STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385251	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Hillsboro	650 SE Oak Street Hillsboro, OR 97123

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 47000 Based on observation, interview and record review it was determined the facility failed to ensure overbed lights and television remotes were accessible for 3 of 5 sampled residents (#s 6, 362 and 364) reviewed for accommodation of needs. This placed residents at risk for loss of independence. Findings include: The facility's 3/2021 Accommodation of Needs Policy indicated the following: -Staff attitudes and behaviors are directed towards assisting residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes, including arranging personal items so that they are in easy reach of the resident. -Adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations include installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible. 1. Resident 6 was admitted to the facility in 1/2023 with diagnoses including chronic kidney disease. Resident 6's 11/7/24 Quarterly MDS revealed the resident was cognitively intact and dependent on staff for assistance with transfers. On 1/13/25 at 1:33 PM Resident 6 was observed in her/his room in bed with her/his television on. Resident 6 asked the state surveyor to turn off her/his television since she/he did not have a remote control. Resident 6 stated she/he did not have a remote for her/his television for over a month and she/he called everyone to inform them the remote was missing. Resident 6 stated she/he was so angry because every time I want to change the channel or turn the television on or off, someone has to come in. I don't want to piss anyone off, so I just don't do it. On 1/16/25 at 11:30 AM Staff 21 (CNA) stated maintenance staff fixed Resident 6's television a month ago but did not provide the resident with a remote for her/his television. On 1/16/25 at 11:44 AM Staff 20 (CNA) stated Resident 6's television remote was missing for two-to-three weeks. Staff 20 stated she thought the resident reported the missing remote to management, they were not doing anything and the resident was frustrated. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/25 at 10:05 AM Staff 10 (Maintenance Director) stated he was unaware Resident 6 did not have a remote control for her/his television. On 1/17/25 at 12:30 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 51846 2. Resident 362 was admitted to the facility in 1/2025 with a diagnosis of pneumonitis (inflammation of lung tissue). On 1/13/25 at 10:25 AM, Resident 362 could not reach the overbed light above her/his bed. The overbed light cord was approximately 3 inches long and out of the resident's reach. There were no other means of adjusting the overbed light. On 1/15/25 at 9:53 AM, Staff 31 (LPN) stated residents should be able to turn the light off on their own and not have to rely on staff to do so. On 1/15/25 at 10:16 AM, Staff 10 (Maintenance) stated that residents should be able to turn their overbed light on and off independently and that cords should be at least 24 inches long. On 1/21/25 at 12:10 PM Staff 1 (Administrator) confirmed the cord to residents' overhead lights should be long enough to drape on the bed for residents to have access. 3. Resident 364 was admitted to the facility in 12/2024 with a diagnosis of severe protein-calorie malnutrition. On 1/15/25 at 9:52 AM, Resident 364's overbed light cord was about 11 inches long and out of the resident's reach. On 1/15/25 at 9:53 AM, Staff 31 (LPN) stated residents should be able to turn the light off on their own and not have to rely on staff to do so. On 1/15/25 at 10:16 AM, Staff 10 (Maintenance) stated residents should be able to turn their overbed light on and off independently and cords should be at least 24 inches long. On 1/21/25 at 12:10 PM Staff 1 (Administrator) confirmed the cord to resident overhead lights should be long enough to drape on the bed for residents to have access.

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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. 47000 Based on observation, interview and record review it was determined the facility failed to ensure a resident request for a personal computer was honored for 1 of 1 sampled resident (#31) reviewed for behavioral-emotional needs. This placed residents at risk for unmet psychosocial and activity needs. Findings include: Resident 31 was admitted to the facility in 12/2019 with diagnoses including Huntington's disease (a genetic disorder that causes nerve cells in the brain to break down, which leads to uncontrolled movements, cognitive decline and emotional disturbances). A 12/3/24 Care Conference Note indicated Resident 31 requested a personal computer to use that was not too hard. A 12/4/24 Social Service Note indicated Witness 1 (Representative Payee) was to load more funds onto [Resident 31's] Visa so a personal computer could be purchased. Resident 31's 12/4/24 Annual MDS revealed the resident was cognitively intact. On 1/21/25 at 9:41 AM Witness 1 stated she received a