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	02/13/2026

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation and interview it was determined the facility failed to provide a private space for resident council meetings for 1 of 1 resident council group reviewed for privacy. This placed residents at risk for a lack of participation in group discussions regarding facility policies, procedures and resident rights. Findings include:On 2/11/26 at 12:35 PM a resident council meeting was held in the facility dining room with state surveyors and eleven residents. The dining room was located next to the therapy gym with only a thin plastic room divider between the two rooms. The therapy gym had only one entrance and exit which required staff to pass through the dining area to get residents to and from therapy.On 2/11/26 between the times of 12:35 PM and 1:05 PM observations of the resident council meeting revealed the following:-Staff and other residents repeatedly entered the dining area in order to get to the therapy gym which caused the resident council meeting to pause.-Conversations between staff and other residents were heard from the therapy room and hallway which created a disruptive environment, and indicated a lack of privacy during the resident council meeting. -Staff entered the dining area in order to get coffee and supplies for residents who were not a part of the resident council meeting.On 2/11/26 at 12:37 PM Resident 11 stated resident council was held in the dining area monthly, and privacy was always an issue. Resident 11 stated it was important for residents to feel they had privacy to discuss topics of concern without staff overhearing or being present which was not possible due to staff being unable to assist residents to the therapy gym without passing through the dining area where resident council was meeting.On 2/12/26 at 10:02 AM Staff 6 (Activities Director) stated she was aware of concerns related to privacy during resident council. Staff 6 stated before each resident council meeting, signage was posted to inform staff of the meeting taking place and she encouraged staff to respect the residents and their privacy during that time. Staff 6 stated it was often difficult to ensure the meeting proceeded without interruption due to the location of the dining area and the need to assist residents to and from the therapy gym.On 2/13/26 at 12:16 PM Staff 1 (Administrator) stated he was aware of the lack of privacy residents had during their monthly resident council meetings and acknowledged no other measures were taken to ensure the residents had privacy during that time.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to ensure advance directives were offered or obtained for 4 of 4 sampled residents (#s 4, 22, 25, and 26) reviewed for advance directives. This placed residents at risk for personal health care choices not being honored. Findings include: 1. Resident 4 was admitted to the facility in 10/2025 with diagnoses including liver failure and heart disease. A 10/28/25 care plan indicated Resident 4 had an advance directive. A review of Resident 4's medical record revealed no evidence of an advance directive. On 2/10/26 at 2:56 PM, Resident 4 stated she/he had an advance directive, but no one in the facility asked her/him about it. On 2/10/26 at 3:12 PM, Staff 7 (Social Service Director) acknowledged Resident 4 was not asked about an advance directive. Staff 7 stated the process was to ask residents if they had an advance directive upon admission, and if they did not have one, staff were to offer an advance directive at admission and periodically throughout their stay. 2. Resident 26 was admitted to the facility in 11/2025 with diagnoses including acute respiratory failure and heart failure. A 12/8/25 revised care plan indicated Resident 26 had an advance directive for full code status with full treatment. A review of Resident 26's medical record revealed no evidence of an advance directive. On 2/10/26 at 2:53 PM, Resident 26 stated she/he did not have an advance directive, was not offered to complete one, and Resident 26 stated she/he was interested in completing an advance directive. On 2/10/26 at 3:12 PM, Staff 7 (Social Service Director) acknowledged Resident 26 was not offered an advance directive. Staff 7 stated the process was to ask residents if they had an advance directive upon admission and if they did not have one, staff were to offer an advance directive at admission and periodically throughout their stay. 3. Resident 22 was admitted to the facility in 12/2025 with diagnoses including diabetes and depression. A review of Resident 22's medical record revealed no indication the resident was asked if she/he had an advance directive or was offered a blank form to complete. On 2/10/26 at 3:01 PM Resident 22 stated the facility never discussed her/his wishes and she/he was not offered an advance directive. On 2/10/26 at 3:12 PM Staff 7 (SSD) stated Resident 22 was not offered an advance directive upon admission to the facility and there was no follow up since admission. