STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385254	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtle Point Rehabilitation & Care	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677 Based on observation, interview, and record review it was determined the facility failed to accommodate resident needs for 2 of 7 sampled residents (#s 8 and 14) reviewed for environment. This placed residents at risk for lack of independence. Findings include: 1. Resident 8 admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness on one side of the body) and depression. On 11/5/24 at 2:38 PM Resident 8 complained she/he was moved to a different room because of a ceiling leak. She/he wanted to move back to the original room because that was where her/his adaptive equipment (trapeze and side rails) were installed to assist Resident 8 with bed mobility. When asked if there was adaptive equipment in her/his current room she/he replied, no it's in my old room. When asked how long she/he was without her/his adaptive equipment, she/he stated it was a few months. On 11/6/24 at 9:06 AM observation of Resident 8's previous room revealed the installed adaptive equipment. Observation of Resident 8's current room revealed no adaptive equipment. On 11/7/24 at 3:08 PM an interview with Staff 12 (Maintenance) revealed Resident 8 was moved from her/his room over two months ago because of a ceiling leak. Staff 12 confirmed he did not move Resident 8's adaptive equipment to the new room, and Resident 8 was without her/his adaptive equipment for over two months. 35855 2. Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). a. A 11/6/23 care plan indicated Resident 14 had an ADL self-care performance deficit with interventions including the use of an electric wheelchair for mobility. A 5/30/24 MDS revealed Resident 14's BIMS was 15 which indicated she/he was cognitively intact. On 7/24/24 the State Survey Agency received a public complaint which indicated Resident 14 requested a new power wheelchair since her/his admission as she/he was borrowing a power wheelchair which was too large for her/him. Resident 14's feet could not touch the floor. The physician completed the paperwork for the new power wheelchair a few months ago, but there was follow-up by staff. (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: 385254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER: Myrtle Point Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 637 Ash Street, Myrtle Point, OR 97458	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 8/9/24 Communication form to Resident 14's provider indicated Resident 14 needed a prescription for a power mobility wheelchair. The provider's response on 8/13/24 was for a physical therapy evaluation to be completed and to schedule an MRI. No documents were found in clinical records a power wheelchair assessment was completed for Resident 14. A review of a Provider Note dated 8/12/24 revealed Resident 14 needed a prescription for a power mobility wheelchair. Resident 14 required a power wheelchair to interact in the community and attend medical appointments. An 8/29/24 Nursing Note revealed a request to the provider for Resident 14 for new wheelchair prescription. A 9/2/24 Provider Note indicated Resident 14 required access to a power wheelchair because of her/his inability to manually utilize a non-powered wheelchair. The power wheelchair she/he was currently using did not fit appropriately, and exacerbated many of her/his physical issues with pain. Resident 14 stated the frustration around the difficulties accessing care exacerbated her/his underlying anxiety and depression. A 9/5/24 Nursing Note stated a new prescription for a power wheelchair was received and sent to the wheelchair and mobility equipment company. An 10/19/24 physician order instructed staff to complete a referral for an electric wheelchair for Resident 14. On 11/6/24 at 9:42 AM Resident 14 stated she/he heard the wheelchair mobility equipment company declined her/his new wheelchair. Resident 14 stated the one she/he was using was too large and her/his feet did not touch the floor. On 11/7/24 at 9:24 AM Witness 7 (Complainant) stated Resident 14's wheelchair did not fit through her/his bathroom door, and she/he had to go to the bathroom in her/his incontinent brief. On 11/8/24 at 9:01 AM in interview with Staff 1 (Administrator) and Staff 2 (Interim DNS), Staff 2 stated she was working with the wheelchair and mobility equipment company because Resdient 14's insurance provider denied coverage for a new power wheelchair. Resident 14 provided incorrect information to the insurance compant and Staff 2 stated she was working to provide the correct information. b. On 3/6/24 the State Survey Agency received a public complaint which indicated Resident 14 could not access personal belongings because staff did not unpack them for her/him. Resident 14 could not reach her/his clothing as the clothing was located too high up in her/his closet for her/him to reach. A 11/6/23 care plan indicated Resident 14 had an ADL self-care performance deficit and required one staff assistance with most ADLs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 Resident 14's room was observed with a shelf next to the window which was full of boxes. There were boxes in her/his closet which came out into the room approximately two feet. The clothes hanger bar in Resident 14's closet was too high for her/him to reach, and additionally the boxes prevented her/his access to the closet. A table located along the wall had multiple items stacked on it. Resident 14 stated staff informed her/him previously they would assist with unpacking the boxes when she/he moved into her/his current room. Review of Resident 14's room census revealed she/he moved into her/his room in 11/2023. On 11/7/24 at 9:24 AM Witness 7 (Complainant) stated staff did not lower Resident 14's clothes hanger bar in her/his closet and did not unpack her/his personal items in her/his room. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated Resident 14 had boxes in her/his room which she/he wanted to go through. Staff 18 stated it was the responsibility of the CNA staff to assist residents to move and unpack their personal belongings and to take inventory. On 11/8/24 at 7:52 AM Staff 19 (CNA) stated it was the responsibility of the CNA staff to assist residents with putting away their personal belongings. On 11/8/24 at 8:44 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they were unaware Resident 14 wanted her/his belongings unpacked and put away rather than left in boxes.

