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	10/11/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on observation, interview and record review it was determined the facility failed to promote self determination for 1 of 3 sampled residents (#5) reviewed for choices. This placed residents at risk for lack of honoring choices and room preferences. Findings include: 1. Resident 5 was admitted to the facility on ,d+[DATE] with diagnoses including anxiety and schizoaffective (a condition that is marked by depression and mania) disorder. The Quarterly MDS dated [DATE], revealed Resident 5 had a BIMS score of 15, which indicated the resident was cognitively intact. Random observations from 10/7/24 through 10/10/24 revealed her/his room was cluttered with multiple items on the bedside table, bed, dresser and on the floor. Resident 5 was observed using a front wheel walker, frequently going out to smoke or walking up and down the halls. On 10/7/24 at 10:44 AM, Resident 5 and Staff 8 (LPN) were present for an interview. Resident 5 stated she/he was told by management she/he would have to move out of her/his room, which she had been in for two years, and be placed in a room with three other female residents. Resident 5 stated this was not right and she/he had not been sleeping well since the conversation. Staff 8 stated Resident 5 was very upset and Staff 8 had noticed an increase in Resident 5 anxiousness. Staff 8 stated the resident was not sleeping well during the night since the information was communicated to Resident 5. On 10/8/27 at 12:36 PM, Staff 16 (CNA) stated Resident 5 had an increase in her/his anxiousness because the resident was told she/he would be moving rooms and sharing with three other female residents. Staff 16 stated the resident felt overwhelmed about moving rooms and did not want to pack up her/his belongings. On 10/9/24 at 11:21 AM, Staff 24 (CNA) and at 1:05 PM, Staff 25 (LPN) both stated Resident 5 was alert and oriented with baseline confusion. Staff 24 and Staff 25 stated Resident 5 was very private, and her/his room was cluttered. Staff 24 and Staff 25 stated the resident did not like her/his room touched. Staff 25 stated Resident 5 struggled with change and very closed off to new outside persons. (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

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	10/11/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 9:55 AM Staff 3 (Social Service Director) and Staff 4 (Social Services) stated Resident 5 had briefly mentioned being told she/he would be moving rooms and sharing with three other female residents. Resident 5 did not want to move from her/his current room and was easily anxious. Staff 3 stated there was not a set time line. On 10/11/24 at 12:10 PM Staff 2 (DNS) stated they were considering moving four long term care female residents into the therapy room (converting to a four room space) and had discussed this with Resident 5. Staff 2 stated the resident was very suspicious of anything new, was a hoarder, and had been in her/his room since 2021. Staff 2 stated Resident 5 had asked other staff about the move and had perseverated on the subject.

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	10/11/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50897 Based on interview and record review it was determined the facility failed to ensure residents were informed in writing of changes in financial coverage for 1 of 3 sampled residents (#3) reviewed for advance beneficiary notification. This placed residents at risk for unknown financial liabilities and lack of knowledge regarding the right to appeal the decision. Findings include: Resident 3 admitted to the facility in 5/2024 with diagnoses including lower extremity paraplegia (the inability to move lower extremities). A review of Resident 3's electronic health record revealed she/he was discharged from Medicare Part A services on 8/9/24 with 37 skilled days remaining. The resident remained in the facility. No evidence was found in the resident's record to indicate she/he received a Notice of Medicare Non-coverage form (NOMNC) or a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN). In an interview on 10/9/2024 at 3:16 PM Staff 4 (Social Services Coordinator) stated she was unable to locate a NOMNC or a SNF ABN for Resident 3. In an interview on 10/11/24 at 12:05 PM, Staff 3 (Social Services Director) stated the facility did not provide a NOMNC or SNF ABN to Resident 3.