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 25 admitted to the facility in 12/2025 with a diagnosis of osteomyelitis (bone infection). A 12/22/25 admission MDS revealed Resident 25 had a BIMS of 15 which indicated she/he was cognitively intact. A 12/23/25 care plan revealed Resident 25 had an advance directive for full code status. A review of Resident 25's medical record revealed no information related to an advance directive. On 2/10/26 at 1:44 PM Resident 25 stated she/he had advance directive paperwork at home and the facility did not ask her/him to provide it to the facility. On 2/10/26 at 2:05 PM Staff 7 (SSD) stated the advance directive information on Resident 25's care plan referred to her/his POLST and she was unaware Resident 25 had an advance directive at home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide a recapitulation of the resident's stay at the time of discharge for 3 of 3 sampled residents (#s 61, 62, and 63) reviewed for Beneficiary Notification Review. This placed residents at risk for lack of knowledge regarding their care and treatment provided during their stay at the facility. Findings include: 1. Resident 61 was admitted to the facility in 12/2025 with diagnoses including sepsis and cellulitis.A review of Resident 61's medical record revealed she/he discharged from the facility on 1/8/26 and there was no indication a written recapitulation of Resident 61's stay was completed and provided to the resident at the time of discharge.On 2/12/26 at 10:42 AM Staff 3 (Assistant Regional Director of Clinical Services) stated at the time of discharge facility staff provided verbal education, a printed copy of the physician orders, lab results as applicable, a printed progress note, and home health details.On 2/13/26 at 12:07 PM Staff 5 (Regional Director of Clinical Services) stated a recapitulation was not completed and provided to Resident 61 at discharge. 2. Resident 62 was admitted to the facility on [DATE] with diagnoses including pneumonia and adult failure to thrive.A review of Resident 62's medical record revealed she/he discharged from the facility on 9/30/25. There was no indication a written recapitulation of Resident 62's stay was completed and provided to the resident at the time of discharge.On 2/12/26 at 10:42 AM Staff 3 (Assistant Regional Director of Clinical Services) stated at the time of discharge facility staff provided verbal education, a printed copy of the physician orders, lab results as applicable, a printed progress note, and home health details.On 2/13/26 at 12:07 PM Staff 5 (Regional Director of Clinical Services) stated a recapitulation was not completed and provided to Resident 62 at discharge. 3. Resident 63 was admitted to the facility on [DATE] with diagnoses including diabetes and muscle weakness. A review of Resident 63's medical record revealed she/he discharged from the facility on 10/2/25. There was no indication a written recapitulation of Resident 63's stay was completed and provided to the resident at the time of discharge.On 2/12/26 at 10:42 AM Staff 3 (Assistant Regional Director of Clinical Services) stated at the time of discharge facility staff provided verbal education, a printed copy of the physician orders, lab results as applicable, a printed progress note, and home health details.On 2/13/26 at 12:07 PM Staff 5 (Regional Director of Clinical Services) stated a recapitulation was not completed and provided to Resident 63 at discharge.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review it was determined the facility failed to investigate the root cause of resident falls for 8 of 10 sampled fall investigations and the facility failed to ensure safety interventions were in place to prevent smoking related accidents for 1 of 6 sampled residents (#7) reviewed for accidents. This placed residents at risk for further falls and smoking injuries. Findings include: 1. Resident 4 was admitted to the facility in 10/2025 with diagnoses including seizures and dementia. On 2/9/26 at 10:35 AM, Resident 4 stated she/he had a lot of falls due to self-transferring when she/he was tired of lying in bed. A 12/27/25 facility investigation indicated on 12/11/25 Resident 44 was found on the floor in the dining room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 12/27/25 facility investigation indicated on 12/12/25 Resident 44 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 12/27/25 facility investigation indicated on 12/18/25 Resident 44 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 12/27/25 facility investigation indicated on 12/20/25 Resident 44 fell while standing using the urinal. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 12/27/25 facility investigation indicated on 12/23/25 Resident 44 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 2/3/26 facility investigation indicated on 1/29/26 Resident 44 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 2/3/26 facility investigation indicated on 1/29/26 Resident 44 was found on the floor in her/his room a second time. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. A 2/3/26 facility investigation indicated on 2/2/26 Resident 44 was found on the floor in her/his room. The investigation did not include an analysis of the root cause of the fall, or whether care planned interventions were effective, or if any additional interventions were put in place. On 2/13/26 at 10:59 AM, Staff 5 (Regional Director of Clinical Services), stated the fall investigations were not thorough, were missing the root cause analysis for the falls, and interventions were not put in place to help prevent further falls or help prevent injuries from falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility's 9/2024 Smoking Policy indicated the following: All smoking materials, including cigarettes, electronic cigarettes and lighters were to be locked up. Resident 7 admitted to the facility in 10/2024 with diagnoses including sepsis (the body's response to an extreme infection). A 1/8/26 Quarterly MDS indicated Resident 7 was cognitively intact. A 1/24/26 Care Plan indicated Resident 7 was assessed to be safe and independent while smoking and had to store her/his smoking supplies at the nurse's station. Multiple observations from 2/9/26 through 2/13/26 revealed Resident 7 had her/his lighter on the bedside table. On 2/11/26 at 8:18 AM Resident 7 stated she/he passed the facility assessment and was allowed to smoke at any time, and was able to keep smoking supplies in her/his room. Resident 7 stated she/he did not receive a lock box to secure the smoking supplies. On 2/11/26 at 8:56 AM Staff 12 (CNA) stated the facility had residents who required supervision while smoking, as well as residents who were cleared to smoke independently. Staff 12 stated residents who required supervision while smoking had to leave their smoking supplies in a secured lock box at the nurse's station and the residents who were able to smoke independently were allowed to keep their smoking items in their room. Staff 12 denied knowing if residents had locked boxes in their rooms. On 2/11/26 at 2:38 PM Staff 10 (LPN) stated the smoking policy required all residents to return smoking items to the nurse's station between each smoke break. Staff 10 stated he was aware of times when Resident 7 failed to return her/his lighter to the nurse's station after smoking. Staff 10 stated the resident never experienced any smoking related accidents and was able to make safe decisions related to smoking. On 2/12/26 at 10:52 AM Staff 1 (Administrator) stated the residents who were identified as smokers were expected to store all smoking supplies in a secured box at the nurse's station or in a personal lock box in their rooms. Staff 1 and the surveyor observed Resident 7 with a lighter on her/his bedside table and Staff 1 acknowledged the lighter was not stored in a secure manner.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 2 of 5 sampled CNA staff (#s 15, 16, and 17) reviewed for sufficient and competent nurse staffing. This placed residents at risk for a lack of competent staff. Findings include:A review of personnel records indicated the following employees did not receive their annual performance evaluations:-Staff 15 (CNA), hire dated was 4/9/22 and a performance review was not completed.-Staff 16 (CNA), hire date was 1/17/22 and a performance review was not completed.-Staff 17 (CNA), hire date was 10/1/13 and a performance review was not completed.On 2/12/26 at 2:26 PM Staff 3 (Assistant Director of Clinical Services) confirmed annual performance reviews for Staff 15, Staff 16, and Staff 17 were not completed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to report allegations of abuse for 1 of 1 sample resident (#2) reviewed for abuse. This placed residents at risk for resident-to-resident abuse. Findings include: 1. Resident 2 was admitted to the facility in 5/2025 with diagnoses including anxiety and depression.Resident 43 was admitted to the facility in 10/2025 with diagnoses including traumatic brain injury and depression.A 11/8/25 Progress Note indicated Resident 