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to provide a clean and homelike environment, and failed to ensure residents' belongings were safe for 2 of 7 sampled residents (#s 18 and 19) and 1 of 1 sunroom reviewed for environment and personal property. This placed residents at risk for an unclean, un-homelike environment, and missing belongings. Findings include: 1. Resident 18 admitted to the facility in 4/2023 with a diagnosis of a stroke. A care plan updated 5/21/24 revealed Resident 18 had hearing aids, but chose not to wear them. On 11/4/24 at 1:21 PM Witness 1 (Complainant) stated Resident 18 had hearing aids, but they were not in her/his room. Witness 1 stated this was reported to staff. On 11/6/24 at 11:42 AM Staff 4 (CNA) stated Resident 18 had hearing aids, but she was not aware where the hearing aids were located. On 11/5/24 at 1:25 PM Staff 3 (Social Services) stated she did not have a grievance for Resident 18's hearing aids. On 11/7/24 at 11:56 AM Staff 2 (Interim DNS) stated Resident 18 had hearing aids, but staff were not able to locate them. Staff 2 stated she would communicate with Resident 18's family to determine if family took the hearing aids home due to non-use. No additional information was provided. 35855 2. Resident 19 admitted to the facility in 3/2024 with diagnoses including depression and respiratory failure. On 8/1/24 the State Survey Agency received a public complaint which indicated the window in Resident 19's room was in disrepair. The glass fell out of the window but was not reinstalled correctly, and yellow and black caution tape was across the window. On 11/5/24 at 9:35 AM Staff 4 (CNA) stated the window in Resident 19's room was fastened with screws because without them the window would fall out. On 11/4/24 at 11:23 AM black and yellow caution tape in an 'X' pattern was observed around Resident 19's window in her/his room. Resident 19 stated the tape was there since she/he admitted to the room. Resident 19 stated she/he was not sure why the window was covered by the tape. On 11/7/24 at 9:54 AM Staff 12 (Maintenance) stated the facility received a bid to have the window fixed. Staff 12 stated if the window was opened the window would slide off its hinges. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/8/24 at 8:34 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated it was expected the window be fixed more quickly. 49676 3. On 11/4/24 at 12:11 PM the sunroom was observed with residents sitting in wheelchairs looking outside through the window. Cobwebs accumulated on the windows prevented a clear view for the residents. On 11/7/24 at 10:46 AM Resident 18 stated, The windows are awfully dirty. I sit here every day and look at filthy windows. They have been dirty for quite awhile. I just go with the flow and look out the filthy windows with all the black spiders. On 11/7/24 at 10:48 AM Resident 12 stated The windows have been dirty for awhile. On 11/7/24 at 10:43 AM Staff 12 (Maintenance) acknowledged the sunroom windows were not clean and needed pressure washed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35855 Based on interview and record review the facility failed to protect residents' right to be free from verbal abuse by staff and neglect related to failure to provide residents needed supplies for 4 of 5 sampled residents (#3, 14, 18, and 20) reviewed for supplies and abuse. Findings include: 1. Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. A 7/14/24 Social Service Note written by Staff 20 (Former Administrator) indicated on 7/11/24 Resident 14 verbalized she/he would inform family members of her/his positive COVID-19 test results in the facility. Review of a Complex Medical Add On note revealed on 7/14/24 Resident 14 tested positive for COVID-19 and refused to stay inside her/his room. On 11/5/24 at 9:15 AM Staff 4 (CNA) stated in 7/2024 when the elevator did not work Staff 20 was yelling and screaming. On 11/5/24 at 11:58 AM Staff 25 (CNA) stated Staff 20 yelled at Resident 14 and there were other residents who also heard the yelling. On 11/6/24 at 9:42 AM Resident 14 stated in 7/2024 she/he tested positive for COVID-19. Staff paused the elevator operation so other residents did not come up the elevator while Resident 14 sat by the elevator, and staff went to get her/him a mask so she/he could go downstairs. Staff 20 came up the stairs and saw Resident 14 and told her/him to go to her/his room. Resident 14 stated she/he was not by any staff or residents and attempted to inform Staff 20 she/he wanted to go outside. Staff 20 became angry and kept telling her/him to go back to her/his room. Resident 14 stated Staff 20 was bullying her/him and she/he felt it was emotional and psychological abuse from Staff 20. Resident 14 stated after that she/he did not want to speak to Staff 20 alone. At a later time she/he was outside and asked Staff 20 to go away as she/he wanted someone else to witness the interaction. Resident 14 stated Staff 20 did not go away and Resident 14 became upset and was calling out for