STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385230	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Redmond Rehabilitation and Nursing Center	3025 SW Reservoir Drive Redmond, OR 97756

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assessed prior to use of a potential restraint for 1 of 1 sampled resident (#17) reviewed for hospice. This placed residents at risk for limited mobility. Findings include: Resident 17 was admitted to the facility in 8/2024 with a diagnosis of dementia. The facility's Enabler Restraint Policy and Procedure revised 10/2022 revealed the facility was to evaluate and routinely review residents prior to the use of enablers or restraints to ensure less restrictive measures were attempted and how the device(s) enabled the resident to function at their highest practical level. An Enabler/Restraint Evaluation and Consent was to be completed prior to implementation of a device to ensure less restrictive measures were attempted and the device enabled a resident to function at their highest practical level. Resident 17's 8/12/25 Annual MDS revealed she/he had severe dementia and was a severe fall risk. The assessment indicated Resident 17's behaviors and memory were becoming worse. The MDS did not indicate Resident 17 had a restraint. Resident 17's 11/10/25 Quarterly MDS revealed she/he did not have a restraint when out of bed. Resident 17's Care Plan last revised on 1/13/26 revealed no interventions related to the use of a pommel cushion (specialized cushion with a raised center [pommel] that separated the thighs, preventing forward sliding). On 1/14/26 at 10:05 AM Resident 17 was observed in bed with her/his eyes shut. A pommel cushion was observed in Resident 17's wheelchair. A review of Resident 17's clinical record found no documented evidence an assessment was completed prior to the use of a potential restraint. On 1/15/26 at 3:55 PM Staff 12 (CNA) stated Resident 17 had a pommel cushion for a few months. Staff 12 indicated Resident 17's pommel cushion was implemented after a fall because she/he slid out of her/his wheelchair. On 1/15/26 at 1:21 PM Staff 3 (RNCM) stated if a resident was to use a potential restraint PT was to evaluate the resident and a restraint assessment was to be completed prior to initiation. Staff 3 stated she was not aware Resident 17 had a pommel cushion.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assisted to with grooming for 1 of 2 sampled residents (#5) reviewed for ADLs. This placed residents at risk for unmet grooming care needs. Findings include: Resident 5 was admitted to the facility in 11/2022 with a diagnosis of pain. Resident 5's 11/14/25 Annual MDS revealed she/he had severe dementia; it was important to her/him to make choices about bathing and required extensive assistance of one staff for hygiene. Resident 5's current Care Plan indicated she/he required extensive assistance by one staff with personal hygiene. The facility's 11/21/25 shower schedule revealed Resident 5 was to be showered on Mondays and Thursdays. Resident 5's 1/12/26 Skin Monitoring: Comprehensive CNA Shower Review Sheet revealed Staff 9 (CNA) assisted the resident with a shower on 1/12/26. On 1/12/26 at 1:33 PM and 1/13/26 at 12:56 PM, Resident 5 was observed to have long facial hair. Resident 5 stated she /he preferred to shave daily but staff did not offer to assist her/him. On 1/13/26 at 1:57 PM, Staff 9 stated she assisted Resident 5 with a shower but did not offer her/him to shave. Staff 9 stated Resident 5 had an electric shaver and would ask if she/he wanted to shave. On 1/14/26 at 8:15 AM, Resident 5 was observed to have a razor on her/his bedside table. Resident 5 was in her/his wheelchair but was not able to reach the electric shaver due to the room layout. Resident 5 stated she/he was not shaved for weeks. Witness 6 (Spouse) stated Resident 5 was not able to shave by her/himself. On 1/15/26 at 1:24 PM, Staff 3 (RNCM) stated Resident 5 preferred to shave daily and wanted to be offered to shave. Staff 3 indicated the care plan did not reflect Resident 5's shaving preference.