request to load money onto [Resident 31's] card back in December 2024. Witness 1 further stated she loaded the funds onto the resident's card on 12/4/24, the computer had still not been purchased and someone at the facility was supposed to assist with this purchase. On 1/21/25 at 10:47 AM Resident 31 was observed in her/his room in her/his wheelchair. No computer was observed in her/his room. Resident 31 stated she/he requested a personal computer in early December 2024 but never received one. Resident 31 further stated she/he still wanted a computer because she/he felt sort of cut off. On 1/21/25 at 11:11 AM Staff 12 and 13 confirmed Resident 31 made a request for a personal computer on 12/4/24, the resident had the funds available to purchase a computer and one had still not been purchased. On 1/21/25 at 11:35 AM Staff 1 (Administrator) acknowledged the facility did not assist Resident 31 to purchase a computer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005 Based on interview and record review it was determined the facility failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notifications to 2 of 3 sampled residents (#s 12 and 48) reviewed for Beneficiary Notification. This placed residents and their representatives at risk for lack of knowledge regarding their right to appeal and unknown financial liabilities. Findings include: 1. Resident 12 was admitted to the facility on [DATE] with Medicare Part A benefits. Resident 12's SNF Beneficiary Protection Notification Review provided by the facility indicated the resident's last covered day for Medicare Part A services was 11/1/24 and Resident 12 remained in the facility. According to the SNF Beneficiary Notification form, the resident was not provided with a SNF ABN notification to inform them or their representative of potential out-of-pocket expenses. On 1/15/25 at 1:40 PM Staff 12 (Social Services Director) stated the facility did not issue SNF ABN notifications to residents when they were discharged from Medicare Part A services and remained in the facility and confirmed Resident 12 did not receive the required SNF ABN notification. On 1/17/25 at 11:43 AM Staff 1 (Administrator) acknowledged the facility did not issue SNF ABN notifications to residents and their representatives as required. 2. Resident 48 was admitted to the facility on [DATE] with Medicare Part A benefits. Resident 48's SNF Beneficiary Protection Notification Review provided by the facility indicated the resident's last covered day for Medicare Part A services was 10/28/24 and Resident 48 remained in the facility. According to the SNF Beneficiary Notification form, the resident was not provided with a SNF ABN notification to inform them or their representative of potential out-of-pocket expenses. On 1/15/25 at 1:40 PM Staff 12 (Social Services) stated the facility did not issue SNF ABN notifications to residents when they were discharged from Medicare Part A services and remained in the facility and confirmed Resident 48 did not receive the required SNF ABN notification. On 1/17/25 at 11:43 AM Staff 1 (Administrator) acknowledged the facility did not issue SNF ABN notifications to residents and their representatives as required.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005 Based on interview and record review it was determined the facility failed to address a grievance for 1 of 3 sampled residents (#38) reviewed for personal property. This placed residents at risk for unresolved grievances. Findings include: The facility's 9/2004 Lost Item Policy indicated the following: -It is the policy of this facility to protect residents' items from theft or loss to the extent possible. Every effort will be made to insure against theft or loss, to recapture lost items, or to make restitution should a lost item not be recovered. Resident 38 was admitted to the facility on ,d+[DATE] with anemia (a condition in which blood lacks adequate healthy red blood cells) and chronic kidney disease (a long-term condition in which the kidneys are damaged and decrease in function). Resident 38's 12/26/24 Quarterly MDS revealed the resident was cognitively intact. On 1/13/25 at 11:03 AM Resident 38 stated she/he was missing several clothing items and a personalized blanket received as a birthday gift several months ago. Resident 38 stated she/he told everyone and someone assisted her/him to file grievances on the missing items with no resolution. Staff 38 stated he/he ran out of clothing and that the CNAs had to get clothing from the donated rack in laundry. On 1/15/25 at 10:24 AM Staff 34 (CNA) stated Resident 38 reported missing clothing and assisted the resident to fill out the Lost or Damaged Item form several months ago. On 1/15/25 at 3:36 PM Staff 12 (Social Services) stated Resident 38 submitted two Lost or Damaged Items forms on 9/19/24 for six missing shirts and a personalized blanket the resident received as a gift. Staff 12 stated the items were not located or replaced. 1/21/25 at 10:32 AM Staff 1 (Administrator) acknowledged Resident 38 had missing items and the grievance was unresolved from 9/2024. Staff 1 stated it was her expectation grievances were to be followed-up with the resident and family for an agreeable resolution.