someone to come as Staff 20 would not leave her/him alone. Resident 14 started crying multiple times during the interview. On 11/7/24 at 9:05 AM Staff 13 (CNA) stated Staff 20 did a lot of loud talking, Staff 20 felt she was the judge and jury and was not pleasant. Staff 13 observed Staff 20 direct Resident 14 to go back to her/his room multiple times in an authoritative voice when Resident 14 was at the nurses' station by the elevator. On 11/7/24 and 11/8/24 attempts to contact Staff 20 were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 7:09 AM Witness 7 (Former Staff) stated Resident 14 did not file any grievances regarding Staff 20 as she/he was concerned she/he would get punished for it, and would not get her/his needs met. Witness 7 stated she observed Staff 20 going down the hallway yelling and cussing before Staff 20 entered a resident room. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated Resident 14 was uncomfortable talking alone with Staff 20. On 11/8/24 at 8:54 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated it was expected to interview Resident 14 and the staff who witnessed the interaction regarding Staff 20's level and tone of voice during the interaction noted above. 2. Resident 3 admitted to the facility in 1/2023 with diagnoses including irritable bowel syndrome and diarrhea. A 11/22/23 care plan revealed Resident 3 was incontinent of bowel and staff were to provide peri-care after each incontinent episode. A 5/13/24 MDS indicated Resident 3's BIMS score was 15 which indicated she/he was cognitively intact. Resident 3 was always incontinent of bowel and was dependent on staff for toileting hygiene. On 7/25/24 the State Survey Agency received a public complaint which indicated the facility lacked supplies incontinent including briefs and wipes. On 8/1/24 the State Survey Agency received a public complaint which indicated the facility was short on supplies for incontinent briefs and wipes. Staff were provided six packages of incontinent wipes to use on all residents for all shifts. When incontinent wipes were requested the staff member was informed the wipes were behind locked doors. Resident 3 had redness in her/his groin area from low-quality briefs. On 11/5/24 at 9:15 AM Witness 8 (Complainant) stated in 7/2024 and 8/2024 the facility did not provide enough briefs for residents and the briefs were not the right size. Some of the residents had redness from the briefs not being the right size. On 11/6/24 at 10:08 AM Staff 15 (Central Supply) stated in 8/2024 there were some delayed supply orders and Staff 20 (Former Administrator) was ordering supplies in 8/2024. The facility had many donations of incontinent briefs during 8/2024 because they were in short supply by the facility. On 11/6/at 10:12 AM Resident 3 stated in 7/2024 and 8/2024 incontinent briefs were not the right size, staff had to cinch the wrong size brief, and they were too tight. In 8/2024 the skin in her/his groin area became red due to the wrong-sized briefs. On 11/8/24 at 11:21 AM Staff 13 (CNA) stated around 7/2024 and 8/2024 the facility could not get the correct size incontinent briefs for bariatric residents, and there were not enough incontinent wipes. The briefs the facility had deteriorated. On 11/8/24 at 8:34 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed staff should have the correct size incontinent briefs available for residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 18 admitted to the facility in 4/2023 with diagnoses including anxiety and skin rash. A review of a 5/4/24 MDS assessment revealed Resident 18's BIMS score was seven, which indicated severe cognitive deficits. Resident 18 was dependent on staff for toileting hygiene, was frequently incontinent of bladder, and always incontinent of bowel. On 7/25/24 the State Survey Agency received a public complaint which indicated the facility lacked supplies including incontinent briefs and wipes, and pillow cases. Resident 18 required XXXL size briefs. Around 7/11/24 there was only one size brief available in the facility for residents which was not size XXXL, staff attempted to keep her/him continent which was difficult, and they had to use liners with the one available size brief. Additionally staff had to use washcloths since no incontinent wipes were available. On 11/5/24 at 9:35 AM Staff 4 (CNA) stated in 7/2024 Resident 18 required extra-large incontinent briefs, the facility only provided large size briefs, and staff had to leave the brief open because it did not fit her/him. On 11/6/24 at 10:08 AM Staff 15 (Central Supply) stated in 8/2024 there were some delayed orders and Staff 20 (Former Administrator) was ordering supplies at that time. The facility had many donations of briefs during 8/2024 because they were in short supply by the facility. On 11/8/24 at 11:21 AM Staff 13 (CNA) stated around 7/2024 and 8/2024 the facility could not get the correct size incontinent briefs for bariatric residents, and there were not enough incontinent wipes. The briefs the facility had deteriorated. On 11/8/24 at 9:10 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed staff should have the correct size incontinent briefs available for residents. 