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review it was determined the facility failed to ensure assessed and preferred activities were provided for 2 of 2 sampled residents (#s 2 and 17) reviewed for activities. This placed residents at risk for decreased quality of life. Findings include: 1. Resident 2 was admitted to the facility in 12/2025 with diagnoses including orthopedic surgery aftercare, PTSD (Post-Traumatic Stress Disorder), and depressive episodes. Resident 2's Activities Initial Review dated 12/8/25 indicated Resident 2 played games on her/his phone and it was very important for the resident to get outside and get fresh air when the weather was good. The 12/9/25 admission MDS indicated Resident 2 had a BIMS assessment score of 14 (cognitively intact) and the resident required extensive assistance by staff to maneuver in her/his wheelchair due to weakness and poor coordination. The 1/12/26 revised Care Plan indicated Resident 2 was at risk for little or no activity due to her/his right rotator cuff repair and staff was to provide in-room visits and one on one activities for the resident. The care plan did not indicate the resident had any interest in outdoor activities. On 1/12/26 at 9:39 AM, Resident 2 was observed with her/his right shoulder in a sling and stated there was no follow up on a request to get outside. Resident 2 stated she/he felt confined to her/his room because of her/his right shoulder. On 1/13/26 at 2:24 PM, Staff 17 (CNA) stated she recalled Resident 2's request to go outside over a week ago and worked with Staff 18 (LPN) to achieve that goal. Staff 17 stated she was unsure if Resident 2's request was granted. On 1/13/26 at 2:50 PM, Staff 8 (Activities) stated she was not aware Resident 2 requested to go outside and acknowledged she was aware it was important for the resident to go outside when the weather was good. Staff 8 stated it was possible communication fell through the cracks since activity requests of residents were verbal. On 1/16/26 at 11:49 AM, Staff 1 (Administrator) and Staff 2 (DNS) expected verbal communication to occur between staff to accomplish the activity requests of residents and acknowledged the activity participation goal for Resident 2 was not met. 2. Resident 17 was admitted to the facility in 8/2024 diagnosis of dementia. Resident 17's 8/9/24 admission MDS revealed she/he expressed it was very important to participate in her/his favorite activities. Resident 17 also reported it was very important to her/him to be outside. Resident 17's Care Plan revised on 8/9/24 revealed she/he was at risk for decreased activity involvement. Care Plan interventions included staff were to open Resident 17's curtains so she/he could enjoy watching birds and people outdoors. The care plan did not include a stuffed animal. Resident 17's 8/10/25 Annual MDS revealed she/he had severe dementia. For activities Resident 17 was assessed to not like group activities, liked to be in bed, and snack. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 17's 11/5/25 Interdisciplinary Care Conference form revealed Resident 17's family member requested her/his bed be moved next to the window so she/he could get sunshine. Resident 17's 11/6/25 Customary Activities Quarterly Participation Review form revealed staff identified Resident 17 preferred independent activities and if staff asked her/him questions she/he would answer. Resident 17's favorite activity was identified to be a nap. Staff were to inquire if Resident 17 wanted a stuffed animal companion. On 1/12/26 at 9:23 AM, 1/13/26 at 1:58 PM, and 1/14/26 at 10:05 AM, Resident 17 was observed in bed. Resident 17's eyes were shut. Resident 17's bed was positioned with a window behind her/his head of the bed and if Resident 17 looked forward she/he looked at a privacy curtain. On 1/15/26 11:12 AM, Staff 8 (Activities Director) stated she completed resident's activity assessment by speaking with residents or residents' families. Staff 8 stated she visited with each resident daily. Residents were provided an activity calendar. Resident 17 liked to observe when in the facility public sitting areas, loved to eat, and liked to go outside when the weather was warmer. Staff 8 stated Resident 17 had a stuffed dog and had a beautiful view of the rose garden from her/his window. Staff 8 acknowledged the intervention for a stuffed animal was not placed on the care plan and Resident 17 would not be able to look out her/his window with the resident's current bed placement.