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50928 Based on interview and record review, it was determined the facility failed to implement a process of notifying the Ombudsman when residents transfered to the hospital for 2 of 2 sampled residents (#s 40 and 60) reviewed for hospitalization . This placed residents at risk of being uninformed. Findings include: 1. Resident 60 was admitted to the facility in 11/2024 with diagnoses including Hypertrophic Pyloric Stenosis (swelling of muscles which creates a blockage of contents from the stomach to the small intestine). A progress note dated 11/13/24 indicated Resident 60 was sent to the hospital for shortness of breath and fluid retention around his abdomen, groin, and legs. A review of Resident 60' s clinical record revealed no indication the Office of the State Long-Term Care Ombudsman was notified the resident was transferred to the hospital. On 1/21/25 at 9:15AM, Staff 1 (Administrator) acknowledged the requirement to notify the Ombudsman and stated the facility did not have a process to implement the requirement. 51846 2. Resident 40 was admitted to the facility in 10/2024 with a diagnosis of pneumonitis (inflammation of lung tissue). Resident 40 was admitted to the hospital on 10/30/24 for being non-responsive to staff. Resident 40 was admitted to the hospital on 11/16/24 for pulmonary embolism (blood clot traveling to lungs and blocking one or more pulmonary arteries) and sepsis (body's immune system overreacting to infection). Resident 40 was admitted to the hospital 12/9/24 for spitting up blood and shortness of breath. Resident 40 was admitted to the hospital on 1/6/25 for pneumonitis (inflammation of lungs). A review of Resident 40's medical records revealed no indication the Office of the State Long-Term Care Ombudsman was notified the resident was transferred to the hospital. On 1/21/25 at 9:15AM, Staff 1 (Administrator) acknowledged the requirement to notify the Ombudsman and stated the facility did not have a process to implement the requirement.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47000 Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activities program for 1 of 2 sampled residents (#46) reviewed for activities. This placed residents at risk for a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's 2/2005 Activities Policy revealed the facility would provide an activities program that addressed the intellectual, social, spiritual, creative and physical needs, capabilities and interests of each resident. Resident 46 was admitted to the facility in 8/2024 with diagnoses including alcoholic cirrhosis of the liver with ascites (a condition where the liver is permanently scarred due to alcohol consumption and fluid builds up in the abdomen). Resident 46's Admission MDS revealed the resident was cognitively intact and reading books, newspapers and magazines, listening to music, keeping up with the news, going outside to get fresh air, doing things with groups of people, doing her/his favorite activities and participating in religious services or practices were important activities to the resident. The Functional Abilities CAA indicated the resident was on hospice and her/his life expectancy was three months or less. Resident 46's 11/5/24 Activity Care Plan revealed the following: -The resident preferred independent or self-directed activities. -The resident would self-initiate activities daily. -Activity interests included blues music, reading and keeping up with the news. -Activity needs included the newspaper and her/his computer. Resident 46's 11/26/24 End-of-Life Care Plan indicated spiritual needs would be offered and met per resident wishes and bereavement support was to be provided to the resident. A 1/2/25 Hospice Progress Note indicated Resident 46 was confused, forgetful and slept more. The facility's 1/2025 Activity Calendar revealed the following activities: -1/13/25: 8:30 AM Room Visits 10:00 AM Bible Study 11:00 AM Large Group Exercises (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:00 PM Teatime Social 3:00 PM Afternoon Rounds and Mail -1/14/25: 8:30 AM Room Visits 10:30 AM Library Cart 2:00 PM Nails and Hand Massages 3:00 to 4:00 PM Afternoon Rounds and Mail -1/15/25: 8:30 AM Room Visits 11:00 AM Large Group Exercises 11:30 AM Resident Shopping 3:00 PM Afternoon Rounds and Mail A review of Resident 46's activity participation documentation from 12/28/24 through 1/15/25 revealed the resident did not receive any one-to-one visits, go outside, utilize her/his computer, listen to music or participate in group activities, including religious services. Observations of Resident 46 from 1/13/25 through 1/15/25 from 5:22 AM to 6:15 PM revealed the resident to be in her/his room either in bed or in her/his wheelchair with the television on. No newspapers, books, magazines or a computer were observed to be accessible to the resident. On 1/13/24 at 11:24 AM Resident 46 stated she/he missed her/his music and she/he wanted to participate in activities at the facility. Resident 46 stated she/he used a computer but was unsure where her/his computer was. On 1/15/25 at 10:07 AM Resident 46 waved the state surveyor in the hall to come into her/his room and stated she/he was up to nothing and would love to do something but did not know if [she/he] could. On 1/15/25 at 3:07 PM Staff 28 (CNA) stated Resident 46 was confused and forgetful, she was not aware of Resident 46's activity interests and she did not know where to find information on the resident's activity interests. