

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Myrtle Point Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 637 Ash Street Myrtle Point, OR 97458	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>25504</p> <p>Based on interview and record review it was determined the facility failed to follow care plan interventions to ensure residents were free from physical abuse for 1 of 6 sampled residents (#2) reviewed for abuse. This placed residents at risk for physical abuse. Findings include:</p> <p>Resident 2 was admitted to the facility in June 2019 with diagnoses including dementia.</p> <p>Resident 1 was admitted to the facility in June 2022 with diagnoses including dementia with agitation.</p> <p>Review of a progress note dated 7/17/23 at 4:45 PM, stated Resident 1 was observed to slap a resident on the left hand.</p> <p>Review of Resident 1's care plan updated 7/17/23, stated Resident 1 was to be at arms length away from other residents.</p> <p>Review of a facility investigation dated 7/21/23, stated Resident 1 had a history of striking out at other residents, verbal comments and aggression. The investigation indicated Resident 1's care plan would be updated to keep Resident 1 at arms length away from other residents and abuse was ruled out.</p> <p>Review of a Facility Reported Incident (FRI) dated 7/24/23, stated on 7/23/23 Resident 2 was wheeled past Resident 1 in front of the nursing station when Resident 1 struck Resident 2 on the left side of the face. No injuries were noted to Resident 2. The report indicated the residents were separated and staff was instructed to ensure Resident 1 was not to close to other residents.</p> <p>Review of the facility's incident investigation dated 8/3/23, stated Resident 1 struck Resident 2 while passing by the nursing station. The investigation indicated abuse was ruled out and the incident was closed. The investigation did not indicate whether Resident 1's care plan interventions were followed or not.</p> <p>Review of Resident 1 and Resident 2's progress notes revealed no documentation of the incident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/4/24 at 11:30 AM, Staff 1 (Administrator) and Staff 2 (DNS) indicated they were not employed at the facility when the incident on 7/23/23 occurred. Staff 1 and Staff 2 acknowledged Resident 2 was struck in the face by Resident 1 on 7/23/23. Staff 1 and Staff 2 also acknowledged Resident 1's care plan was not followed after the 7/17/23 incident, which led to the incident on 7/23/23.</p>