4. Resident 20 admitted to the facility in 6/2024 with diagnoses including kidney disease and dementia. A 6/10/24 MDS indicated Resident 20's BIMS score was five indicating she/he had severe cognitive impairment. Resident 20 was always incontinent of bowel and bladder, and required substantial to maximal assistance with toileting hygiene. On 7/25/24 the State Survey Agency received a public complaint which indicated the facility lacked incontinent supplies including briefs and wipes. On 8/1/24 the State Survey Agency received a public complaint which indicated the facility was short on supplies for incontinent briefs and wipes. Staff were provided six packages of incontinent wipes to use on all residents for all shifts. When incontinent wipes were requested the staff member was informed the wipes were behind locked doors. Resident 3 had redness in her/his groin area from low-quality briefs An 8/1/24 Skin Integrity Issue investigation revealed Resident 20 had a red abrasion to the right hip. Resident 20 believed it was from the incontinent brief rubbing on her/his skin. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 9:15 AM Witness 8 (Complainant) stated in 7/2024 and 8/2024 the facility did not provide enough incontinent briefs for residents and the briefs were not the right size. Some of the residents had redness from the briefs not being the right size. On 11/6/24 at 10:08 AM Staff 15 (Central Supply) stated in 8/2024 there were some delayed orders and Staff 20 (Former Administrator) was ordering supplies at that time. The facility had many donations of briefs during 8/2024 because they were in short supply by the facility. On 11/8/24 at 11:21 AM Staff 13 (CNA) stated around 7/2024 and 8/2024 the facility could not get the correct size incontinent briefs for bariatric residents, and there were not enough incontinent wipes. The briefs the facility had deteriorated. On 11/8/24 at 9:10 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed staff should have the correct size incontinent briefs available for residents.

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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. 35855 Based on interview and record review it was determined the facility failed to report allegations of abuse for 1 of 2 sampled residents (#14) reviewed for abuse reporting. This placed residents at risk for abuse. Findings include: Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. Review of a Complex Medical Add On note revealed on 7/14/24 Resident 14 tested positive for COVID-19 and refused to stay inside her/his room. On 11/5/24 at 11:58 AM Staff 25 (CNA) stated Staff 20 (Former Administrator) yelled at Resident 14 and there were other residents who also heard the yelling. On 11/6/24 at 9:42 AM Resident 14 stated in 7/2024 she/he tested positive for COVID-19. Staff paused the elevator operation so other residents did not come up the elevator while Resident 14 sat by the elevator, and staff went to get her/him a mask so she/he could go downstairs. Staff 20 came up the stairs and saw Resident 14 and told her/him to go to her/his room. Resident 14 stated she/he was not by any staff or residents and attempted to inform Staff 20 she/he wanted to go outside. Staff 20 became angry and kept telling her/him to go back to her/his room. Resident 14 stated Staff 20 was bullying her/him and she/he felt it was emotional and psychological abuse from Staff 20. Resident 14 stated after that she/he did not want to speak to Staff 20 alone. At a later time she/he was outside and asked Staff 20 to go away as she/he wanted someone else to witness the interaction. Resident 14 stated Staff 20 did not go away and Resident 14 became upset and was calling out for someone to come as Staff 20 would not leave her/him alone. Resident 14 started crying multiple times during the interview. On 11/7/24 at 9:05 AM Staff 13 (CNA) stated Staff 20 did a lot of loud talking, Staff 20 felt she was the judge and jury and was not pleasant. Staff 13 observed Staff 20 direct Resident 14 to go back to her/his room multiple times in an authoritative voice when Resident 14 was at the nurses' station by the elevator. On 11/7/24 at 7:09 AM Witness 7 (Former Staff) stated Resident 14 did not file any grievances regarding Staff 20 as she/he was concerned she/he would get punished for it, and would not get her/his needs met. Witness 7 stated she observed Staff 20 going down the hallway yelling and cussing before Staff 20 entered a resident room. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated Resident 14 was uncomfortable with talking alone with Staff 20. There was no indication the allegation of abuse was reported to the State Survey Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 8:54 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they expected an allegation of abuse to be reported to the State Survey Agency.

