STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385244	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nehalem Valley Care Center	280 Rowe Street Wheeler, OR 97147

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview it was determined that the facility failed to ensure a dignified dining experience for 2 of 5 sample residents (#s 8 and 20) reviewed for dining. This placed residents at risk for decreased quality of life. Findings include: On 6/23/25 at 12:39 PM two meal trays were observed in the dining room with black plastic garbage bags over the trays. Each tray had the main meal served in a disposable clamshell container, the fruit was served in a disposable paper soup cup and there were plastic utensils for residents to utilize. Staff 22 (CNA) provided the meal trays to Residents 8 and 20 who were sitting at a communal table with three other residents. On 6/24/25 at 11:42 AM Staff 27 (Cook) stated the plastic covered trays with disposable containers and utensils were for people on precautions. On 6/25/25 at 03:17 PM Staff 3 (Regional Nurse) stated the plastic bag covering the tray and the use of the clamshell, disposable soup cups and utensils were not part of the protocol for residents on contact precautions. On 6/26/25 at 11:33 AM Resident 20 stated she/he preferred to have a normal tray if the disposable tray was not required for safety. On 6/26/25 at 11:37 AM Resident 8 stated she/he wanted to be like everyone else and have the same tray.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and record review it was determined the facility failed to ensure residents with diagnoses of dementia were free from unnecessary use of antipschotic medication for 1 of 5 sampled residents (#7) reviewed for medications. This placed residents at risk for adverse side effects of antipsychotic medication. Findings include: Resident 7 was admitted to the facility in 11/2023 with diagnoses including a stage four pressure ulcer and dementia. The following psychoactive medications were ordered on Resident 7's 6/2025 MAR: · quetiapine (an antipsychotic) · trazodone (an antidepressant) · venlafaxine (an antidepressant and antianxiety agent) · Namenda (an anti-Alzheimer ' s agent) · hydroxyzine (an antianxiety agent) On 5/15/24 Resident 7's Abnormal Involuntary Movement Scale (AIMS) total score was 7 indicating the symptoms/side effects of psychoactive medication use were present. On 2/4/25 the facility notified Resident 7's physician that she/he was experiencing symptoms including sweating, and involuntary smiling and grimacing. The physician ordered a reduction of Resident 7's venlafaxine dose, but did not address the resident's use of quetiapine. The 3/31/25 Psychotropic Committee Meeting Review form indicated no additional GDRs were ordered, and there was nothing to indicate Resident 7's use of antipsychotic medication despite the presenece of adverse side effects was assessed. On 4/24/25 Resident 7's AIMS total score was 9 indicating worsening symptoms/side effects of antipsychotic medication were present. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's clinical record from 5/2025 through 6/2025 indicated staff were to monitor for calling out behaviors. The document indicated the behavior did not occur. On 6/22/25 at 12:28 PM, 6/24/25 at 12:48 PM, and 6/25/25 at 10:31 AM Resident 7 was observed in her/his room and interacted with staff with no negative behaviors or signs of distress noted. On 6/24/25 at 12:30 PM Staff 4 (LPN) stated Resident 7's calling out behaviors lessened in the past several months and she/he was able to express her/his wants and needs. On 6/24/25 at 2:56 PM Staff 29 (NA) stated Resident 7 was able to express her/his needs and did call out for things like a pillow or pain medication, but denied the resident exhibited signs of distress. On 6/25/25 at 3:15 PM Staff 6 (LPN Resident Care Manager) stated the facility did not assess Resident 7 for antipsychotic medication use, but rather they relied on the pharmacist reviews and recommendations. On 6/26/25 at 10:30 AM Staff 2 (DNS) and Staff 3 (Regional RN) acknowledged antipsychotic medication was prescribed to address Resident 7's calling out behaviors that were disturbing to those around her/him, but did not seem to cause distress to the resident. Staff 3 further acknowledged a comprehensive risk/benefit assessment should have been completed to determine if continued use of the medication was appropriate despite the presence of adverse side effects.