STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385232	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Hill Nursing Center	859 NE 6th Street Grants Pass, OR 97526

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40774 Based on interview and record review it was determined the facility failed to report to the State Survey Agency an allegation of abuse for 3 of 3 sampled residents (#s 7, 12 and 19) reviewed for abuse. This placed residents at risk for reoccurring abuse. Findings include: 1. Resident 7 was admitted to the facility in 3/2022 with a diagnosis of dementia. The 6/2/23 care plan revealed Resident 7 had impaired cognitive function related to dementia. Staff were to ask yes/no questions to determine her/his needs. The facility's investigation revealed on 11/24/24 Staff 32 (Former CNA) reported to Staff 34 (Former LPN) Resident 7 had inappropriately touched another resident. The 1/26/25 Quarterly MDS indicated Resident 7 had mild cognitive impairment. On 3/25/25 multiple attempts were made to contact Staff 32 and Staff 18 (Former DNS) but no response was received. On 3/27/25 at 9:21 PM Staff 34 confirmed Staff 32 told her that she witnessed Resident 7 touch another resident inappropriately. Staff 34 further stated she did not report the allegation to the State Survey Agency. On 12/9/24 a Facility Reported Incident (FRI) was submitted to the State Survey Agency. The report revealed the facility became aware of the allegation of sexual abuse on 11/24/24 but did not report the allegation until 16 days later. On 3/28/25 at 9:02 AM Staff 1 (Administrator) stated she did not become aware of the allegation until two weeks later. Staff 1 acknowledged the facility failed to report the allegation of sexual abuse to the State Survey Agency in a timely manner. 2. Resident 19 admitted to the facility in 11/2024 with a diagnosis of stroke. The 3/3/25 Quarterly MDS indicated Resident 19 had severe cognitive impairment. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigation revealed on 11/24/24 Staff 32 (Former CNA) reported to Staff 34 (Former LPN) she witnessed another resident touch Resident 19's breast. On 3/25/25 multiple attempts were made to contact Staff 32 and Staff 18 (Former DNS) but no response was received. On 3/27/25 at 9:21 PM Staff 34 confirmed Staff 32 told her that she witnessed Resident 19 being touched inappropriately by another resident. Staff 34 further stated she did not report the allegation to the State Survey Agency. On 12/9/24 a Facility Reported Incident (FRI) was submitted to the State Survey Agency. The report revealed the facility became aware of the allegation of sexual abuse on 11/24/24 but did not report the allegation until 16 days later. On 3/28/25 at 9:02 AM Staff 1 (Administrator) stated she did not become aware of the allegation until two weeks later. Staff 1 acknowledged the facility failed to report the allegation of sexual abuse to the State Survey Agency in a timely manner. 41455 3. A 10/2022 revised facility Incident Documentation and Investigation policy indicated staff were to document and investigate incidents to protect residents from further incidents, including resident to resident altercations. Resident 12 was admitted to the facility in 3/2025 with diagnoses including dementia and depression. The 3/9/25 Admission MDS and Cognition CAA indicated Resident 12's cognition was moderately impaired, and she/he was at risk for depression, anxiety, diminished psychosocial well-being and non-participation in activities. Resident 20 was admitted to the facility in 4/2024 with diagnoses including delusional (beliefs that are contrary to reality) disorders and mild cognitive impairment. A 1/22/25 Quarterly MDS indicated Resident 20 had hallucinations, delusions, and one to three verbal behaviors directed towards others during the review period. On 3/24/25 at 12:44 PM Resident 12 was asked by a surveyor if she/he ever felt abused at the facility. Resident 12 stated, a few weeks ago during dinner, Resident 20 yelled and cussed at Resident 12 which made her/him feel uncomfortable and intimidated by Resident 20. Resident 12 stated she/he was only eating her/his meal at the same table as Resident 20 when the incident occurred. On 3/25/25 at 11:28 AM Staff 2 (DNS) stated she was not informed of an incident between Resident 12 and Resident 20. On 3/25/25 at 11:36 AM Staff 13 (CNA) stated she was aware Resident 20 was upset with Resident 12, but was not present during the incident. Staff 13 stated she received information about an incident between Resident 12 and Resident 20 at shift change on 3/23/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 11:53 AM Staff 17 (Social Services Manager) stated staff were instructed to report any altercation between residents to the administration and was unaware of any incident between Resident 20 and Resident 12. On 3/25/25 at 12:20 PM and 3/28/25 at 