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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41455 Based on observation, interview, and record review, it was determined the facility failed to protect the resident's right to be free from verbal abuse by a resident for 1 of 3 sampled residents (#12) reviewed for abuse. This placed residents at risk for abuse. Findings include: The facility's 10/2022 revised Abuse/Neglect/Misappropriation/Exploitation policy was to implement procedures designed to prevent, identify, report, and investigate potential instances of abuse and mistreatment. 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, the resident had short and long term memory loss, 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 were contrary to reality) disorders and mild cognitive impairment. The 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 experienced abuse at the facility. Resident 12 was observed to sit alone at a dining room table during lunch and stated she/he preferred to eat with others. 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 eating her/his meal at the same table as Resident 20 when the incident occurred. Resident 12 stated staff separated her/him from Resident 20 and explained to Resident 12 that Resident 20's behaviors were not uncommon. 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 any incident. Staff 13 stated she received information about an incident between Resident 12 and Resident 20 at shift change on 3/23/25. Staff 13 stated on 3/24/25 Resident 20 stated look at how Resident 12 stares at me and continued to glare at Resident 12 throughout the day. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 8:41 AM Staff 27 (Dietary Manager) stated he heard commotion from the kitchen on 3/22/25 during lunch. Staff 27 stated Resident 12 was at the dining room table with Resident 20 when Resident 20 yelled. Staff 27 stated CNAs had the situation under control in the dining room and Resident 20's behaviors were not isolated to 3/22/25. Staff 27 was not aware if any incident report was filed. On 3/27/25 at 10:20 AM Staff 3 (LPN) stated she was unaware of any incident between Resident 12 and Resident 20. Staff 3 stated she heard yelling in the dining room during the previous week, but there were no reports of any issues from staff. On 3/28/25 at 10:49 AM Staff 21 (CNA) stated she was aware of an incident between Resident 20 and Resident 12 when they were both at the same dining room table. Resident 20 yelled at Resident 12 who became upset by the altercation. Staff 21 stated she reassured Resident 12 that Resident 20's behaviors and yelling were normal. Staff 21 stated she did not report the incident to a nurse because the situation was de-escalated. Staff 21 stated, the following day, Resident 12 chose to sit at a dining room table alone and Resident 20 remained at the table with other residents. On 3/28/25 at 9:57 AM Staff 1 (Administrator) stated the idea held by staff that Resident 20's behavior was normal towards Resident 12 needed correction. Staff 1 acknowledged Resident 12 was verbally abused by Resident 20.

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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. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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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	385232	A. Building B. Wing	03/28/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 26991 Based on interview and record review it was determined the facility failed to assess a pressure ulcer at the time it was identified for 1 of 2 sampled residents (#83) reviewed for pressure ulcers. This placed residents at risk for delayed treatment and pain. Findings include: An Incident Documentation and Investigation policy revised on 10/2022 revealed an incident report was to be completed when new pressure ulcers, Stage II (partial thickness skin loss or may present as an intact or open/ruptured blister) or greater were identified. When the incident occurred, the resident was to be examined by the nurse and care provided. Once immediate care was provided, the nurse was to initiate an investigation. Resident 83 was admitted to the facility in 3/2025 with a diagnosis of a respiratory illness. Resident 83's 3/13/25 Admission Profile form revealed, upon admission to the facility in 3/2025, she/he did not have a pressure ulcer. Resident 83's 3/2025 Documentation Survey Report (CNA documentation of care provided) revealed on 3/18/25, during the evening shift, a CNA identified a new open area to Resident 83's left leg. Resident 83's clinical record did