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	10/11/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50897 Based on observation, interview, and record review it was determined the facility failed to ensure personal privacy was honored for 1 of 1 resident (#187) reviewed for privacy. This placed residents at risk for breaches of confidentiality. Findings include: Resident 187 admitted to the facility in 9/2024 with diagnoses including intracranial (inside the skull) abscess. On 10/10/24 from 1:00 PM through 2:00 PM, Resident 187 was observed meeting with Staff 27 (Physician's Assistant) in a corner of the main dining room. The survey team was meeting in the activity room adjacent to the main dining room and the two rooms were separated by a curtain. The survey team was able to hear the medical conversation. The resident and Staff 27 were discussing private health information including diagnoses, symptoms, medications and prognosis. Resident 187 was overheard telling Staff 27 about her/his discomfort with the lack of privacy associated with sharing a room with three roommates and stated she/he wanted to leave the facility due to the lack of privacy. In an interview on 10/11/24 at 9:28 AM Staff 27 stated he had private conversations with residents in the facility in their rooms or in the dining room. Staff 27 stated the conversation he had with Resident 187 might have been more appropriate in a more private area. Staff 27 stated he was not aware of a private meeting area in the facility. In an interview on 10/11/24 at 9:52 AM, Resident 187 stated she/he preferred to have a private area to meet with Staff 27. Resident 187 stated it was difficult to find a place to have a private phone call in the facility, and it was impossible to have privacy while sharing a room with three other residents. In an interview on 10/11/24 at 11:32 AM Staff 3 (Social Services Director) stated she tried to have private meetings or conversations in the Social Services office but sometimes residents preferred their rooms. Staff 3 stated she frequently utilized the activity room and residents utilized the outdoor areas for privacy. Staff 3 stated she had concerns about proposed changes in the facility which would impact the residents' privacy due to a lack of dedicated meeting space in the facility. In an interview on 10/11/24 at 1:16 PM Staff 1 (Administrator) stated residents had a right to privacy when receiving care and a place to meet in private. Staff 1 stated residents were informed they could request to use staff offices for private meetings. Staff 1 stated Resident 187 did not request to use a staff office for her/his meeting with Staff 27. When asked where Staff 1 would like to have a conversation regarding personal medical information, Staff 1 stated he would like the conversation to be held in a private location.

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	10/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18073 Based on observation and interview it was determined the facility failed to ensure carpet, flooring and doors were in good repair 1 of 1 facility and 3 of 19 resident rooms reviewed for homelike environment. This placed residents at risk for injury from damaged surfaces and lack of a homelike environment. Findings include: Multiple observations between 10/7/24 and 10/11/24 revealed hall carpet throughout the facility was heavily stained and worn. Observations on 10/9/24 at 9:36 AM revealed a metal floor latch socket was missing below the fire doors between rooms [ROOM NUMBERS]. This created a hole in the flooring 2.5 inches long, 1.5 inches wide and an inch deep; large enough for canes and walkers to catch on. On 10/10/24 at 10:50 AM the floor covering surrounding the base of the toilet between rooms [ROOM NUMBERS] was observed to be damaged with exposed under floor. The exposed surface was rough, brownish-gray and was not a cleanable surface. The rest of the bathroom floor was worn and had patches of gray discoloration. On 10/10/24 at 10:15 AM the hinge side of the door to room [ROOM NUMBER] was observed to have an approximately 18 inch section of rough damaged surface. The door to room [ROOM NUMBER] also had rough damage to the hinge side of door. The door of room [ROOM NUMBER] had a deeply gouged and splintered surface from the door knob to the floor with sharp edges. In an interview on 10/11/24 at 10:41 AM Staff 21 (Maintenance director) confirmed the facility carpet was heavily stained and worn. He stated it was regularly steam cleaned but the stains remained. He stated the hole in the floor at the fire door was for a latch no longer in use for the type of fire door and it needed to be filled. Staff 21 confirmed damage to room doors was on his list of needed repairs, however, he was not specifically aware of the damage to room [ROOM NUMBER]. Staff 21 agreed the edge of the door was sharp. He was not aware of the damage to the bathroom floor between rooms [ROOM NUMBERS] and confirmed the flooring needed to be replaced. On 10/11/24 at 1:01 PM these findings were reviewed with Staff 1 (Facility Administrator) who stated the facility was working on a plan for the flooring and the doors.

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	10/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 18073 Based on interview and record review it was determined the facility failed to develop a comprehensive person centered care plan for 1 of 3 recently admitted residents (#85) reviewed for incontinence and respiratory care. This placed residents at risk for unmet needs. Findings include: Resident 85 was admitted in 9/2024 with diagnoses including diabetes, chronic obstructive pulmonary disease, history of lung cancer, heart failure and generalized weakness. Resident 85's Admission MDS and CAAs dated 9/24/24 identified the resident was frequently incontinent of urine related to weakness and the use of diuretic medication, and the resident required staff assistance with toileting. Current Physician orders for Resident 85 included an order for a 2000 ml per day fluid restriction. Resident 85's care plan dated 9/21/24 identified bladder incontinence related to the use of diuretic medication, impaired mobility and the need for extensive assistance with transfers. Interventions directed staff to check and change frequently throughout the shift and PRN. The care plan did not include interventions to reduce incontinent episodes. The resident's Comprehensive Care Plan was last revised on 10/9/24. The care plan included a focus area that indicated the resident was at risk for dehydration or electrolyte imbalance related to diabetes and diuretic use. Interventions included encourage increase PO [oral] fluids. The care plan did not address the prescribed fluid restriction. The Care Plan indicated the resident had an Advance Directive (a written instruction, such as a living will or durable power of attorney . to direct the provision of health care when the individual is incapacitated). Further review of the resident's record revealed she/he was offered a blank Advance Directive form upon admission but did not have an Advance Directive in place. On 10/11/24 at 10:51 AM Staff 2 (DNS) stated care plans were reviewed quarterly and after input from care conferences. Staff 2 confirmed Resident 85's care plan was not completely accurate or individualized.