2 was involved in a verbal altercation with Resident 43 and Resident 43 threatened to hit Resident 2 with her/his hand and with a box of gloves.A 11/8/25 written statement by Staff 23 (CNA) indicated Resident 43 rose her/his hand towards Resident 2 and Resident 2 expressed fear.Resident 2 was unable to be interviewed related to this incident due to cognitive impairment. On 2/11/26 at 11:51 AM, Staff 2 (DNS) acknowledged there was no investigation completed for the 11/8/25 altercation between Resident 2 and Resident 43 and stated the incident was not reported to the State Agency.On 2/11/26 at 1:35 PM, Staff 23 stated on 11/8/25 Resident 43 became upset with Resident 2 and Resident 43 raised her/his hand at Resident 2. Staff 23 stated Resident 2 flinched when Resident 43 raised her/his hand at Resident 2.On 2/13/26 at 10:49 AM Staff 5 (Regional Director of Clinical) stated the resident-to-resident incident described above should have been reported to the State Agency.2. Resident 2 was admitted to the facility in 5/2025 with diagnoses including anxiety and depression.Resident 43 was admitted to the facility in 10/2025 with diagnoses including traumatic brain injury and depression.On 2/11/26 at 11:51 AM, Staff 2 (DNS) provided an investigation for a 11/9/25 resident-to-resident altercation. Staff 2 stated abuse and neglect was immediately ruled out so the incident was not reported to the State Agency.Resident 43's 11/9/25 Progress Note written by Staff 24 (LPN) indicated Resident 43 kicked Resident 2 when Resident 2 would not give Resident 43 a cigarette.A 11/10/25 investigation indicated Staff 24 did not mean to chart Resident 43 kicked Resident 2. The investigation indicated Staff 24 witnessed the altercation from a distance and witnessed Resident 43 kick at Resident 2, but no physical contact was made.On 2/12/26 at 2:01 PM, Staff 24 stated on 11/9/25 there was an altercation between Resident 43 and Resident 2. Staff 24 stated she saw Resident 43's and Resident 2's wheelchairs bump into each other and Resident 2 stated Resident 43 hit her/him. Staff 24 stated the on-call nurse was notified of the incident.On 2/13/26 at 10:49 AM Staff 5 (Regional Director of Clinical) stated the identified resident-to-resident incident was not reported to the State Agency, but should have been reported.

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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. Based on interview and record review it was determined the facility failed to investigate an allegation of abuse for 1 of 1 sampled resident (#2) reviewed for abuse. This placed residents at risk for continued abuse. Findings include:1. Resident 2 was admitted to the facility in 5/2025 with diagnoses including anxiety and depression.Resident 43 was admitted to the facility in 10/2025 with diagnoses including traumatic brain injury and depression.A 11/8/25 Progress Note indicated Resident 2 was involved in a verbal altercation with Resident 43 and Resident 43 threatened to hit Resident 2 with her/his hand and with a box of gloves.A 11/8/25 written statement written by Staff 23 (CNA) indicated Resident 43 rose her/his hand towards Resident 2 and Resident 2 expressed fear.Resident 2 was unable to be interviewed related to this incident due to cognitive impairment.On 2/11/25 at 11:51 AM, Staff 2 (DNS) stated there was no investigation completed for the 11/8/25 altercation between Resident 2 and Resident 43.On 2/11/26 at 1:35 PM, Staff 23 (CNA) stated on 11/8/25 Resident 43 became upset with Resident 2 and Resident 43 raised her/his hand at Resident 2. Staff 23 stated Resident 2 flinched when Resident 43 raised her/his hand at Resident 2.On 2/13/26 at 10:49 AM Staff 5 (Regional Director of Clinical) stated the 11/8/25 resident-to-resident incident should have been investigated.2. Resident 2 was admitted to the facility in 5/2025 with diagnoses including anxiety and depression.Resident 43 was admitted to the facility in 10/2025 with diagnoses including traumatic brain injury and depression.On 2/11/26 at 11:51 AM, Staff 2 (DNS) provided an investigation for a 11/9/25 resident-to-resident altercation. Staff 2 stated abuse and neglect was immediately ruled out so the incident was not reported to the state agency.Resident 43's 11/9/25 Progress Note written by Staff 24 (LPN) indicated Resident 43 kicked Resident 2 when Resident 2 would not give Resident 43 a cigarette.A review of Resident 2's medical record revealed no evidence of documentation related to an altercation with Resident 43. A 11/10/25 investigation indicated Staff 24 errantly documented that Resident 43 kicked Resident 2. The investigation indicated Staff 24 witnessed the altercation from a distance and witnessed Resident 43 kick at Resident 2, but no physical contact was made.On 2/12/26 at 2:01 PM, Staff 24 stated on 11/9/25 there was an altercation between Resident 43 and Resident 2. Staff 24 stated she saw Resident 43's and Resident 4's wheelchairs bump into each other and Resident 2 stated Resident 43 hit her/him. Staff 24 stated the on-call nurse was notified of the incident.On 2/13/26 at 10:49 AM Staff 5 (Regional Director of Clinical) stated the identified resident-to-resident incident was not investigated thoroughly.