9:57 AM Staff 1 (Administrator) stated she expected an incident report regarding the altercation between Resident 12 and Resident 20 which occurred on 3/20/25. Staff 1 stated a FRI was completed on 3/25/25 and acknowledged the required reporting to the State Agency for the resident to resident altercation was not completed timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40774 Based on interview and record review it was determined the facility failed to thoroughly investigate allegations of abuse and injuries of unknown origin for 3 of 3 sampled residents (#s 4, 7 and 19) reviewed for abuse and skin conditions. This placed residents at risk for abuse. Findings include: 1. Resident 4 was admitted to the facility in 2/2025 with diagnoses including dementia. The 2/25/25 Admission MDS indicated Resident 4 had severe cognitive impairment and was never/rarely able to make decisions. The 2/25/25 Fall Risk Evaluation revealed Resident 4 had no falls within the past three months. The 2/26/25 Initial Skin Evaluation revealed no bruising. On 3/24/25 at 1:12 PM Resident 4 was observed to have a dark bruise/mark under her/his left eye that was approximately 1-inch by 1-inch. The resident was unable to be interviewed due to her/his impaired cognition. On 3/25/25 at 1:29 PM Staff 25 (LPN) stated approximately a week ago Staff 5 (CNA) reported Resident 4's black eye during the morning shift. Staff 25 confirmed sometimes it took 2 to 3 aides to help with the resident's bed mobility and transfers but she did not recall who else assisted with the resident. Staff 25 acknowledged she did not collect witness statements from all CNAs involved. On 3/26/25 at 4:15 PM Staff 5 (CNA) stated she and two additional CNA's assisted Resident 4 out of bed before breakfast. Staff 5 stated she only remembered Staff 21's (CNA) name and she did not recall who reported the incident to the nurse or providing a witness statement. On 3/27/25 at 9:08 AM Staff 21 stated it sometimes took two or three aids to assist Resident 4 with bed mobility and transfers due to the resident's fear and anxiety. She confirmed she did not assist Resident 4 with care that morning but noticed the bruise while the resident was being wheeled down the hall. Staff 21 reported Staff 7 assisted Staff 5 during the resident's care and stated she informed the DNS how she believed the black eye may have occurred. On 3/27/25 at 9:15 AM Staff 7 (CNA) confirmed she assisted Staff 5 with Resident 4's bed mobility and transfers. She noticed a bruise under the resident's left eye which darkened over the next few days. She assumed Staff 5 reported the bruise to management and acknowledged she was also responsible for completing a witness statement and management did not follow up with her. On 3/28/25 at 6:54 AM Staff 8 (CNA) confirmed she worked with Resident 4 the day before during the night shift and was not asked to fill out a witness statement. On 3/28/25 at 7:11 AM Staff 19 (LPN) confirmed she worked with Resident 4 the day before during the night shift. She stated no one contacted her regarding the resident's bruise and she was not asked to fill out a witness statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/25 at 8:45 AM Staff 1 (Administrator) and Staff 2 (DNS) confirmed the investigation was not thorough or complete. 2. Resident 7 was admitted to the facility in 3/2022 with diagnoses including dementia. Resident 19 was admitted to the facility in 11/2024 with diagnoses including stroke. The facility's 10/2022 Incident Documentation and Investigation revealed the following: -Licensed nurses were required to obtain witness statements from the assigned nursing assistants and other staff in the immediate area. The 11/24/24 facility investigation indicated Staff 32 (Former CNA) reported to Staff 34 (Former LPN) she witnessed Resident 7 touching Resident 19's breast The Incident Witness Statement completed by Staff 34 on 12/9/24 confirmed other witnesses were present during the incident, but no additional details were provided. The Incident Witness Statement completed by Staff 32 on 12/9/24 was incomplete. It failed to document: -The time of the incident -The type and location of the incident -Events preceding and following the incident -The witnesses' names and signatures On 3/25/25 multiple attempts were made to contact Staff 32 but no response was received. On 3/27/25 at 9:21 PM Staff 34 confirmed she received this report from Staff 32. Staff 34 stated three additional CNAs witnessed the incident but she did not recall their names or obtain witness statements. Staff 34 further stated she was unaware of the facility's abuse protocol. On 3/28/25 at 9:02 AM Staff 1 (Administrator) acknowledged staff failed to conduct a thorough investigation of the alleged incident. On 3/28/25 at 9:02 AM Staff 1 (Administrator) acknowledged staff failed to conduct a thorough investigation of the alleged incident.