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 9:54 AM Staff 32 (CNA) stated Resident 46 had declined and needed help to make decisions. Staff 32 stated Resident 46 used to play bingo and do puzzles with other residents when she/he was independent but now the resident was pretty dependent and mostly watched television. Staff 32 stated the resident used a computer and liked to receive the newspaper but she had not seen the resident with either this week. On 1/16/25 at 12:02 PM Staff 33 (LPN) stated Resident 46 spent more and more time in bed and her/his cognition changed every day. Staff 33 stated the resident needed support to direct her/his day and to make decisions. Staff 33 stated she had not seen the resident on her/his computer, listen to music or with a newspaper or book for maybe three weeks. On 1/16/25 at 1:04 PM Resident 46 again waved the state surveyor in the hall to come into her/his room and asked if there was any music going on? On 1/17/25 at 11:33 AM Staff 14 (Activity Director) stated Resident 46 was more isolated, did not get out of her/his room and was unable to self-initiate or direct activities. Staff 14 stated activity interests documented in a resident's MDS should be included in the resident's care plan and acknowledged Resident 46's activity care plan was not comprehensive. Staff 14 stated she had never seen the resident listen to music or use her/his computer. Staff 14 stated a facility volunteer did a weekly Bible study with residents who expressed interest and Resident 46 was supposed to be on that list. Staff 14 found the Bible study list, confirmed Resident 46 was not on the list and did not participate in this activity. Staff 14 further stated she did not receive really any training on how to provide activities for residents on hospice, including how and when to adjust care plans for residents at end-of-life, or how to complete person-centered one-to-one visits with residents. Staff 14 stated she was unaware Resident 46 was on hospice but was aware of her/his declining cognition because other residents reported Resident 46's declines to her. On 1/17/25 at 12:17 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (Regional Nurse Consultant) acknowledged the findings of this investigation and Staff 1 stated Resident 46's activity care plan was in need of revision.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to ensure a safe environment and care plan interventions to prevent falls were implemented for 1 of 3 sampled residents (#46) reviewed for accidents. This placed residents at risk for injury from accidents. Findings include: The facility's 3/2018 Falls and Fall Risk Policy indicated staff would identify interventions related to a resident's specific risks and causes to prevent the resident from falling and to minimize complications from falling. The policy further identified incorrect bed height as an environmental factor that could contribute to the risk of falls. The facility's 7/2024 Code Pink Guidelines directed the following: -An elopement/exit-seeking/wandering assessment, called a code pink documentation tool, was completed at the time a resident was identified as at risk for elopement/exit-seeking/wandering. -General guidelines for when a door alarm sounded included to check the door and the immediate area near the exit (outside and inside to determine no resident exited or attempted to exit the facility unaccompanied and reset the alarm. -Door alarms to be checked per door alarm policy. Resident 46 was admitted to the facility in 8/2024 with diagnoses including alcoholic cirrhosis of the liver with ascites (a condition where the liver is permanently scarred due to alcohol consumption and fluid builds up in the abdomen). 1a. Resident 46's 8/11/24 Fall Risk Evaluation indicated the resident was at moderate risk to fall. Resident 46's 8/18/24 Admission MDS revealed the resident was cognitively intact, did not exhibit any behaviors and experienced a fall in the last month prior to her/his admission to the facility. A 12/28/24 Fall Incident Report and Investigation for Resident 46 revealed the following: -The resident was confused, exited the facility from an emergency exit door located next to her/his room (room [ROOM NUMBER]) and experienced a fall outside of the facility. -Staff 21 (CNA) noticed the emergency exit door next to the resident's room was not completely closed which alerted her to look outside of the facility for the resident. -Staff 21 found the resident on the ground outside of the facility in a bed of bark