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review it was determined the facility failed to accurately code an MDS assessment for 1 of 2 sampled residents (#1) reviewed for respiratory care. This placed residents at risk for unassessed needs. Finding include:Resident 1 was admitted to the facility in 9/2025 with diagnoses including cancer of the larynx and lungs.A 12/10/25 Physician Order revealed orders for oxygen as needed.A review of the 12/2025 MAR revealed Resident 1 received oxygen daily.A 12/10/25 Physician Order revealed orders to monitor for need for suctioning every four hours.A review of the 12/2025 MAR revealed documentation Resident 1 needed suctioning two to three times a day.A 12/20/25 Significant Change MDS indicated Resident 1 did not receive oxygen and did not need to be suctioned.On 2/12/26 at 1:26 PM, Staff 3 (Assistant Director of Clinical) stated Resident 1 received oxygen and suctioning during the look back period for the 12/20/25 Significant Change MDS. Staff 3 acknowledged the MDS was coded incorrectly.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to complete a baseline care plan within 48 hours of a resident's admission for 1 of 1 sampled resident (#28) reviewed for dialysis. This placed residents at risk for dialysis access site complications. Findings include: The facility's Baseline Plan of Care policy, last updated 9/2024, indicated the following:-It is the policy of this facility that direct caregivers have accurate information available to them to properly care for their residents.-The licensed nurse completes the initial nursing database upon admission. The nurse collects information about the resident and their needs. Interventions are implemented and available on the plan of care for the CNA and other caregivers to review.The facility's Hemodialysis Care policy, last updated 9/1/24, indicated the following:-Care Plan interventions are individualized to the resident, but also include the following:a. No blood draws on access arm.b. No blood pressure readings on access arm - unless otherwise specified by dialysis center or physician as some allow.c. Emergency supplies kept at beside.d. Routine weight per medical provider order.Resident 28 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease and diabetes.A review of the 1/24/26 Nursing admission Evaluation and Assessment revealed Resident 28 received dialysis (a medical treatment that removes waste products from the blood when the kidneys are not working properly) treatments.A review of the care plan revealed in the undated Special Instructions at the top of the care plan, Resident 28 received dialysis on Monday, Wednesday, and Fridays at 6:00 AM with transportation arriving at 5:00 AM. A care plan initiated on 1/28/26 (four days after admission) revealed Resident 28 required dialysis for end stage renal failure with a fistula to her/his left forearm and was at risk for bleeding at the access site, edema, hypertension and hypotension. Staff were to check the fistula site dressing upon return from dialysis.Resident 28's care plan did not include instructions related to blood draws, blood pressure, location of emergency supplies, or information about obtaining routine weights.On 2/13/26 at 9:43 AM Staff 4 (Assistant DNS/LPN) and Staff 2 (DNS) acknowledged Resident 28's baseline care plan did not adequately address the resident's care needs related to dialysis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to develop a comprehensive care plan for 2 of 5 sampled residents (#s 22 and 28) reviewed for nutrition and pain. This placed residents at risk for unmet needs. Findings include:A review of the undated facility Comprehensive Person-Centered Care Plans policy revealed the following:-The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.