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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. 35855 Based on interview and record review it was determined the facility failed to investigate an allegation of abuse for 1 of 2 sampled residents (#14) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. Review of a Complex Medical Add On note revealed on 7/14/24 Resident 14 tested positive for COVID-19 and refused to stay inside her/his room. On 11/5/24 at 11:58 AM Staff 25 (CNA) stated Staff 20 (Former Administrator) yelled at Resident 14. On 11/6/24 at 9:42 AM Resident 14 stated in 7/2024 she/he tested positive for COVID-19. Staff paused the elevator operation so other residents did not come up the elevator while Resident 14 sat by the elevator, and staff went to get her/him a mask so she/he could go downstairs. Staff 20 came up the stairs and saw Resident 14 and told her/him to go to her/his room. Resident 14 stated she/he was not by any staff or residents and attempted to inform Staff 20 she/he wanted to go outside. Staff 20 became angry and kept telling her/him to go back to her/his room. Resident 14 stated Staff 20 was bullying her/him and she/he felt it was emotional and psychological abuse from Staff 20. Resident 14 stated after that she/he did not want to speak to Staff 20 alone. At a later time she/he was outside and asked Staff 20 to go away as she/he wanted someone else to witness the interaction. Resident 14 stated Staff 20 did not go away and Resident 14 became upset and was calling out for someone to come as Staff 20 would not leave her/him alone. Resident 14 started crying multiple times during the interview. On 11/7/24 at 9:05 AM Staff 13 (CNA) stated Staff 20 did a lot of loud talking, Staff 20 felt she was the judge and jury and was not pleasant. Staff 13 observed Staff 20 direct Resident 14 to go back to her/his room multiple times in an authoritative voice when Resident 14 was at the nurses' station by the elevator. On 11/7/24 at 7:09 AM Witness 7 (Former Staff) stated Resident 14 did not file any grievances regarding Staff 20 as she/he was concerned she/he would get punished for it, and would not get her/his needs met. Witness 7 stated she observed Staff 20 going down the hallway yelling and cussing before Staff 20 entered a resident room. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated Resident 14 was uncomfortable with talking alone with Staff 20. No documentation was found in Resident 14's clinical records an investigation was completed for Staff 20 directing Resident 14 to return to her/his room after she/he tested positive for COVID-19. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Myrtle Point Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 637 Ash Street Myrtle Point, OR 97458	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 8:54 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated it was expected for an abuse investigation to be 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 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. 35855 Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 4 sampled residents (#14) reviewed for ADLs. This placed resident at risk for unmet needs. Findings include: Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. A 11/6/23 care plan indicated Resident 14 had an ADL self-care performance deficit with interventions including she/he would activate her/his call light for assistance, and she/he required one-person assistance with most ADLs. On 11/6/24 at 9:42 AM Resident 14 stated Staff 13 (CNA) and Staff 19 (CNA) responded to her/his call light while her/his roommate was sleeping, so she/he told staff to keep quiet and to not turn on the light. Staff 13 and Staff 19 left the room. Resident 14 then waited another 45 minutes to an hour to receive assistance, and sat in a soiled brief during the wait. On 11/6/24 at 12:11 PM Resident 14's call light was activated, and Staff 8 (CMA) went into Resident 14's room and requested Resident 14 turn off her/his call light. At 12:51 PM Resident 14 stated she/he requested batteries for her/his television remote at 7:30 AM, then again at 12:11 PM, and had not yet received the batteries. At 1:11 PM Resident 14's lunch tray was delivered, and Staff 10 (RN) stated she would go check about the batteries. On 11/8/24 at 7:52 AM Staff 19 stated she was requested not to work with Resident 14 because of a morning when Staff 13 and Staff 19 answered Resident 14's call light and Resident 14 started shushing Staff 19 and Staff 13 to not wake her/his roommate. Resident 14's roommate was looking right at Staff 19 and Staff 13. The room was dark, and Resident 14 did not want the light turned on. Staff 19 asked Resident 14 how they were supposed to help her/him if they could not see or talk. Staff 19 and Staff 13 left and informed two other CNAs. Staff 19 stated Staff 13 and Staff 19 were in another room for approximately 10 to 15 minutes before going to answer Resident 14's call light. After leaving the room they told Staff 11 (Former LPN) on shift, and he may have gone into the room. Staff 19 stated she did not believe Resident 14 waited a total of 45 minutes before she received care. On 11/5/24 and 11/7/24 attempts to contact Staff 11 were unsuccessful. On 11/8/24 at 8:44 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they expected staff to address an issue if a call light was turned off in a room and staff could not see, by either speaking to the resident to help problem-solve, or engage a nurse in charge to assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 11:30 AM Staff 13 stated on morning shift there were four CNAs working that day. Staff 13 and Staff 19 answered Resident 14's call light and she wanted to turn the room light on so she could see as it was dark in the room. Resident 14 told them to be quiet so not to wake her roommate. Staff 13 stated the roommate was looking right at Staff 13 and Resident 14 did not want the light on, so they went to the nurses' station to have the other two CNAs provide care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50930 Based on observation, interview and record