chips. -Staff 35 (LPN) assessed the resident for injuries and vital signs were obtained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident experienced minor injuries from the fall. -After the fall, the resident agreed to move to a room closer to the nurses station to allow for increased staff observation. No evidence was found in Resident 46's clinical record to indicate a thorough investigation of the environmental factors that contributed to the resident's elopement from the facility and subsequent fall was completed, including an investigation of the emergency exit door. On 1/16/25 at 2:01 PM Staff 21 stated she was Resident 46's assigned CNA on 12/28/24. Staff 21 stated the resident seemed out of it on 12/28/24 prior to her/his elopement and fall. Staff 21 stated she entered the resident's room on this day at approximately 4:45 PM and noticed she/he was not in her/his room. Staff 21 stated she checked the bathroom and then walked a circle around the facility and still could not find the resident. Staff 21 stated after walking the facility, she ended up back at room [ROOM NUMBER] when she noticed the emergency exit door was not closed all the way which prompted her to check outside for the resident. Staff 21 stated she was so mad because the alarm for the emergency exit door did not sound and that was [her] backup if [the resident] ever did that. Staff 21 stated the incident was scary and could have not been so bad if the door alarm would have sounded. On 1/16/25 at 2:35 PM a sign that read: Emergency Exit Only. Alarm will Sound was observed on the emergency exit door next to room [ROOM NUMBER]. At this time, the state surveyor pushed open the door. The alarm did not sound and the door remained open until the state surveyor pulled it closed. A concrete path was located on the other side of the emergency exit door which led to a sidewalk. On the far side of the side walk was a bed of bark chips which bordered a busy street. On 1/16/25 at 2:46 PM Staff 1 (Administrator) stated the emergency exit door next to room [ROOM NUMBER] remained unlocked as it was a fire exit but it had an alarm that sounded when it was opened. At this time, the state surveyor open the emergency exit door next to room [ROOM NUMBER] and no alarm sounded. Staff 1 stated that was not good and it looked like the alarm was broken. Staff 1 stated she thought this door and its alarm were investigated following Resident 46's elopement and fall on 12/28/24 but she was not sure. On 1/16/25 at 3:53 PM Staff 35 stated Resident 46 was extra confused on 12/28/24. Staff 35 stated staff usually kept really good eyes on everyone but she also figured the alarm would have worked on the emergency exit door next to room [ROOM NUMBER] if a resident attempted to exit through it. On 1/17/25 at 10:01 AM Staff 10 (Maintenance Director) stated he was unaware the emergency exit door by room [ROOM NUMBER] needed to have a working alarm. Staff 10 stated he was informed that particular door needed an alarm on 1/16/25 because if a resident escaped from it, staff would know. On 1/17/25 at 10:28 AM Staff 1 confirmed the emergency exit door next to room [ROOM NUMBER] was not investigated following Resident 46's elopement and fall on 12/28/24 and should have been. Staff 1 further stated the Door Alarm Policy referred to in the facility's Code Pink Policy did not exist. 1b. Resident 46's 12/4/24 Fall Care Plan directed the resident's bed to be at appropriate height except during care. Resident 46's 12/28/24 Fall Risk Evaluation indicated the resident was at moderate risk to fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Resident 46 from 1/13/25 to 1/15/25 between 5:22 AM through 2:39 PM revealed the resident to be in bed. The height of the resident's bed was observed to be at knee and waist height at times and in a low position at other times. On 1/16/25 at 12:53 PM Staff 36 (CNA) reviewed Resident 46's care plan and stated she guessed the language in the care plan indicated Resident 46's bed was to be in the low position when occupied. On 1/17/25 at 11:01 AM Staff 7 (LPN/RCM) reviewed Resident 46's care plan and clarified that appropriate height indicated the resident's bed was to be in the lowest position when occupied on account of the resident's history of falls. On 1/17/25 at 12:17 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (Regional Nurse Consultant) were present for an interview. Staff 1, 2 and 3 acknowledged Resident 46's care plan was unclear and her/his bed should always be in the low position when occupied.

