STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385245	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivercrest Post Acute	148 Hood Street Oregon City, OR 97045

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 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. 41453 Based on interview and record review it was determined the facility failed to ensure falls were evaluated to ensure resident safety and to ensure care plan interventions were followed for 2 of 4 sampled residents (#s 3 and 7) reviewed for accidents. This placed residents at risk for continued accidents. Findings include: 1. Resident 3 admitted to the facility in 11/2024, with diagnoses including heart failure. A 12/1/24 at 02:26 AM Progress Note indicated Resident 3 slid out of bed, landed on the floor and got a skin tear on her/his leg. The same progress note indicated Resident 3 was sent out to the hospital per her/his request, not due to injury. The resident did not return to the facility. The progress note did indicate if Resident 3's fall was witness or unwitnessed. Record review found no documented evidence to show the resident's fall was evaluated to ensure resident safety and care plan interventions were followed. On 4/18/25 at 10:15 AM, Staff 2 (DNS) and Staff 3 (RN consultant) confirmed that a thorough and complete analysis was not done for Resident 3's fall incident. 2. Resident 7 admitted to the facility 3/2025, with diagnoses including failure to thrive. Resident 7's 4/1/25 Un-witnessed Fall Investigation was incomplete. Resident 7 was unaware of any details of the incident. The analysis of the fall incident was not in the report and no evidence to show the resident's fall was evaluated to ensure resident safety and to ensure care plan interventions were followed. Review of Resident 7's clinical record indicated the resident's fall on 4/1/25 was not her/his first fall in the facility. On 4/18/25 at 10:15 AM, Staff 2 (DNS) and Staff 3 (RN consultant) confirmed that a thorough and complete analysis of the incident was not done for Resident 7's 4/1/25 fall.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41453 Based on observation, interview and record review it was determined the facility failed to ensure staff followed contact precautions for 1 of 3 sampled residents (#1) reviewed for infection control. This placed residents at risk for cross contaminations. Findings include: Resident 1 was admitted to the facility on ,d+[DATE], with diagnoses including a stage 4 and stage 3 pressure ulcer. On 4/17/25 at 9:09 AM, Staff 4 (LPN) and Staff 5 (CNA) performed a dressing change for Resident 1. Staff 4 removed the old dressing and carefully cleaned Resident 1's wound. Staff then re-dressed the wound per physician order. Staff 4 did not change her gloves between handling soiled dressings and clean dressings. On 4/17/25 at 9:18 AM, Staff 4 (LPN) removed her PPE gown improperly. Staff 4 came into contact with the exterior side of the gown when it was removed. On 4/17/25 at 9:21 AM, Staff 4 (LPN) confirmed she was aware she should have changed her gloves between dirty and clean portions of the procedure. Staff 4 stated she understood the contamination risk related to how a PPE gown should be removed. On 4/18/25 at 10:15 AM, Staff 3 (RN consultant) and Staff 2 (DNS) stated the expectation was gloves were changed between dirty and clean portions of a dressing change. Staff 2 and Staff 3 also confirmed a PPE gown should not be removed over a person's head.