review it was determined the facility failed to provide an ongoing activity program to meet the needs of residents for 1 of 1 sampled resident (#6) and 1 of 1 facility reviewed for activities. This placed residents at risk for decrease in quality of life. Findings include: 1. Resident 6 admitted to the facility in 2024 with diagnoses including chronic kidney disease and depression. On [DATE] at 1:40 PM Resident 6 stated she/he wanted to go fishing more often and the facility could not take residents on outings because the facility van was not road legal. On [DATE] at 12:26 PM Staff 3 (Social Services/Activities) stated the facility van's registration was not up-to-date, and she could not take residents on outings. Observation of the facility van's registration stickers on [DATE] at 2:43 PM revealed the registration was out of date. On [DATE] at 10:04 AM multiple residents at the resident council meeting stated they were unhappy the van was not available, and they wanted to go on outings. On [DATE] at 12:32 PM Staff 12 (Maintenance Director) verified the facility van's registration was expired, and he was not able to get them renewed because the title to the van was in the previous owner's name. He stated the regional representative for the facility was working on getting the title transferred to the facility, but he did not know when it would be completed. Staff 12 stated he would contact the regional representative for more information. No further information was provided. 35855 2. On [DATE] the State Survey agency received a public complaint which indicated the Social Services and Activity Directors' employment was around the first part of ,d+[DATE], and the positions remained vacant. There were no activities available for the residents. A review of Resident 16's Documentation Survey Report for ,d+[DATE] indicated she/he had one personal visit on [DATE], but no other activities were documented in ,d+[DATE]. A review of Resident 3's Documentation Survey Report for ,d+[DATE] revealed Resident 3 exercised on [DATE] and [DATE], but no other activites were documented for the month. A review of Resident 20's Documentation Survey Report for ,d+[DATE] revealed Resident 20 did not participate in any activities from [DATE] through [DATE]. A review of Resident 18's Documentation Survey Report for ,d+[DATE] revealed no documented activities for ,d+[DATE]. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:05 AM Staff 13 (CNA) stated in ,d+[DATE] Staff 20 (Former Administrator) fired the Activity Director and there were no activities for the residents. The activity calendar was posted on the wall, but no activities were occurring. On [DATE] at 10:02 AM Staff 3 (Activity Director and Social Services) stated she started as the Activity Director in ,d+[DATE]. Staff 3 stated she worked as a CNA on Sundays before she was hired as the Activity Director and there were no activities on Sundays when she worked as a CNA.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677 Based on interview and record review it was determined the facility failed to respond to changes in condition and follow physician orders for 2 of 7 sampled residents (#s 4 and 29) reviewed for change of condition. This placed residents at risk for delayed treatment and unmet needs. Findings include: 1. Resident 4 admitted to the facility on [DATE] with diagnoses including Parkinson's disease, constipation and chronic kidney disease. A review of the 10/2024 MAR revealed a physician order for Miralax to be administered if Resident 4 had no BM for three days. Resident 4 was noted to have no BM from 10/19/24 through 10/23/24; a period of five days. Resident 4 was administered Miralax on 10/24/24, day six, and it was noted to be effective. Staff 2 (DNS) confirmed the medication was not given in accordance with physician orders. 35855 2. Resident 29 admitted to the facility in 9/2018 with diagnoses including dementia and UTI. A review of a 1/21/24 POLST revealed Resident 29's preference was limited treatment which included antibiotics. Resident 29 would be transferred to the hospital if indicated and provided basic medical treatments. A 6/2/24 at 4:21 AM Alert Note indicated Resident 29 returned from the hospital with new orders to start Levofloxacin every 24 hours for five days, and the initial dose was administered at the hospital. The prescription was sent to the pharmacy with associated diagnoses of UTI, dehydration, and acute kidney failure. Three liters of IV fluids were infused. A 6/2/24 at 12:20 PM Alert Note indicated Resident 29 awoke with moderate difficulty and was unable to stay awake. Resident 29 had difficulty eating with difficulty swallowing. Resident 29 was assisted with eating. A 6/3/24 at 7:15 PM Nursing Note indicated Resident 29's oxygen levels were at 64 percent with oxygen at two liters per minute. Breathing was slightly labored, eyes open and pupils pinpoint. Resident 29 stared but did not respond to voice. The physician notified and Resident 29 was transported to the hospital. On 11/5/24 at 9:29 AM Staff 4 (CNA) stated a couple of days before Resident 29 passed away her/his tongue and lips were blue and she/he was not eating solid food. Resident 29 started choking and aspirated and Staff 4 and Staff 13 (CNA) had to hold Resident 29 up. Staff 11 (Former LPN) was sitting at the nurses' station and did not get up to assess Resident 29. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 9:05 AM Staff 13 stated in one instance she was at the nurses' station when Resident 29's tongue was black and she/he was choking. Staff 11 was sitting at the nurses' station but did not get up to assess Resident 29. Staff 11 acted like Resident 29's choking was normal. Staff 13 stated Staff 11 was not a hands on nurse for the residents. On 11/8/24 at 8:00 AM Staff 6 (CNA) stated Staff 11 was slow to attend to residents and took his time to assess residents. Attempts to contact Staff 11 on 11/5/24 and 11/7/24 were unsuccessful. On 11/8/24 at 9:25 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated the expectation was for Staff 11 to timely assess a resident who had a black tongue and was choking.

