an order to apply warm compress and then apply medihoney daily for the left lateral forearm wound care. Resident 3's October 2024 TARS revealed the left lateral forearm was not completed as ordered on 10/2/24 and 10/9/24. d. Resident 3's 9/17/24 Physician Visit Note revealed an order to send a stool sample to the lab to test for clostridiodes dificile (c-diff). Resident 3's bowel records revealed she/he had a bowel movement on 9/19/24. The 9/24/24 Lab Results revealed the stool sample was collected on 9/23/24; six days after the test was ordered. On 11/21/24 at 1:04 PM, Staff 2 (DNS) verified the c-diff test was ordered on 9/17/24, should have been completed on 9/19/23, but not completed until 9/23/24. 3. Resident 13 admitted to the facility in 9/2024, with diagnoses including cirrhosis of the liver and fractured femur (largest bone of the leg). Resident 13's 9/2024 Admission Orders revealed the resident was to be administered lactulose (a liquid medication used to help those with liver disease eliminate waste) 20 ml twice a day. Resident 13's September 2024 MARS revealed the following medication was not administered: -9/16/24 at 7:00 PM: lactulose -9/17/24 at 7:00 AM: lactulose A review of Resident 13's medical records revealed the provider was not notified regarding the two missing doses for 24 hours. Resident 13's 9/17/24 at 7:55 PM Progress Note revealed Staff 25 (RN) notified the provider. New orders were received to increase dosage of lactulose to '30 ml tonight instead of the scheduled 20 ml due to missed doses this last AM and last EVE.' (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 3:09 PM, Staff 42 (LPN) stated if a medication is missed you notify the provider right away. On 11/19/24 at 2:04 PM, Staff 2 (Interim DNS) acknowledged the resident's two doses of lactulose were missed and she expected the provider to be notified timely.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42271 Based on observation, interview and record review it was determined the facility failed to ensure residents received appropriate care and services for a feeding tube for 1 of 3 sampled residents (#3) reviewed for feeding tubes. This placed residents at risk for complications related to the use of a feeding tube. Findings include: On 11/22/24 a public complaint was received by the State Survey Agency which alleged the facility failed to ensure the care and services regarding the resident's nasogastric tube, NG (a tube inserted through the nose to the stomach and used to provide nutrition). On 11/25/24 at 10:30 AM Witness 4 (Complainant) stated the facility had called 911 several times associated with this concern over the last two weeks. Witness 4 stated the facility stated addressing the clogged NG tube was within their scope of practice of the facility staff. The facility had planned on addressing the issue at a later date. Staff 2 (Interim DNS) informed the complainant until education was completed the facility will continue to call 911 for clogged NG tubes. Witness 4 shared records which indicated the following dates 911 was called for Resident 3's clogged NG tube: 11/9/24, 11/10/24, 11/15/24, 11/19/24 and 11/20/24. Resident 3 was admitted to the facility in 10/2024, with diagnoses including chronic hepatic failure and dysphagia (difficulty swallowing). Resident 3's 11/24 Physician Enteral Feed Orders stated to verify placement every shift, water flushes pre and post medication administration, water flushes pre and post tube feeding administration and to administer Glucerna 1.5 Cal Oral Liquid (nutritional supplement) via NG-tube two times a day. Resident 3's November 2024 TAR indicated she/he did not receive her/his tube feedings on the following dates: -11/9; -11/10; -11/15; -11/19; and -11/20. A 11/9/24 Progress Note revealed Staff 41 (Agency RN) attempted to unplug and flush the residents NG tube but was unable and Resident 3 was transferred to the hospital. A 11/15/24 progress note revealed Staff 35 (LPN) wrote: The tube feeding was not ran last night due to the NG tube clogged. On 11/15/24 at 4:00 PM the resident was transferred to the hospital. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/24 at 12:47 PM, Staff 3 (DNS) and the Surveyor observed the supply closet. Staff 3 noted there were no NG tube supplies and stated the facility accepted residents with NG tubes. Staff 3 acknowledged the facility did not supply the NG tubes for replacement or maintenance. Staff 3 stated the nurses did not complete a competency checklist for NG tubes. Staff 3 stated inserting a NG tube is a nursing task. On 11/25/24 at 11:40 AM, Resident 3 was observed to be sitting up in bed with the taped NG tube from her/his nose attached to a tube feeding pump. Tube feeding of Glucerna was infusing. Resident 3 stated she/he had been sent to the hospital because the NG tube was clogged. Resident 3 stated the staff are flushing it now but previously staff were half-ass flushing it when they felt like it. On 11/25/24 at 12:06 PM Staff 27 (LPN) stated another nurse had trained her on feeding tubes, which included if the NG tube became clogged, how to initiate a visit to the emergency department. On 11/25/24 at 12:10 PM, Staff 9 (Infection Preventionist) stated there were no competencies for the nursing staff on NG tube placement. Staff 9 stated there were no NG tube supplies in the building and stated she would think the facility would have supplies available if the facility had residents with NG tubes. On 11/25/24 at 12:23 PM, Staff 41 (RCM) stated the facility informed the nursing staff we do not insert NG tubes here and did not provide supplies for the NG tubes. Staff 41 stated if the facility accepted residents with NG tubes the supplies should be available to maintain the NG tubes. On 11/25/24 at 2:30 PM, Staff 10 (LPN) stated she had a smattering of training since working at the facility. Staff 10 stated there were no NG tube supplies in the facility if the NG tube needed to be replaced. On 11/25/24 at 3:51 PM, Staff 1 (Administrator) acknowledged the nurses have not been trained on tube feedings, there were no competencies for tube feedings and NG tubes and the facility did not supply NG tubes for replacement or maintenance.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42271 Based on interview and record review it was determined the facility failed to ensure staff were trained on appropriate skills and competencies necessary to care for residents with feeding tubes and NG tubes (nasogastric tube inserted through the nose to the stomach, used for nutritional supplementation) for 3 of 3 staff (#s 9, 26 and 45) reviewed for nurse competencies. This placed residents at risk for lack of care by competent staff. Findings include: During the survey period, the facility had four residents residing at the facility who had feeding tubes or NG tubes. On 11/25/24 12:47 PM, Staff 3 (DNS) stated a nurse's meeting was held in May or June, where a training on NG tubes was presented. Staff 3 was unable to produce any feeding tube or NG tube training documentation. Staff 3 stated there were no documented competencies for feeding tubes and NG tube management. On 11/25/24 at 3:24 PM, Staff 3 (DNS) stated no nurse training had been done on NG tube competencies. On 11/25/2024 at 3:51 PM, Staff 1 (Administrator) stated the nurses have not been trained on feeding tubes or NG tubes and there are no documented competencies. Staff 1 stated the nurses had a meeting in May, but there are no meeting notes. Staff 1 stated there should be education on feeding tubes and NG tubes when nursing staff are first hired with a competency checklist. Staff 1 stated agency nurses had no additional training from the facility when they come in to work at the facility. On 11/26/24 at 11:00 AM, Staff 7 (HR, payroll coordinator) provided the Revised January 2024 Required Employee Orientation Checklist for Staff 9, Staff 26 and Staff 45. The checklist was reviewed with Staff 7 who acknowledged Tube Feedings and NG tube training was not on the list of subjects reviewed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 33179 Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 2 of 10 sampled residents (#s 3 and 13) reviewed for medications. Findings include: 1. Resident 3 admitted to the facility in 9/2024, with diagnoses including liver transplant and diabetes. Resident 3's 9/14/24 Admission Orders included the following orders: -Prednisone (a corticosteroid used in transplant patients to suppress the immune system and prevent organ rejection) 5 mg daily to prevent organ rejection. -Tacrolimus (a calcineurin inhibitor used to prevent prevent organ rejection by selectively suppressing T-cell activation) 1 mg BID to prevent organ rejection. -Valganciclovir (a medication which inhibits viral DNA polymerase to prevent replication of cytomegalovirus or CMV. Prophylaxis against CMV, the leading cause of morbidity and mortality in transplant recipients) 450 mg, two tablets daily to prevent dangerous infection. -Midodrine (a blood pressure medication used in transplant patients to improve perfusion to vial