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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** 34703 Based on observation, interview, and record review it was determined the facility failed to follow physician orders and provide medications to treat a chronic condition for 4 of 4 sampled residents (#s 6, 19, 25, and 84) reviewed for constipation, hospice, abuse, and choices. This placed residents at risk for bowel obstruction and unmet care needs. Findings include: 1. Resident 6 was admitted to the facility in 12/2017 with diagnoses including stroke. The 1/7/25 physician's order indicated Resident 6's bowel care protocol for constipation included: -Senna (laxative medication) tablets or Miralax powder (laxative medication) may be used as needed if there was no bowel movement (BM) within 24 hours after two consecutive days without a BM. -Take one bisacodyl (laxative medication) tablet orally every 24 hours if there was no BM in three days. -Administer one bisacodyl suppository rectally every 24 hours if no BM in four days. If this occurs, notify provider. -A fleet enema (laxative medication) should be administered every 24 hours if there was no bowel movement for five days. A review of Resident 6's clinical record from 2/24/25 through 3/1/25 revealed no bowel care medication was administered to Resident 6 after five days without a bowel movement. From 3/6/25 through 3/14/25. A Bisacodyl tablet was administered on 3/10/24, after four consecutive days without a bowel movement and an enema was given on 3/14/25. No bowel medication was provided after four consecutive days without a bowel movement. On 3/27/25 at 10:03 AM, Staff 2 (DNS) stated she expected the timely administration of bowel medication and acknowledged the physician's order for Resident 6's bowel care was not followed. 40774 2. Resident 19 was admitted to the facility in 11/2024 with diagnoses including stroke affecting the left and right sides. The 2/27/25 care plan revealed Resident 19 was at risk for falls related to cognitive and communication deficits, right and left side impairment, and a history of seizures. The resident was totally dependent on staff for ADL care. The 3/3/25 Quarterly MDS revealed Resident 19 had one fall without injury. On 3/24/25 at 12:27 PM Resident 19 was observed in the dining room. She/he was able to answer simple yes/no questions but tired quickly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 12:47 PM Staff 13 (CNA) stated she was aware of the resident's fall history. Staff 13 stated anytime a resident had an unwitnessed fall, the nurses assessed the resident for injury and started neuro checks. CNAs were required to complete a full set of vitals for the following 72 hours and report back to the nurse. Staff 13 stated CNAs wrote the vitals down on a piece of paper and gave them to the nurse and they put the vitals in the resident's chart. On 3/25/25 at 1:12 PM Staff 4 (CNA/RA) stated Resident 19 had a history of unwitnessed falls and she was familiar with the facility's fall protocol. On 3/27/25 at 9:28 AM Staff 22 (RN) stated she started the 3/11/25 fall investigation after Resident 19's unwitnessed fall. Staff 22 stated for an unwitnessed fall nurses were required to assess the resident for injury, ROM and complete a set of [NAME] checks. CNAs continued to take the resident's vitals per facility protocol write them down on a piece of paper and give them to the nurse to document in the resident's chart. Staff 22 stated she did not follow up with the CNAs to ensure the resident's vitals were completed but it was her responsibility. On 3/27/25 at 9:21 PM Staff 31 (Former LPN) stated Resident 19 had a history of unwitnessed falls. Nurses were required to assess the resident for injury, ROM and obtain a full set of vitals. CNAs were expected to continue taking vitals per facility policy for the following 72 hours and give a copy to the nurse. On 3/28/25 at 8:45 AM Staff 1 (Administrator) stated staff were expected to complete neuro checks for unwitnessed falls. Staff 1 was unable to provide documentation of completed neuro checks or completed staff education for the 3/11/25 unwitnessed fall. 41455 3. Resident 25 was admitted to the facility in 1/2025 with diagnoses including heart failure and encounter for palliative care (specialized treatment for serious illnesses). The 1/30/25 care plan revealed Resident 25's pain management was provided by hospice. The 2/3/25 Admission MDS indicated Resident 25 was moderately cognitively impaired, received hospice services, and had unstable angina (chest pains). A 2/24/25 signed physician order indicated to administer nitroglycerin (medication to treat chest pain) as needed to Resident 25 every five minutes for chest pains and to call hospice after the first tablet was given. The 3/2025 MAR indicated Resident 25 received nitroglycerin three times on 3/3/25 and one time on 3/6/25. On 3/26/25 at 9:41 AM Staff 30 (RN) stated she was not present when Resident 25 was administered nitroglycerin and verified the orders for the medication included to notify hospice. On 3/26/25 at 11:09 AM Resident 25 recalled when medication was provided to address her/his chest pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 2:58 PM Witness 11 (Hospice Director) stated each resident on hospice had different needs and confirmed hospice was not informed Resident 25 was administered nitroglycerin on 3/3/25 or 3/6/25 as ordered. On 3/27/25 at 6:47 PM Staff 28 (LPN) acknowledged he administered Resident 16's nitroglycerin medication on 3/3/25, but was unaware of the order to contact the hospice physician when the medication was administered. On 3/28/25 at 10:19 AM Staff 2 (DNS) stated orders to notify hospice of Resident 25's nitroglycerin administration should be followed. 