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review it was determined the facility failed to ensure fall interventions were followed and ensured medications were not left at a resident's bedside for 3 of 5 sampled residents (#s 5, 8, and 17) reviewed for accidents, hospice and ADLs. Findings include: 1. Resident 17 was admitted to the facility in 8/2024 with a diagnosis of dementia. Resident 17's 8/10/25 Annual MDS revealed she/he had severe dementia, received hospice services, required extensive assistance with propelling a wheelchair, and was assessed to be a severe fall risk. Resident 17 had falls while residing in the facility. Resident 17's Care Plan revised on 9/20/24 revealed she/he was not to be left unattended while in a wheelchair related to elopement risk and high risk for falls related to self-transferring. Resident 17's 12/2025 MAR revealed she/he had PRN orders for the following pain medications: -Tylenol (over the counter pain medication) and was administered zero doses. -Morphine Sulfate (narcotic pain medication) and was administered zero doses. -Oxycodone (narcotic pain medication) and was administered zero doses. -Diclofenac sodium (nonsteroidal anti-inflammatory medication) external gel and was administered zero doses. Resident17's Fall investigation revealed on 1/11/26 at 9:10 AM staff observed Resident 17 on the ground as well as an empty unlocked wheelchair in another resident's room. Resident 17 was found on the floor on her/his back. Staff assessed Resident 17 then assisted the resident back into the wheelchair. The investigation indicated staff last saw Resident 17 approximately 10 minutes prior to the fall and Resident 17 likely self-propelled into the other resident's room and self-transferred. Resident 17's 1/2026 MAR revealed she/he had PRN and scheduled orders for the following pain medications: --Diclofenac sodium external gel and was administered zero doses. -Oxycodone PRN and 17 doses were administered from 1/11/26 through 1/15/26. -Tylenol PRN and was administered two times on 1/12/26 -Morphine and was administered two doses on 1/14/26 -Fentanyl patch (narcotic pain medication) scheduled to be applied every three days and was initiated 1/14/26. On 1/14/26 at 9:30AM, 9:57 AM, and 10:05 AM, Resident 17 was observed in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/26 at 8:54 AM Staff 6 (RN) stated Resident 17 fell on 1/11/26. Staff 6 stated Resident 17 was able to propel a wheelchair and on 1/11/26 she/he propelled her/himself to another residents' room and was found on the floor. Resident 17 may have fractured a hip but after extensive conversations with hospice and Resident 17's family, the choice was to not send Resident 17 to the hospital for evaluation and treatment. Staff 6 stated the facility was assisting Resident 17 with pain control. Prior to the fall Resident 17 was up for all meals. On 1/15/26 at 9:00 AM Staff 11(CNA) stated before Resident 17 fell on 1/11/26 she/he was up for all meals but was now assisted to eat while in bed. Staff 11 stated after the 1/11/26 fall Resident 17 had increased pain. On 1/15/26 at 3:55 PM Staff 29 (CNA) stated Resident 17 slid out of her/his wheelchair and a pommel cushion was used to help prevent falls. Staff 29 stated on 1/11/26 Resident 17 was placed by the nurse's station and she/he must have propelled to the other resident's room and fell. On 1/16/26 at 9:15 AM Staff 10 (CNA) stated on 1/11/26 she was assigned to care for Resident 17. Staff 10 stated Resident 17 was to be supervised when up in a wheelchair. Staff 10 stated after breakfast she assisted Resident 17 to the nurse's station where a CNA and nurse were present to observe her/him. Staff 17 stated she left the area to assist another resident and left Resident 17 at the nurse's station. Staff 17 stated she did not recall if she informed the staff at the nurse's station to monitor Resident 17. Staff 10 stated Resident 17 must have propelled from the nurse's station to the other resident's room and self-transferred. Staff 10 stated prior to the fall Resident 17 may have had a little pain, but the pain was now worse. On 1/16/26 at 12:14 PM Staff 26 (Corporate RN) stated Resident 17 had a care plan for supervision when up