organs, stabilize hemodynamics and prevent complications. Impaired blood flow to critical organs would risk ischemia (tissue damage) and multi-organ dysfunction) 10 mg tab, give three tabs daily for blood pressure. Resident 3's October 2024 MARS revealed the following significant medication errors: -10/1/24: midodrine 3:30 PM dose was not administered. -10/2/24: midodrine 3:30 PM dose was not administered. -10/8/24: valganaciclovir 9:30 dose was not administered. -10/9/24: prednisone 9:30 AM dose was administered at 10:49 AM. -10/9/24: valganciclovir 9:30 AM dose was administered at 10:52 AM. -10/9/24: tacrolimus 9:30 AM dose was administered at 10:49 AM. -10/10/24: tacrolimus 9:30 AM dose was administered at 12:39 PM. -10/10/24 valganciclovir 9:30 AM dose was administered at 12:39 PM. -10/10/24: prednisone 930 AM dose was administered at 12:39 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385225	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evan Terrace Post Acute	421 SE Evans Street McMinnville, OR 97128

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 had a recent liver transplant and not administering medication or administering her/his medications late placed the resident at risk for organ rejection. On 11/21/24 at 9:10 AM, Staff 2 (DNS) acknowledged the above significant medication errors related to medication omissions and late medication administration. 42271 2. Resident 13 admitted to the facility in 9/2024, with diagnoses including alcoholic cirrhosis of the liver. Resident 13's 9/16/24 Admission Orders included the following orders: -Lactulose (a critical medication used for management of hepatic failure which is caused by the accumulation of ammonia and other toxins in the bloodstream due to impaired liver function) oral solution 20 ml by mouth two times a day for bowel care. Resident 13's September 2024 MARS revealed the following significant medication errors: -9/16/24: lactulose 7:00 PM dose was not administered. -9/17/24: lactulose 7:00 AM dose was not administered. Resident 13 had a diagnosis of hepatic encephalopathy. The resident's lactulose medication was necessary to remove her/his body of toxins which could not be filtered by the liver. By omitting doses of lactulose, Resident 13 was put at risk for liver failure and potential death. On 11/19/2024 at 2:04 PM, Staff 2 (Interim DNS) acknowledged staff did not give the lactulose per MD orders. Staff 2 stated I would expect if there was an order it would be given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385225	A. Building B. Wing	11/26/2024

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42271 Based on interview and record review it was determined the facility failed to update the Facility Assessment and failed to show resources needed to care for residents with tube feeding requirements for 1 of 1 Facility Assessment reviewed. This failure placed residents at risk for being uninformed of facility ownership, unmet care needs due to lack of staff training on services rendered and an insufficient supply of equipment needed to provide care for the residents. Findings include: A review of the Facility assessment dated [DATE] through 7/6/24, showed the previous owners listed as Prestige McMinnville and not the current owners as [NAME] Terrace Post-Acute owned by PACs. The assessment did not include the current administrator or DNS and the listed Quality Improvement Director no longer worked with the facility or current owners. The assessment revealed the facility accepted residents with feeding tubes and the care requirements would be provided upon hire to the nursing staff and in monthly training. The medical and non-medical equipment required did not list the necessary equipment needed to provide care to the residents if a feeding tube/naso-gastric (NG) tube became dislodged. Review of facility records revealed no evidence the nursing staff was trained on feeding tube care and services. An observation of the supply closet with Staff 3 (DNS) at 11/25/24 at 12:47 AM, revealed no feeding or NG tubes. Staff 3 stated the facility did not have any feeding or NG tubes and staff were not trained to insert the feeding or NG tubes. Staff 3 further stated the facility accepted residents with feeding tubes/NG tubes according to the Facility Assessment and verified replacing a feeding tube/NG tube was in the nurses' scope of practice. 11/25/24 at 10:40 AM, Staff 1 (Administrator) acknowledged the Prestige McMinnville Facility assessment dated [DATE] through July 26, 2024 had not been updated as required.