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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. 43690 Based on observation, interview, and record review it was determined the facility failed to ensure resident respiratory equipment was maintained for 2 of 3 sampled residents (#s 9 and 10) reviewed for respiratory care. This placed residents at risk for increased respiratory concerns. Findings include: 1. Resident 9 admitted to the facility in 8/2024 with diagnoses including chronic respiratory failure and fracture. The 12/4/24 Quarterly MDS indicated Resident 9 was cognitively intact. Resident 9's physician order dated 9/10/24 revealed she/he required continuous oxygen. On 1/14/25 at 9:11 AM the oxygen concentrator was observed to have an external foam filter with a thick layer of dust. Resident 9 stated she/he used the oxygen concentrator continuously and was concerned about the dirty filter. On 1/15/25 at 11:41 AM Staff 16 (LPN) observed Resident 9's oxygen concentrator and acknowledged the foam filter was dirty and needed to be cleaned. On 1/15/25 at 12:17 PM Staff 2 (DNS) stated the facility did not have a cleaning schedule for the oxygen concentrators. 2. Resident 10 admitted to the facility in 6/2023 with diagnoses including chronic obstructive pulmonary disease and cellulitis. The 10/18/24 Quarterly MDS indicated Resident 10 was cognitively intact. Resident 10's physician order dated 10/10/24 revealed she/he required PRN use of oxygen. On 1/14/25 at 9:21 AM the oxygen concentrator was observed to have an external foam filter with a thick layer of dust. Resident 10 stated she/he used the oxygen concentrator when needed. On 1/15/25 at 11:41 AM Staff 16 (LPN) observed Resident 9's oxygen concentrator and acknowledged the foam filter was dirty and needed to be cleaned. On 1/15/25 at 12:17 PM Staff 2 (DNS) stated the facility did not have a cleaning schedule for the oxygen concentrators.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 47000 Based on observation, interview and record review it was determined the facility failed to identify a resident's past history of trauma and potential triggers of re-traumatization for 1 of 1 sampled resident (#31) reviewed for behavioral-emotional needs. This placed residents at risk for re-traumatization. Finding include: The facility's 8/2022 Trauma-Informed Care and Culturally Competent Care Policy directed the following: -Universal screening of residents was to be performed, which included a brief, non-specialized identification of possible exposure to traumatic events. -Screening could include information such as trauma history, including type, severity and duration and trauma-related symptoms. -The initial screening was to be utilized to identify the need for further assessment and care. -Individualized care plans would be developed to address past trauma in collaboration with the resident and family, as appropriate, and to identify and decrease exposure to triggers that may re-traumatize the resident. Resident 31 was admitted to the facility in 12/2019 with diagnoses including Huntington's disease (a genetic disorder that causes nerve cells in the brain to break down, which leads to uncontrolled movements, cognitive decline and emotional disturbances). Resident 31's 12/4/24 Annual MDS revealed the resident was cognitively intact. Resident 31's 12/4/24 Social Service Quarterly Review indicated the resident was sometimes saddened and angered by [her/his] decline due to disease process and she/he received bupropion (an antidepressant) daily for major depressive disorder. On 1/13/25 at 11:08 AM and 1/21/25 at 10:47 AM Resident 31 was observed in her/his room in her/his wheelchair. Resident 31 stated she/he felt generally depressed, no one at the facility had ever talked to her/him about her/his trauma history and she/he was open to a conversation about her/his past traumas and potential trauma triggers. On 1/15/25 at 11:03 AM Staff 29 (RN) stated Resident 31's mood varied, she/he got upset at staff and had outbursts. On 1/21/25 at 11:11 AM Staff 12 (Social Services) stated all residents were supposed to receive a trauma assessment and confirmed Resident 31 had not received one. On 1/21/25 at 11:35 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 47000 Based on observation, interview and record review it was determined the facility failed to identify and provide necessary behavioral health care and services for 1 of 1 sampled resident (#31) reviewed for behavioral-emotional needs. This placed residents at risk for unmet behavioral and emotional needs and a decrease in their quality of life. Findings include: Resident 31 was admitted to the facility in 12/2019 with diagnoses including Huntington's disease (a genetic disorder that causes nerve cells in the brain to break down, which leads to uncontrolled movements, cognitive decline and emotional disturbances), major depressive disorder and anxiety. A review of Resident 31's PHQ-9 (Patient Health Questionnaire, a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) interview results from 12/2023 through 9/2024 revealed the following scores: -12/4/23: a score of a 2, indicative of a minimal depression. -3/5/24: a score of a 14, indicative of a moderate depression. -6/5/24: a repeat score of a 14. -9/5/24: a repeat score of a 14. Resident 31's 12/4/24 Annual MDS revealed the resident was cognitively intact and felt down, depressed or hopeless several days over the last two weeks. Resident 31's 12/4/24 Social Service Quarterly Review indicated the resident was sometimes saddened and angered by [her/his] decline due to disease process and she/he received bupropion (an antidepressant) daily