-The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Resident 22 was admitted to the facility in 12/2025 with diagnoses including a wedge compression fracture of the lumbar (lower back), pain in an unspecified joint and opioid dependence.A review of the 12/31/25 admission MDS revealed Resident 22 had frequent pain and received scheduled and PRN pain medication. The Pain CAA revealed Resident 22 had chronic pain in her/his back that limited her/his day-to-day activities, participation in rehab therapy and disturbed her/his sleep. Staff were to encourage Resident 22 to turn and reposition for comfort and Resident 22's care plan would be developed to monitor pain management.A review of Resident 22's care plan revealed no indication the pain care plan was developed, and no goals or interventions were implemented to monitor the residents pain management.On 2/13/26 at 9:41 AM Staff 2 (DNS) stated Resident 22's pain care plan needed to be created upon admission and updated as staff became aware of any changes or new interventions. 2. Resident 28 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD) and malnutrition.A review of the 1/24/26 Nursing admission Evaluation and Assessment revealed Resident 28 received dialysis (a medical treatment that removes waste products from the blood when the kidneys are not working properly) treatments.A review of the 1/29/26 admission Nutritional Risk Assessment revealed Resident 28 was at nutritional risk related to malnutrition, was on a therapeutic diet, and there was potential for decreased intake related to ESRD with dialysis. It was noted Resident 28's weight fluctuations were expected to shift with dialysis treatments, and the resident would benefit from additional protein with meals.A review of the 1/31/26 admission MDS Nutritional Status CAA revealed Resident 28 was dependent on dialysis treatments, had a diagnosis of malnutrition and the nutrition care plan would be developed and updated as needed.A review of Resident 28's care plan revealed no indication the nutrition care plan was developed, and no goals or interventions were implemented related to the resident's diagnosis of malnutrition.On 2/13/26 at 10:01 AM Staff 4 (Assistant DNS/LPN) stated she oversaw Resident 28's comprehensive care plan, and it needed a nutrition care plan related to the risk for malnutrition. Staff 4 confirmed Resident 28 did not have a nutrition care plan.On 2/13/26 at 10:03 AM Staff 2 (DNS) stated she expected each resident's comprehensive care plan to be developed to include goals and interventions related to nutrition.

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	385245	A. Building B. Wing	02/13/2026

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

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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 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. Based on observation, interview and record review it was determined the facility failed to ensure residents received treatment and care for a catheter for 1 of 1 sampled resident (#25) reviewed for urinary catheter. This placed residents at risk for urinary tract infections. Findings include: Resident 25 admitted to the facility in 12/2025 with diagnoses including osteomyelitis (bone infection) and neurogenic bladder (loss of bladder control). A 12/15/25 Nursing admission Assessment revealed Resident 25 admitted to the facility with a catheter in place.A 12/22/25 admission MDS revealed Resident 25 had an indwelling catheter in place. A review of Resident 25's physician orders revealed no orders related to the care of her/his indwelling catheter until 2/9/26.On 2/9/26 at 1:53 PM Resident 25 was observed with a catheter. Resident 25 stated she/he felt the facility did not provide required care for the catheter. On 2/10/26 at 2:54 PM Staff 19 (RN) stated physician orders were required to direct the nursing staff to provide care for catheters, including when to flush and change them. Staff 19 stated she did not change Resident 25's catheter and did not recall any issues with it.On 2/12/26 at 9:54 AM Staff 20 (LPN Resident Care Manager) stated Resident 25 admitted to the facility with a catheter in place, but the facility did not obtain orders to provide care for it until 2/9/26.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary antiplatelet medications for 1 of 1 sampled resident (#28) reviewed for dialysis. This placed residents at risk for adverse side effects. Findings include:Resident 28 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD) and acute embolism and thrombosis of deep veins in lower extremity (a blood clot forms inside a blood vessel then breaks off and travels through the bloodstream until it lodges in a narrower vessel).A review of the 1/24/26 Hospital Transfer orders revealed Resident 28 was to start Eliquis (an anticoagulant) on 1/24/26. Resident 28 was to then start Plavix (an antiplatelet) on 3/6/26. Special instructions stated to not take Plavix while on Eliquis.A review of the January 2026 MAR revealed Resident 28 started Eliquis on 1/24/26 per physician orders and continued receiving Eliquis through 2/9/26. The