not have documentation to indicate her/his new open area, identified on 3/18/25 to the left leg, was assessed by a nurse on 3/18/25 during the evening shift. Resident 83's 3/19/25 New Pressure Injury investigation revealed on 3/19/25 a CNA reported Resident 83 had a new wound on her/his heel that needed to be assessed because it was leaking. Resident 83's 3/19/25 Skin and Wound Evaluation form revealed she/he had a Stage II pressure ulcer to the left heel and coccyx. The left heel pressure ulcer was 6.2 cm long and 4.8 cm wide and had heavy drainage which was blood tinged. On 3/27/25 at 1:53 PM Staff 20 (LPN) stated she was assigned to care for Resident 83 on 3/18/25 and the CNA did not notify her that Resident 83 had a new pressure ulcer to her/his left heel. On 3/27/25 On 4:39 PM Staff 10 (LPN Wound Nurse) stated she was not sure what time on 3/19/25 she was notified of Resident 83's new heel pressure ulcer, but when she was notified, she assessed the wound, and provided treatment. On 3/27/25 at 4:51 PM Staff 19 (LPN) stated she worked the evening shift on 3/18/25 when Resident 83 was identified to have a new left heel pressure ulcer, but was not assigned to care for Resident 83. Staff 19 stated a CNA notified her Resident 83 had an open area, and Staff 19 informed the CNA to let Staff 20 know when she returned from her/his lunch break. Staff 19 stated she also notified the CNA to let her know if Staff 20 was unable to assess the open area. Staff 19 stated the CNA did not reapproach her, did not ask her to assist with Resident 83, and she did not assess Resident 83's pressure ulcer when it was first identified. (continued on next page)

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	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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 1:30 PM Staff 15 (LPN Resident Care Manager) verified staff identified Resident 83's pressure ulcer on the evening shift of 3/18/25 but it was not assessed and treatment was not provided until 3/19/25 on the day shift. An interview occurred on 3/28/25 at 10:05 AM with Staff 2 (DNS) and Staff 12 (Regional RN). Staff 2 stated CNAs were to document new skin issues on shower sheets and also on residents' ADL documentation reports. Staff 2 stated CNA staff were also able to create an alert in a resident's clinical record to notify the nurse regarding a change in condition. Staff 12 stated Resident 83's pressure ulcer was identified on 3/18/25 during the evening shift and was assessed the following morning. Staff 2 and Staff 12 acknowledged there were no treatments placed to protect the blister and to ensure the heel was elevated to prevent potential discomfort after the ulcer was initially identified.

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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. 41455 Based on interview and record review it was determined the facility failed to provide appropriate dosing of medications for 1 of 6 sampled residents (#12) reviewed for medications. This placed residents at risk for complications related to medications. Findings include: Resident 12 was admitted to the facility in 3/2025 with diagnoses including atrial fibrillation (irregular heart rhythm) and high blood pressure. The 3/9/25 revised care plan indicated Resident 12 received medication for her/his atrial fibrillation and medications were to be provided according to physician orders. The 3/2025 MAR indicated to administer hydralazine (blood pressure medication) three times daily and hold for a systolic (upper number) blood pressure less than 120. Resident 12 was administered hydralazine as follows: -3/13/25 at 8:00 AM with a systolic blood pressure of 119. -3/13/25 at 12:00 PM with a systolic blood pressure of 119. -3/13/25 at 4:00 PM with a systolic blood pressure of 104. -3/18/25 at 4:00 PM with a systolic blood pressure of 108. -3/19/25 at 12:00 PM with a systolic blood pressure of 115. On 3/26/25 at 9:37 AM Staff 30 (RN) reviewed Resident 12's medication administration record for 3/19/25 and acknowledged she incorrectly provided the resident's hydralazine outside of the written parameters on 3/19/25. On 3/27/25 at 10:07 AM Staff 22 (LPN) stated the medication administration system required her to enter a blood pressure for Resident 12 before her/his hydralazine was administered and she double-checked her results. Staff 22 confirmed she administered Resident 12's blood pressure medication incorrectly on 3/13/25 and 3/18/25. On 3/27/25 at 10:45 AM Staff 2 (DNS) confirmed physician orders should be followed and acknowledged staff did not follow the parameters for the administration of Resident 12's hydralazine.