for major depressive disorder. Resident 31's 1/6/25 Psychosocial Well-Being Problem Care Plan revealed the resident needed assistance and support to identify problems that could not be controlled. On 1/13/25 at 11:08 AM Resident 31 was observed in her/his room in her/his wheelchair. Resident 31 stated she/he felt generally depressed, she/he had not been offered the opportunity to talk to someone about her/his depression, including a counselor, and she/he wanted to receive additional support related to her/his depression. On 1/21/25 at 10:47 AM Resident 31 stated the social workers at the facility just dealt with razors and clothes and did not provide support for resident moods or emotional needs. On 1/15/25 at 11:03 AM Staff 29 (RN) stated Resident 31's mood varied, she/he got upset at staff and had outbursts. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 2:14 PM Staff 12 (Social Services) stated she created a care plan for psychosocial well-being for a resident when a PHQ-9 mood interview was triggered. Staff 12 stated the care plan would consist of the mood symptom the resident identified as experiencing on the PHQ-9 and the total score from the PHQ-9. Staff 12 stated she discussed mood interventions with residents when the MDS assessment process prompted her to do so. Staff 12 further stated Staff 13 (Social Services) completed Resident 31's mood interviews and could better speak to her/his current mood state. On 1/21/25 at 8:38 AM Staff 37 (RN) described Resident 31's mood to be off and on and stated some days she/he wanted to be totally left alone. Staff 37 stated on these days, she checked on the resident to determine the problem but the resident was hard to communicate with. On 1/21/25 at 8:49 AM Staff 38 (CNA) stated Resident 31's mood varied which was dependent on her/his uncontrolled movements and level of pain. Staff 38 further stated the resident got frustrated quickly if you could not understand her/him. On 1/21/25 at 11:11 AM Staff 12 and Staff 13 were present for an interview. Staff 13 stated Resident 31 had a short fuse and was really down in the dumps at times because she/he experienced decline related to her/his disease progression. When questioned about who provided the support to identify problems the resident could not control, such as the natural progression of her/his diagnosed Hungtington's disease, as outlined in Resident 31's Psychosocial Well-Being Care Plan, Staff 13 stated the resident's care plan was confusing. Neither Staff 12 nor Staff 13 were able to identify any specific mood interventions offered to the resident following her/his reported increased depression from the PHQ-9 interviews from 3/5/24, 6/5/24 or 9/5/24. Staff 13 stated she spoke with Staff 5 (LPN/RCM) about Resident 31's mood and depression in December 2024 but did not think she spoke directly with the resident about her/his mood and why she/he felt down, depressed or hopeless. Staff 13 further stated she had a difficult time understanding Resident 31 on account of her/his slurred speech. Staff 12 stated the resident's activity care plan was in need of revision because activity staff should encourage and help with psychosocial well-being. On 1/21/25 at 12:19 PM Staff 14 (Activity Director) stated her interactions with Resident 31 consisted of dropping off puzzles and newspapers at least weekly and to assist the resident to turn pages of her/his book if she/he experienced increased tremors. On 1/21/25 at 2:00 PM Staff 1 (Administrator) acknowledged the findings and stated Resident 31's care plans could be improved.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 43690 Based on observation, interview and record review it was determined the facility failed to provide physical and occupational therapy services as ordered for 1 of 2 sampled residents (#35) reviewed for rehabilitation services. This placed residents at risk for a decline in functional abilities and diminished quality of life. Findings include: The facility's 11/2005 Rehab Services Policy indicated a therapist will provide therapy upon written order of the resident's attending physician. Resident 35 admitted to the facility in 3/2024 with diagnoses including gastroenteritis (stomach and intestine inflammation) and colitis (colon inflammation). Resident 35's 9/16/24, 10/31/24 and 12/10/24 Physician Orders revealed PT and OT to be provided as indicated. Resident 35's 12/26/24 Quarterly MDS indicated the resident was cognitively intact. The MDS indicated the resident did not receive any PT or OT during the review period. On 1/15/25 at 6:42 AM Staff 17 (RA) stated Resident 35 was motivated with her/his therapies prior to her/his hospital stays. Staff 17 stated Resident 35 was doing good with her/his ambulation but had declined since her/his last hospital stay. On 1/15/25 at 8:18 AM Resident 35 was observed in her/his room in bed. Resident 35 stated she/he had received therapies in the past and did not know why they stopped since her/his last hospital stay. Resident 35 stated she/he wanted to participate in therapies so she/he could walk again. On 1/15/25 at 8:49 