MAR also revealed on 1/28/26 an order for Plavix was entered and administered to Resident 28 starting on 1/29/26 and continuing through 2/9/26 (12 days).A 2/9/26 Progress Note indicated Resident 28 returned from a dialysis treatment with abnormal lab results and was sent to the Emergency Department (ED) to be evaluated.A 2/10/26 Progress Note indicated Resident 28 returned from the ED, had low hemoglobin lab results and the resident was told not to take Eliquis and Plavix together.On 2/11/26 at 4:00 PM Staff 10 (LPN) stated he entered the order for Plavix on 1/28/26 in error. A 2/13/26 Medication Error Incident Report revealed the 2/9/26 ED discharge orders indicated Resident 28 Plavix should have been held until Resident 28 was done taking Eliquis, but the Plavix was not held. On 2/13/26 at 9:59 AM Staff 2 (DNS) stated on 2/9/26 Resident 28 went to the ED due to abnormal lab results and it was found Resident 28 received Eliquis and Plavix together for 12 days. Staff 2 stated Plavix should have been held during the course of Eliquis, and it was not.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to store resident food in a sanitary manner for 1 of 1 resident refrigerator reviewed for food safety. This placed residents at risk for contamination and at risk for foodborne illness. Findings include:A review of the 9/1/24 Resident Food from Outside Source facility policy revealed the following:-Refrigerated food items from an outside source are stored in a container with the date it was received, name of product type, and resident name/room number.-Refrigerated products are discarded on the following schedule: homemade items, restaurant leftovers, take out items, milk, cottage cheese and similar type items are discarded on day three. During a review of the resident refrigerator located in the dining room on 2/12/26 at 3:50 PM, the following was found:-One clear plastic container that contained what appeared to be sliced peppers that were brown in color. It was labeled with a resident's name and dated 1/6/26 (stored 37 days).-A clump of thick brown creamy substance located on the ceiling of the refrigerator.-Sticky brown residue on the shelf of the door.On 2/12/26 at 3:55 PM Staff 9 (Dietary Manager) stated the resident refrigerator was cleaned weekly and as needed. Staff 9 stated it was the responsibility of the kitchen staff to clean and discard outdated food items. Staff 9 stated they followed the use by or sell by date, and any homemade items were discarded on day three. Staff 9 confirmed the condition of the refrigerator and the outdated food items. On 2/13/26 at 11:24 AM Staff 1 (Administrator) acknowledged the findings and stated he expected the resident refrigerator to remain clean.

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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. Based on observation, interviews, and record review it was determined the facility failed to follow transmission-based precautions for 1 of 1 facility reviewed for infection control. This placed residents at risk for infection. Findings include:Resident 25 was admitted to the facility in 12/2025 with diagnoses including diabetes.On 2/9/26 at 11:47 AM Resident 25 was observed to have a urinary catheter in place, and Staff 20 (CNA) was observed transferring Resident 25 into her/his wheelchair without a gown on.On 2/9/26 at 12:02 PM, Staff 20 stated Resident 25 was on enhanced barrier precautions, and she should have worn a gown when transferring Resident 25 out of bed.On 2/11/25 at 1:19 PM Staff 4 (LPN Infection Preventionist/Assistant Director of Nursing) stated Resident 25 was on enhanced barrier precautions due to having a urinary catheter and wounds. Staff 4 stated when residents were on enhanced barrier precautions, staff were expected to wear gloves and a gown when providing direct patient care such as transferring residents out of bed.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and record review it was determined the facility failed to ensure survey results of the previous year were readily accessible for 1 of 1 facility reviewed for resident council. This placed residents and the public at risk for not being informed of the facility's survey history. Findings include:On 2/12/26 at 8:46 AM after the resident council meeting, Resident 37 stated she/he reviewed the survey results binder, and she/he noticed the survey results posted in the binder were from two years ago.On 2/12/26 at 9:16 AM the survey binder was observed near the entrance of the facility. The report from the facility's most recent survey was not found.On 2/12/26 at 10:52 AM Staff 1 (Administrator) acknowledged the most recent survey results were not included in the facility survey binder.