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review it was determined the facility failed to ensure sufficient nursing staff to meet resident care needs in a timely manner for 3 of 3 resident halls reviewed for staffing. This placed residents at risk for lack of timely assistance and unmet care needs. Findings include: Resident Council Notes indicated the following: -3/25/25: Showers were not being done. -4/30/25: CNAs were not getting residents to activities in a timely manner and meal service was late. A review of the facility's Direct Care Staff Daily Reports from 2/11/25 through 2/18/25 and 5/23/25 through 6/23/25 revealed the facility had insufficient CNA staff, according to state minimum staffing requirements, for one or more shifts on the following dates: -5/30/25 -6/2/25 -6/7/25 -6/9/25 -6/11/25 -6/19/25 Interviews with residents revealed the following concerns: -On 6/22/25 at 11:59 PM Resident 28 stated on 6/22/25 at 8:20 PM she/he pushed her/his call light and staff did not answer her/his light until 9:15 PM. -On 6/22/25 at 12:12 PM Resident 231 stated at night it took up to an hour for the call light to be answered. -On 6/22/25 at 12:34 PM Resident 21 stated she/he received late showers related to the facility's staffing issues. -On 6/22/25 at 12:54 PM Resident 15 stated call lights took up to 45 minutes to be answered and meals were delivered late. -On 6/22/25 at 2:40 PM Resident 9 stated it took up to an hour for staff to answer her/his call-light and at times she/he had to go into the hall to find help and often nobody was around. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews with staff revealed the following concerns: -On 6/23/25 at 9:30 AM Staff 25 (Agency CNA) stated the facility was short staffed and she was often rushed to complete her basic tasks which included resident showers and answering call lights. -On 6/24/25 at 9:40 AM Staff 16 (CNA) stated all shifts, both weekdays and weekends, had staffing issues. Staff 16 stated she was usually assigned to 8-12 residents which made it hard to answer call-lights and provide resident care timely. -On 6/24/25 at 10:55 AM Staff 24 (CNA) stated it was often hard to get basic tasks done timely and she often felt rushed. -On 6/24/25 at 11:25 AM Staff 15 (CNA) stated it was normal for staff to be rushed and not have enough time to provide showers. Staff 15 stated answering call lights timely was a constant challenge. -On 6/25/25 at 11:25 AM Staff 26 (Agency CNA) stated the facility was always short staffed and it was common for residents to wait over 20 minutes for call lights to be answered. On 6/26/25 at 11:27 AM Staff 1 (Administrator) acknowledged the staffing concerns related to timely assistance and confirmed the staffing shortages.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to ensure RN coverage for eight consecutive hours per day for 3 of 43 days reviewed for staffing. This placed residents at risk for unassessed needs and lack of care. Findings include: Review of the Direct Care Staff Daily Reports from 2/11/25 through 2/18/25 and 5/23/25 through 6/23/25 indicated there was no RN coverage for eight consecutive hours on 2/13/25, 2/15/25, and 6/20/25. On 6/26/22 at 10:17 PM Staff 1 (Administrator) and Staff 3 (Regional Nurse) acknowledged the facility lacked RN coverage on the identified days.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined the facility failed to ensure pureed foods were prepared using methods that conserved nutritive value and flavor for 2 of 2 meals served to residents requiring pureed diets. This placed residents at risk for consuming unpalatable, nutritionally compromised food. Findings include: The facility's dining menu on 6/25/25 indicated the entrée for the lunch meal was roasted salmon. The facility's recipe for preparation of pureed food indicated to add hot cooking liquid and/or hot broth and food thickener to the roasted salmon while it was being processed to the puree texture. On 6/25/25 at 11:58 AM Staff 28 (Cook) was observed adding approximately 6-8 ounces of clear liquid to the salmon puree as it was being processed. Staff 28 stated he was preparing the salmon for one resident tray. Staff 28 confirmed the clear liquid was water. On 06/25/25 at 02:47 PM Staff 7 (Dietary Manager) stated water was not be used to prepare a pureed meal. Instead, a liquid with more nutritional value was to be added.