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	10/11/2024

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 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. 36494 Based on observation, interview, and record review it was determined the facility failed to ensure residents received appropriate ADL assistance for 1 of 3 sampled residents (#136) reviewed for activities of daily living. This placed residents at risk for lack of grooming and personal hygiene. Findings include: Resident 136 was admitted to the facility in 10/2024 with diagnoses including stroke. A review of Resident 136's Baseline Care plan dated 10/5/24 revealed the resident required substantial/maximal assistance from one person for showers. A review of Resident 136's 10/2024 shower task form revealed the resident received a bed bath on 10/6/24. An observation and interview on 10/7/24 at 2:36 PM revealed Resident 136 was in bed and her/his hair was greasy. Resident 136 stated she/he received one bed bath since admission, but her/his hair was not washed, which would have been nice. Random observations from 10/8/24 through 10/9/24 revealed Resident 136 was in her/his bed or up in her/his wheelchair, and the resident's hair was greasy. On 10/9/24 at 11:56 AM Resident 136 stated she/he did not receive a shower and would kill to have her/his greasy hair washed. On 10/9/24 at 1:40 PM, Staff 15 (CNA) and at 5:58 PM, Staff 13 (CNA) stated residents received a shower or a bed bath two times weekly. Staff 15 and Staff 13 stated they noticed Resident 136's hair was greasy and should have been washed as part of her/his bed bath. On 10/11/24 at 10:59 AM, Staff 5 (Resident Care Manager LPN) stated residents were scheduled for a shower or bed bath twice weekly. Staff 5 stated staff were expected to use warm soapy water for a bed bath, including washing all body parts, including Resident 136's hair. Staff 5 acknowledged Resident 136's hair was not washed.

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	10/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18073 Based on interview and record review it was determined the facility failed to ensure residents received support to maintain continence for 1 of 2 residents (#85) reviewed for incontinence. This placed residents at increased risk for skin breakdown and loss of dignity. Findings include: Resident 85 was admitted in 9/2024 with diagnoses including chronic obstructive pulmonary disease, heart failure and generalized weakness. Resident 85's Admission MDS dated [DATE] identified the resident was frequently incontinent of urine and the resident required staff assistance with toileting. The 9/24/24 Urinary Incontinence CAA identified the type of incontinence as a mixture of urge, related to use of diuretic medication and functional, due to weakness and impaired mobility. According to the CAA as the resident regained strength, it was anticipated the resident would be more able to self-toilet and avoid incontinence issues. Resident 85's care plan dated 9/21/24 indicated the presence of moisture associated skin breakdown to the resident's groin and perineum related to incontinence episodes. Interventions included a directive to keep the resident's skin clean and dry to the extent possible. The care plan also identified bladder incontinence related to the use of diuretic medication, impaired mobility and the need for extensive assistance with transfers. Interventions directed staff to check and change frequently throughout the shift and PRN. The care plan did not address the type of incontinence (urge or mixed) or a specific strategy to reduce the frequency of incontinent episodes. In an interview on 10/7/24 at 10:31 AM Resident 85 reported slow call light response times that caused the resident to be incontinent of urine. Resident 85 was told by staff to plan better but the resident felt this was impossible due to use of diuretic medication and subsequent urgency to void. Resident 85 indicated five to 10 minutes was too long to wait to avoid an incontinent episode and voiding in a brief was undignified. Resident 85 reported a history of skin breakdown on the tailbone which was healed but Resident 85 was concerned that wearing a wet brief would cause the area to breakdown again. On 10/9/24 at approximately 4:00 PM Staff 13 (CNA) stated she was familiar with Resident 85. Staff 13 stated the resident was able to call for assistance and was unable to toilet or use a urinal without staff assistance. On 10/9/24 at 4:15 PM Staff 26 (CNA) indicated he was new to caring for the resident and stated Resident 85 needed assistance to the toilet and assistance to get cleaned up after using it. Toileting assistance was provided when the resident called for it. He did not know if the resident used a urinal independently. On 10/10/24 at 9:47 AM Staff 18 (CNA) stated the resident called for assistance if she/he needed to toilet and needed assistance to use the urinal. (continued on next page)

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	10/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1:18 PM Staff 5 (Resident Care Manager-LPN) confirmed interventions were not in place to reduce the frequency of incontinent episodes or the resident's desire to not rely on the use of a brief.