in a wheelchair, but believed it was for her/his elopement risk. 2. Resident 5 was admitted to the facility in 11/1/22 with a diagnosis of encephalopathy (altered brain function). Resident 5's 11/5/25 Annual MDS revealed she/he had severe dementia. Resident 5's 1/2026 MAR revealed she/he had orders for PRN Tums (antacid) and was administered Tums on 1/9/26 on the evening shift. On 1/12/26 at 1:40 PM Resident 5 was observed sitting in her/his wheelchair in front of a bedside table and one large pink tablet was observed in a medication cup on her/his table. Staff 28 (RN) sated Resident 5 had an order for Tums (pink large tablet) but did not have an order to keep medications at the beside or to self-administer the medication. On 1/12/2026 at 1:46 PM Staff 27 (RN) stated medications were not to be kept at the beside without an order. On 1/15/26 1:36 PM Staff 2 (DNS) stated residents were not to have medications at the bedside with an assessment, physician orders, and locked storage. 3. Resident 8 was admitted to the facility in 7/2025 with diagnoses including cognitive decline and repeat falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/27/25 Fall Investigation revealed Resident 8 had no socks or shoes on when the resident fell during an attempt to self-transfer from her/his bed to a wheelchair. The 11/2/25 Quarterly MDS indicated Resident 8 had a BIMS assessment score of nine (moderately cognitively impaired), had one fall during the previous assessment period, and required partial assistance by staff for transfers, dressing and toileting hygiene. A 12/14/25 Fall investigation revealed Resident 8 had one sock on and did not use her/his call light when the resident fell during an attempt to self-transfer from her/his wheelchair to the bed. A 1/7/26 revised care plan indicated Resident 8 was at risk or falls; staff were to ensure the resident's call light was within reach and wear non-slip socks while in bed or when footwear was unavailable. On 1/13/26 at 1:22 PM, Resident 8 was observed resting on her/his bed while wearing plain white socks on both of her/his feet. On 1/13/26 at 1:28 PM and 1/14/26 at 1:03 PM, Staff 16 (CNA) and Staff 6 (RN) stated Resident 8 was able to use her/his call light successfully to ask for assistance and non-slip socks were not in place as expected. On 1/13/26 at 3:26 PM, Staff 19 (CNA) stated regular white socks were provided to Resident 8 when non-slip socks were unavailable. On 1/15/26 at 12:49 PM, Resident 8 was observed in her/his room in a wheelchair near the foot of her/his bed as Staff 20 (CNA) assisted a roommate. Staff 20 left the room, Resident 8 confirmed she/he was unable to reach for her/his call light which was near the head of the bed and out of reach for the resident due to the location of the resident's bedside table. On 1/15/26 at 1:08 PM, Staff 6 observed Resident 8 in her/his room and confirmed the resident's call light was not within reach as expected. On 1/15/26 at 1:15 PM, Staff 20 stated she did not bring Resident 8 into her/his room after lunch and assumed the resident's call light was within reach when she left. On 1/15/26 at 3:33 PM, Staff 12 (CNA) stated that she recalled Resident 8 was not wearing non-slip socks at the time of her/his fall on 10/27/25. Staff 12 stated Resident 8 was asked if she/he preferred to wear non-slip socks in bed and this option continued to be offered to the resident. On 1/16/26 at 9:14 AM, Staff 11 (CNA) stated that on 1/15/25, she returned Resident 8 to the entrance of her/his room after a meal and acknowledged she did not ensure the resident's call light was within reach before she left the resident. On 1/16/26 at 11:29 AM, Staff 2 (DNS) expected Resident 8's call light to be within reach and staff to follow the care plan to ensure non-slip socks were in place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based observation, interview, and record review it was determined the facility failed administer oxygen for 1 of 1 sampled resident (# 26) reviewed for respiratory care. This placed residents at risk for respiratory distress. Findings include: Resident 26 admitted to the facility in 6/2025 with diagnoses including hypoxemia (low levels of oxygen), acute respiratory distress (severe difficulty breathing due to lack of