AM Staff 4 (Rehab Director) reviewed Resident 35's physician orders and stated the resident had physician orders for PT and OT but since Resident 35 had been in and out of the hospital multiple times she did not do an evaluation and therapies were not started. On 1/16/25 at 12:19 PM Staff 27 (Physician) stated it was his expectation he would have been notified of the therapy orders for Resident 35 and the PT and OT evaluations were to be completed as ordered. On 1/17/25 at 10:51 AM Staff 2 (DNS) and Staff 3 (Regional Nurse Consultant) stated it was their expectation residents were evaluated per physician orders. Staff 3 stated Resident 35 slipped through the cracks, the resident was not evaluated and physician orders were not followed. On 1/21/25 at 9:25 AM Staff 1 Administrator stated it was her expectation residents would be evaluated for PT and OT per physician orders when admitted . Staff 1 stated Resident 35 should have been evaluated when she/he readmitted from the hospital on the above listed dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47000 Based on observation, interview and record review it was determined the facility failed to ensure resident records were accurate for 4 of 5 sampled residents (#s 6, 31, 35 and 363) reviewed for vaccination records. This placed residents at risk for inaccurate health records. Findings include: The facility's Immunization Documentation Procedure (undated) indicated the following: - Make sure all signatures and dates are filled in on form. 1: Resident 31 was admitted to the facility in 12/2019 with diagnoses including Huntington's disease (a genetic disorder that causes nerve cells in the brain to break down, which leads to uncontrolled movements, cognitive decline and emotional disturbances). Resident 31's 1/6/25 Nutritional Problem Care Plan indicated the resident was to receive aspiration precautions (a set of practices that help prevent food or liquid from entering the airway), which included close supervision by staff at meal times. Resident 31's 1/6/25 ADL Self Care Performance Deficit Care Plan indicated the resident required occasional supervision from staff at meal times. On 1/13/25 at 10:35 AM Resident 31 was observed to eat independently in her/his room. On 1/14/25 at 3:02 PM Staff 28 (CNA) stated Resident 31 required close supervision at meal times, so you need to sit one-by-one with [her/him]. On 1/15/25 at 11:03 AM Staff 29 (RN) stated Resident 31 was pretty independent with eating and staff were to check on Resident 31 every so often during meal times. On 1/15/25 at 12:33 PM Staff 7 (LPN/RCM) stated Resident 31 required occasional supervision from staff at meal times and the resident's Nutritional Problem Care Plan was inaccurate. On 1/17/25 at 12:17 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (Regional Nurse Consultant) acknowledged the findings of this investigation and confirmed Resident 6's care plan was inaccurate. 51846 2. Resident 6 was admitted to the facility in 1/2023 with a diagnosis of Urinary Tract Infection. A review of Resident 6's records revealed vaccine consent forms missing ID number, Nursing Care Center, Living Unit, Address, Physician, the person giving resident education, and the date the forms were signed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 10:00 AM, Staff 6 (LPN, Infection Preventionist)'s stated expectations included vaccine consent forms should be accurately dated and completely filled out. On 1/21/25 at 11:40 AM, Staff 2 (DNS) confirmed resident consent forms were expected to be completed prior to being administered a vaccine, including being dated with the resident's name and physician information. 3. Resident 35 was admitted to the facility in 3/2024 with a diagnosis of infectious gastroenteritis and colitis (inflammation of stomach/intestines and colon). A review of Resident 35's records revealed vaccine consent forms missing ID number, Nursing Care Center, Living Unit, Address, Physician, the person giving resident education, and the date on which the forms were signed. On 1/16/25 at 10:00 AM, Staff 6 (LPN, Infection Preventionist)'s stated expectations included vaccine consent forms should be accurately dated and completely filled out. On 1/21/25 at 11:40 AM, Staff 2 (DNS) confirmed resident consent forms were expected to be completed prior to being administered a vaccine, including being dated with the resident's name and physician information. 4. Resident 363 was admitted to the facility in 1/2025 with signs and symptoms involving the musculoskeletal system. A review of Resident 363's records revealed the vaccine consent form missing ID number, the person giving resident education, Address, and the date on which the form was signed. On 1/16/25 at 10:00 AM, Staff 6 (LPN, Infection Preventionist)'s stated expectations included vaccine consent forms should be accurately dated and completely filled out. On 1/21/25 at 11:40 AM, Staff 2 (DNS) confirmed resident consent forms were expected to be completed prior to being administered a vaccine, including being dated with the resident's name and physician information.