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	10/11/2024

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 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. 18073 Based on observation, interview and record review it was determined the facility failed to follow physician's orders for continuous oxygen use for 1 of 1 (#85) sampled resident reviewed for respiratory care. This place residents at risk for complications related to chronic respiratory disease. Findings include: Resident 85 was admitted to the facility in 9/2024 for rehabilitation with diagnoses including chronic obstructive pulmonary disease (COPD), obstructive sleep apnea and heart failure. Resident 85's physician orders dated 9/17/24 and Comprehensive Care Plan dated 9/21/24 directed staff to administer continuous humidified oxygen at 6 liters per minute via nasal cannula to keep oxygen saturation (percentage of oxygen in the resident blood) between 89 and 92%. Review of a published cylinder duration chart for medical oxygen indicated an E-cylinder, if full, would last 1. 7 hours at a flow rate of 6 liters per minute. This information was not part of the resident's plan of care. On 10/7/24 at 1:23 PM Resident 85 was observed to transfer from a wheelchair to bed. The resident had a portable E-sized oxygen cylinder on the back of the wheelchair and was wearing a nasal cannula. The resident's oxygen tank was observed to be empty. The resident was cued by the surveyor to activate her/his call light. A CNA responded after approximately five minutes, moved the resident's oxygen to the in-room oxygen concentrator and obtained a new tank for the resident's wheelchair. On 10/7/24 at 3:28 PM Resident 85 described a recent incident when staff assisted her/him to the toilet without oxygen and Resident 85 had to call out for staff due to almost passing out. On 10/9/24 at 8:20 AM Resident 85 was seated in a wheelchair in the dining room. The resident's oxygen tank was observed to be set a 6 liters per minute and was nearly empty. At 8:26 AM staff changed out the oxygen tank for a full one. Resident 85 remained up in her/his wheelchair until 10:31 AM when the resident returned to bed and resumed using oxygen via the in-room concentrator. On 10/9/24 at 11:19 AM Resident 85 stated her/his BiPap machine (bi-level positive airway pressure machine used for management of sleep apnea) was humidified at night but oxygen was not humidified at other times. Resident 85 stated her/his nose was dry. On 10/9/24 at 4:23 PM Staff 19 (LPN) confirmed Resident 85 had an order for humidification of oxygen and there was no humidifier on the oxygen concentrator in the resident's room. On 10/10/24 at 1:18 PM Staff 5 (Resident Care Manager-LPN) stated she was not aware Resident 85's oxygen was without humidification. Staff 5 confirmed a portable tank at the resident's ordered flow rate would not last very long. (continued on next page)

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	10/11/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 10:02 AM Staff 17 (CNA) stated she thought Resident 85's tank lasted about a shift to a half a shift depending on how long the resident was up in a wheelchair. Staff 17 stated she recalled an incident when the resident was up in the bathroom without oxygen and felt faint. She stated she wasn't aware at the time the resident needed oxygen at all times. She reported that staff sometimes forgot to turn the tank off when they switched the resident to the concentrator and this depleted the oxygen in the tank.

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	10/11/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18073 Based on observation and interview it was determined the facility failed to ensure medication storage areas were free of expired medication and biologicals for 1 of 1 medication storage room and 1 of 3 treatment carts reviewed for medication storage. This placed residents at risk for diminished treatment efficacy. Findings include: On [DATE] at 11:08 AM observations within the medication storage room refrigerator revealed a vial of tuberculin used for tuberculosis screening labeled as opened on [DATE]. Staff 2 (DNS) confirmed the tuberculin was to be discarded 30 days after opening. A bottle of acidophilus with an expiration date of , d+[DATE] was located in the door compartment of the refrigerator. Staff 2 confirmed it was expired. Observations of one of three facility treatment carts on [DATE] at 11:20 AM revealed a vial of Bacitracin (antibacterial) ointment with an expiration date of ,d+[DATE]. Staff 2 (DNS) confirmed the used tube of Bacitracin was expired.

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	10/11/2024

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 36494 Based on interview and record review it was determined the facility failed to have the Medical Director attend the Quality Assessment and Assurance and Quality Assurance Performance Improvement (QAA/QAPI) committee meetings. This placed residents at risk for unidentified needs. Findings include: Documentation of QAA/QAPI meeting minutes were requested from 4/2024 through 9/2024 which revealed Staff 23 (Former Medical Director) did not attend any of the QAA/QAPI meetings. On 10/8/24 at 9:59 AM, and on 10/11/24 at 1:51 PM, Staff 1 (Administrator) stated Staff 23 the Former Medical Director refused to attend the QAA/QAPI meetings in person or via skype.