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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 35855

Based on observation, interview, and record review it was determined the facility failed to maintain an environment free from accident hazards and to monitor a resident after a fall for 2 of 4 sampled residents (#s 6 and 18) reviewed for accidents. This placed residents at risk for accidents. Findings include:

1. Resident 6 admitted to the facility in 5/2023 with diagnoses including stroke.

A review of Resident 6's care plan dated 6/2024 revealed Resident 6 was at risk for falls, with interventions including she/he was a high fall risk and to meet her/his needs.

On 7/24/24 the State Survey Agency received a public complaint which indicated Resident 6 fell because the main entrance door did not work, and there was a sign to use the back door. The back door had a wheelchair ramp with no railing, and she/he fell and hurt her/his back and bruised her/his hip after the tire of her/his electric wheelchair slipped off the edge of the ramp.

A 7/24/24 Fall investigation revealed at about 2:30 PM Resident 6 was found lying on the ground with her/his electric wheelchair next to her/his side. A CNA was checking her/his vitals and checking for injuries. A non-bleeding skin tear was found on Resident 6's left elbow. Resident 6 stated she/he was trying to open the side back door to the building, and when she/he backed up one of her/his wheels went off the ramp and she/he tipped over. The notes indicated Resident 6 was out at an appointment, came back to the facility, and the security keypad on the door was broken so she/he attempted to open the door manually. When she/he attempted to open the door her/his wheelchair collided with the door, which caused the wheelchair to tip over. The keypad on the door was not functioning, so the door would not open automatically.

On 8/1/24 the State Survey Agency received a public complaint which indicated Resident 6 fell because the automated front door that residents used was broken. Resident 6 used the doorbell for assistance to enter the building, she/he received no response, and so she/he went to the back entrance which was for staff use only. There was a slight incline and she/he tipped over in her/his wheelchair sustaining left hip bruising and road rash.

On 11/5/24 at 9:26 AM Staff 4 (CNA) stated the doorbell on the front door did not work, Resident 6 went to the back door by the kitchen and fell off the concrete ramp. Staff 4 stated the door was not functioning properly for approximately two weeks.

On 11/5/24 at 12:48 PM Staff 15 stated the keypads which operated the front door and the back door by kitchen were both not functioning.