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure residents were provided dental services for 1 of 1 sampled resident (#26) reviewed for dental. This placed residents at risk for unmet dental needs. Findings include: Resident 26 was admitted to the facility in 12/2024 with a diagnosis of a stroke. Resident 26's 1/4/25 admission MDS revealed Resident 26 was alert, unable to communicate, had likely cavities, and broken molars. Resident 26's 1/13/25 Care Conference did not address if Resident 26 or her/his representative wanted Resident 26 to be assessed by a dentist for her/his identified dental issues. On 3/25/25 at 11:53 AM Resident 26 was observed to eat and did not show signs of pain while eating. On 3/26/25 at 11:07 AM Staff 17 (Social Services) stated if a resident was assessed to have dental issues on the MDS, staff were to offer dental services. Staff 17 stated she did not reach out to Resident 26's representative to offer dental services. On 3/26/25 at 11:12 AM and on 3/27/25 at 12:15 PM Staff 15 (LPN Resident Care Manager) stated if a resident was assessed to have dental issues, a dental referral was made. Staff 15 stated Resident 26 had dental issues, but did not report dental pain. Staff 15 stated she did not address the dental issues with Resident 26's representative. An interview occurred on 3/28/25 at 9:57 AM with Staff 2 (DNS) and Staff 12 (Regional RN). Staff 2 stated if a resident had missing or broken teeth, or cavities, the MDS triggered staff to make a referral to dental after checking with the resident and or resident representative.

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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. 41455 Based on observation, interview, and record review it was determined the facility failed to properly follow dish sanitation practices for 1 of 1 kitchen. This placed residents at risk for food borne illnesses. Findings include: Instructions for the facility dish machine revealed the dish machine required 50 parts per million of chlorine rinse to santize. On 3/27/25 at 12:40 PM Staff 26 was observed to use the dish machine to wash dishes. Staff 26 stated she started the dish machine in the mornings when she worked and ensured chemicals were visually flowing into the dish machine to verify the chemical concentration was adequate in the dish machine. Staff 26 stated she did not know how to test for the chemcial levels of the dishwasher. The 3/2025 Sanitizing Strips and Dish Machine log indicated Staff 26 (Cook) verified the concentration of the chemical sanitation for the dishwasher was at 50 for multiple shifts on the following days she worked: 3/1/25 through 3/3/25, 3/8/25 through 3/20/25, and 3/18/25 through 3/22/25. On 3/27/25 at 1:24 PM Staff 26 stated she completed the Dish Machine log using the documented trends of other staff. Staff 27 (Dietary Manager) acknowledged the Dish Machine log was not accurate and the facility did not verify proper chemical levels of the dish machine during each shift. On 3/28/25 at 10:19 AM Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Director of Clinical Operations) acknowledged consistent testing of the chemical levels in the dish machine using test strips should be completed to ensure proper dish sanitation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40774 Based on observation and interview it was determined the facility failed to ensure clean items were not stored in contaminated areas for 1 of 1 laundry room reviewed for infection control. This placed residents at risk for cross contamination. Findings include: On 3/26/25 at 12:16 PM observations of the dirty side of the laundry room revealed the following: -approximately 15 pillows -four uncovered styrofoam cushions -and a triangular wedge were present on the shelf. On 3/26/25 at 12:02 PM Staff 35 (Laundry/housekeeping) stated the pillows, styrofoam cushions and a triangular wedge had been stored on the dirty laundry side for approximately one month. She reported her concerns to the maintenance director but the items were not removed. On 3/26/25 at 12:17 PM Staff 36 (Assistant Maintenance Director) confirmed he placed the pillows, styrofoam cushions, and a triangular wedge in the laundry room on the soiled linen side some time ago. He stated he did not know this was an infection control issue. On 3/28/25 at 9:20 AM Staff 1 (Administrator) and Staff 2 (DNS) were informed of the findings from the laundry room observation. Staff 1 and 2 confirmed the storage of clean items in proximity to dirty laundry posed an infection control concern due to potential cross-contamination.