26991 4. Resident 84 was admitted to the facility in 4/2024 with a diagnosis of chronic pancreatitis (long term condition: symptoms include stomach pain). Resident 84's 4/22/24 hospital Discharge Orders revealed staff were to administer Zenpep (medication to help digest food when the pancreas does not make enough enzymes to digest food) three times a day with food. A 4/24/24 Facility/Account clinical Edit Notification form revealed the facility approved to be billed the cost of Resident 84's Zenpep. Resident 84's 4/2024 and 5/2024 MAR revealed she/he received Zenpep three times a day from 4/27/24 through 5/14/24. A 5/21/24 Encounter Note by Staff 11 (Physician) revealed Resident 84 had a diagnosis of chronic pancreatitis and the facility was not able to obtain Zenpep since the resident's admission to the facility. The note indicated even without taking the medication, she/he did not have nausea, vomiting, or diarrhea. Staff 11 discontinued the Zenpep and staff were to monitor the resident. A 5/27/24 Nursing Communication fax to Staff 11 revealed Resident 84 reported nausea and diarrhea for three days and requested immodium (treats diarrhea). Resident 84 reported to staff she/he took Zenpep for her/his pancreatic condition, but recently on 5/14/24, the medication was stopped. Staff 11 responded with a note indicating the facility was not able to obtain the mediation and to communicate with the pharmacy to obtain a medication which could be substituted for Zenpep or to see if Resident 84 was able to supply her/his own medication. On 3/27/25 at 11:27 AM Staff 11 stated she was informed by Staff 18 (Former DNS) the facility was not able to obtain Resident 84's Zenpep and the pharmacy did not have the medication, therefore, she discontinued the order. On 3/27/25 at 11:39 AM Witness 9 (Pharmacy Technician) stated in 5/2024 the facility sent a second Facility/Account clinical Edit Notification form to the facility requesting approval to bill the facility for Resident 84's Zenpep, but the facility did not send back a response. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 12:08 PM Staff 12 (Regional RN) stated there was nothing in Resident 84's clinical record to indicate the facility attempted to find alternatives to Resident 84's Zenpep or to ensure she/he received medication to treat her/his chronic pancreatitis.

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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. 41455 Based on interview and record review it was determined the facility failed to ensure residents were free from significant pain medication errors for 1 of 6 sampled residents (#16) reviewed for medications. This placed residents at risk for complications related to medications. Findings include: Resident 16 was admitted to the facility in 2/2025 with diagnoses including prostate cancer, UTI, and chronic pain. The 2/18/25 Admission MDS indicated Resident 16 had constant pain throughout the day and her/his pain frequently interfered with her/his daily activities. The 2/2025 MAR revealed Resident 16 was to receive one fentanyl transdermal patch (opioid pain medication applied to the skin) every three days for 14 days beginning on 2/15/25 and to remove the old fentanyl patch when the new fentanyl patch was applied. On 2/27/25 the fentanyl patch was applied by Staff 22 (LPN). A 2/17/25 care plan indicated staff were to monitor Resident 16's pain and her/his pain medication administration. A 3/2/25 Nursing Note indicated two fentanyl patches were found on Resident 16, the resident was easily aroused from sleep, and no new orders were received from the physician. A 3/2/25 Medication Error investigation completed by Staff 29 (RNCM) for Resident 16 revealed, during the process of applying a new fentanyl patch on the resident, Staff 23 (LPN) found two fentanyl patches on the front of both of the resident's shoulders. The investigation revealed no dates or signatures were found on either of Resident 16's patches on 3/2/25. On 3/27/25 at 9:09 AM Witness 6 (Family) stated it was difficult to manage Resident 16's pain when she/he was in the facility. On 3/27/25 at 10:17 AM Staff 22 stated her process for Resident 16's fentanyl patch administration was to rotate locations on her/his skin. On 3/27/25 at 5:57 PM Staff 23 confirmed he discovered two fentanyl patches on Resident 16 on 3/2/25. Staff 23 stated the standard of practice was to remove the old fentanyl patch prior to the administration of a new patch. On 3/28/25 at 10:19 AM Staff 2 (DNS) confirmed, after the 3/2/25 medication error, the expectation for nurses was as follows: -Ensure fentanyl patches were applied as ordered. -Identify fentanyl patches with dates and initials when applied. -A witness must observe the disposal of the old fentanyl patch. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The deficient practice was identified as Past Noncompliance based on the following: On 3/3/25, the deficient practice was identified by the facility and was corrected when the facility implemented a Plan of Correction which included: 1. Nursing staff were educated regarding fentanyl patch administration, 2. Other residents with fentanyl patches were reviewed for proper administration. 3. Licensed nurses were instructed to initiate incident reports for medication errors. 4. The fentanyl patch administration procedure was updated to include a witness nurse signature in the fentanyl administration record. During the survey process from 3/24/25 through 3/28/25 no concerns regarding fentanyl patch administration were identified.