oxygen) and was on hospice. The 10/28/25 Care Plan revealed Resident 26 required 2-3 litters of continuous oxygen. The 11/18/25 Physician Order instructed staff to deliver 2 litters of oxygen per minute for comfort. On 1/12/26 at 11:02 AM, Resident 26 was observed seated in her/his wheelchair and was not interviewable. Resident 26's oxygen tubing was positioned along the side of the resident's face. Resident 26's portable oxygen tank gauge was observed in the red, indicating the tank was empty. On 1/12/26 at 12:37 PM, Resident 26's portable oxygen tank gauge was observed in the red, indicating the tank was empty. On 1/12/26 at 1:32 PM, Resident 26 remained seated in her/his wheelchair and the portable oxygen tank remained empty. On 1/12/26 at 1:57 PM, Staff 4 (RN) stated Resident 26 required oxygen. Staff 4 stated Resident 26's portable oxygen tank should be changed every two hours and confirmed the tank was empty. Staff 4 checked Resident 26's oxygen saturation which was 95 percent. Staff 4 stated she would ask a CNA to replace the portable oxygen tank. On 1/12/26 at 3:03 PM, Staff 30 (CNA) stated she was assigned resident 26 and was not informed of the portable oxygen tank was empty. Staff 30 confirmed the tank gauge was in the red and stated this meant the tank was low and that she would check the tank after assisting another resident. On 1/13/26 at 11:39 AM, Resident 26 was sitting in her/his wheelchair. Resident 26's oxygen tubing was wrapped behind her/his wheelchair and lying on the floor, the resident was not wearing the oxygen tubing. On 1/13/26 at 11:51 AM, Staff 9 (CNA) stated hospice staff assisted Resident 26 out of bed at approximately 9:40 AM. Staff 9 stated she normally checked the resident every two hours and confirmed the resident was not wearing her/his oxygen. Staff 9 stated she believed hospice staff did not apply to oxygen tubing aftercare and reported this to the nurse. On 1/13/26 at 12:00 PM, Staff 4 confirmed hospice staff assisted Resident 26 with care, and they did not apply the resident's oxygen tubing. Staff 4 stated from approximately 9:40 AM to 11:51 AM resident was not wearing oxygen. Resident 26's oxygen saturation was reported as 90 percent. On 1/13/26 at 10:30 AM, Staff 2 (DNS) stated Resident 26 had oxygen orders for comfort, however the care plan indicated continuous oxygen at 2 to 3 L. Staff 2 expected staff to ensure the oxygen tank was full, oxygen was in place, and oxygen saturation were maintained above 91 percent.

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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. Based on interview and record review it was determined the facility failed to implement trauma informed care interventions for 1 of 5 sampled residents (#2) reviewed for medications. This place residents at risk for re-traumatization. Findings include:Resident 2 was admitted to the facility in 12/2025 with diagnoses including PTSD (Post-Traumatic Stress Disorder) and depressive episodes. The 12/9/25 admission MDS indicated Resident 2 had a BIMS assessment score of 14 (cognitively intact) and she/he received an antidepressant for mood and sleep. A 12/26/25 Encounter Note indicated Resident 2 recently had an episode of nightmares when she/he was choking a person and woke up from sleep acting out the dream. Resident 2 was concerned about the nightmare because she/he received medication for sleep. Review of Resident 2's clinical record revealed no assessment or care plan interventions related to her/his PTSD. On 1/14/26 at 8:38 AM, Resident 2 acknowledged there was danger for staff if she/he was woken from sleep because of her/his PTSD. On 1/14/26 at 11:35 PM, Staff 6 (RN) stated he was aware Resident 2 had a stressful situation during sleep but was unaware of any details. On 1/14/26 at 11:46 AM, Staff 13 (Social Services) stated he was not aware of concerns related to Resident 2's PTSD and contacted a psychologist to address the resident's psychological needs. On 1/14/26 at 11:59 AM, Staff 2 (DNS) stated the facility was aware of Resident 2's nightmare and confirmed there was no follow up with the resident. Staff 2 acknowledged a thorough PTSD assessment was not conducted. Staff 2 expected an updated care plan and staff education to address Resident 2's PTSD triggers.