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure proper hand hygiene during meals and failed to use proper PPE for contact-based precautions for 1 of 1 dining room and 2 of 2 of sampled residents (#s 8 and 12) reviewed for dining and infection control. This placed residents at risk for cross contamination. Findings include: According to the Centers for Disease Control and Prevention (CDC) website (https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html): · Use Contact Precautions for patients with known or suspected infections that present an increased risk for contact transmission. · Use personal protective equipment (PPE) appropriately including gloves and gown. · Wear a gown and gloves for all interactions that may involve contact with the patient or patient's environment. · Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. · If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient. The facility's Standard Precautions policy revised September 2022 stated the following: · Hand hygiene is performed with Alcohol-Based Hand Rub (ABHR) or soap and water: before and after contact with the resident. · Gloves are worn when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact. · (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reusable equipment is not to be used for the care of more than one resident until it has been appropriately cleaned and reprocessed. 1. On 6/23/25 at 9:10 AM Staff 22 (CNA) entered Resident 12's room who was on Contact Precautions. Prior to entering the room, Staff 22 did not don PPE. Staff 22 exited the resident's room without performing hand hygiene. A CDC Contact Precautions sign was prominently displayed on the room door. On 6/23/25 at 9:20 AM Staff 22 returned to Resident 12's room with a cup of coffee and again entered without donning PPE. No hand hygiene was observed upon exiting the room. On 6/23/25 at 9:23 AM Staff 22 acknowledged the resident was on Contact Precautions, and that she/he did not don PPE upon entering the room or perform hand hygiene upon exiting. On 6/25/25 at 2:22 PM Staff 2 (DNS) and Staff 3 (Regional RN) acknowledged staff were to use appropriate PPE for residents on Contact Precautions. Staff 2 and Staff 3 indicated some staff were confused about the difference between Enhanced Barrier Precautions and Contact Precautions. 2. On 6/23/25 at 9:24 AM Staff 23 (LPN) entered Resident 8's room who was on Contact Precautions. Staff 23 did not don PPE and used a reusable blood pressure device to take a reading on the resident. Staff 23 exited the resident's room and placed the blood pressure device on top of a medication cart without putting down a barrier first. Staff 23 returned to the resident's room to administer medications and did not don PPE before she/he entered. A CDC Contact Precautions sign was prominently displayed on the room door. On 6/23/25 at 9:29 AM Staff 23 acknowledged the resident was on Contact Precautions and that she/he did not don PPE before entering the resident's room. Staff 23 acknowledged she did not clean the reusable blood pressure cuff after using it on the resident. On 6/25/25 at 2:22 PM Staff 2 (DNS) and Staff 3 (Regional RN) acknowledged staff were to use appropriate PPE for residents on Contact Precautions. Staff 2 and Staff 3 indicated some staff were confused about the difference between Enhanced Barrier Precautions and Contact Precautions. Based on observation, interview and record review it was determined the facility failed to ensure proper hand hygiene was implemented during meals and failed to use proper PPE for contact-based precautions for 1 of 1 dining room and 2 of 2 of sampled residents (#s 8 and 12) reviewed for dining and infection control. This placed residents at risk for cross contamination. Findings include: On 6/23/25 from 12:22 PM to 12:42 PM, Staff 22 was observed assisting residents to dine in the main dining room wearing the same gloves and without hand hygiene. Staff 22 was observed to: On 6/23/25 at 12:22 PM Staff 22 (CNA) was observed wearing gloves while serving a resident her/his meal tray in the main dining room. Staff 22 took off plastic wrap from resident's fruit bowl using gloves while touching every surface of the bowl including the fruit, this was repeated with at least three residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/25 at 12:39 PM Staff 22 (CNA) was observed handling his phone with the same gloves on, he then provided beverages to residents with the same gloves on. Staff 22 (CNA) then assisted a resident with getting food and uncovering the food with the same gloves. Staff 22 (CNA) poured more beverages for residents with the same gloves on. On 6/23/25 at 12:42 PM Staff 22 (CNA) pushed a resident closer to the table with the same gloves on, then poured more beverages and opened creamers to put into coffee with the same gloves on. Staff 22 then finally removed the soiled gloves, but did not perform hand hygiene. On 6/23/25 at 12:56 PM Staff 22 (CNA) stated he usually performed hand hygiene and glove changes only twice during meal service. When Staff 22 was asked about glove changes after touching his phone he noted he took the gloves off right away but should have performed hand hygiene. On 6/26/25 at 11:20 AM Staff 3 (Regional RN) stated staff were expected to perform hand hygiene in between helping residents in the dining room.