On 11/6/24 at 9:57 AM the back door by the kitchen was observed to have a concrete ramp from the parking lot up to the back door. The ramp did not have any type of railing, and the distance from the highest point of the ramp to the parking lot surface was approximately 16 inches.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 12:32 PM Staff 12 (Maintenance) stated in 7/2024 there was nobody who was doing maintenance. Staff 12 stated he started working at the facility during the first part of 8/2024. On 11/8/24 at 9:08 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they wanted to review the information related to Resident 6's fall. No additional information or documentation was provided from Staff 1 or Staff 2 related to Resident 6's fall, or the timeline regarding when the doors were fixed. 26991 2. Resident 18 admitted to the facility in 4/2023 with a diagnosis of a stroke. a. A 2/14/24 Fall investigation revealed on 2/14/24 at 12:45 PM staff heard Resident 18 call for help. It was determined Resident 18 attempted to self-transfer. The investigation revealed Resident 18's wheelchair brakes were not locked. Resident 18 denied hitting her/his head when found on the floor. Resident 18's record did not include neurological checks (assessment to identify heard injuries). On 11/6/24 at 11:49 AM Staff 9 (LPN) stated if a resident had an unwitnessed fall staff were to complete neurological assessments which were to be documented. Staff 9 also stated the neurological assessments were to be completed even if a resident denied hitting her/his head. On 11/7/24 at 4:03 PM Staff 2 (Interim DNS) stated she was unable to locate the neurological assessments. b. A 2/22/24 Fall investigation revealed Resident 18 fell on [DATE] at 8:26 PM. Staff found Resident 18 on the floor in the bathroom. It was determined Resident 18 propelled to the bathroom and fell without asking for assistance. On 11/6/24 at 11:49 AM Staff 9 (LPN) stated if a resident had an unwitnessed fall staff were to complete neurological assessments (assessment to identify head injuries) which were to be documented. Staff 9 also stated the neurological assessments were to be completed even if a resident denied hitting her/his head. On 11/7/24 at 4:03 PM Staff 2 (Interim DNS) stated she was unable to locate the neurological assessments. c. On 11/5/24 at 1345 PM Resident 18 was observed to have non-slip matrerial on her/his wheelchair cushion. Resident 18's care plan initiated 5/2/23 indicated she/he was at risk for falls. Interventions did not include non-slip material was to be placed on her/his wheelchair cushion. On 11/4/24 at 1:47 PM Staff 24 (DNS) acknowledged Resident 18's care plan did not reflect the use of non-slip material on her/his wheelchair cushion.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 35855 Based on interview and record review the facility failed to provide pain medications as ordered for 1 of 2 sampled residents (#14) reviewed for pain management. This placed residents at risk for uncontrolled pain. Findings include: Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 11/6/23 Care plan indicated Resident 14 had chronic pain with interventions including to administer pain medications as ordered by the physician. A 2/2024 MAR instructed staff to administer Methadone (to treat moderate to severe pain) three times a day for chronic pain with a start date of 1/11/24. On 2/7/24 at 4:00 AM, 2/20/24 at 8:00 PM and 2/21/24 at 4:00 AM the MAR referred the reader to review Medication Administration Notes. A 2/7/24 Medication Administration Note indicated Methadone was not administered to Resident 14 because the facility was waiting on the delivery from the pharmacy. No documentation was found in Medication Administration Note for 2/20/24 why Resident 14 did not receive her/his Methadone. A 2/21/24 Medication Administration Note indicated Resident 14's Methadone was not delivered to the facility yet. On 3/6/24 the State Survey Agency received a public complaint which indicated Resident 14's pain medication was not re-ordered timely and she/he did not receive the medication timely. A 3/7/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. Resident 14 was on scheduled pain medication and was almost always in constant pain which frequently affected sleep and day to day activities. A 3/2024 MAR instructed staff to administer Methadone three times a day for chronic pain. On 3/17/24 at 12:00 PM, 8:00 PM and 3/18/24 at 4:00 AM the MAR referred the reader to review Medication Administration Notes. A 3/17/24 11:44 AM Medication Administration Note indicated Methadone was not administered because the facility was waiting on a physician order. A 3/17/24 8:08 PM Medication Administration Note indicated Methadone was not administered because the medication was unavailable, and the facility was waiting for the medication. A 3/18/24 4:39 PM Medication Administration Note indicated Methadone was not administered to Resident 14 because the facility was waiting on a delivery from the pharmacy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation was found in clinical records Resident 14's physician was notified of missed Methadone administrations. A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. On 11/6/24 at 9:34 AM Resident 14 stated almost every month her/his pain medications were late or missed. On 11/7/24 at 9:24 AM Witness 7 (Complainant) stated the facility consistently mismanaged Resident 14's medications. On 11/7/24 at 9:24 AM Witness 2 (Complainant) stated the facility mismanaged Resident 14's medications, and it was a hardship for her/him. On 11/8/24 at 8:39 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated Resident 14 was frequently out in the community away from the facility. Staff 2 stated she expected the physician to be notified if Resident 14 missed a dose of pain medication.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50930 Based on observation, interview, and record review it was determined the facility failed to have adequate staff available to meet the needs of residents for 2 of 4 residents (#s 14 and 18) reviewed for ADLs, and 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. Resident 18 admitted to the facility in 2023 with diagnoses including dementia and cognitive impairment. A 5/4/24 annual MDS revealed Resident 18 had moderate cognitive impairment. A 7/19/24 provider note stated Resident 18 had dementia and arrived at her/his appointment without their required facility staff escort. The note stated the provider called the facility and was told no escort was available due to short staffing. On 11/8/24 at 11:35 AM Staff 1 (Administrator) stated she expectated staff to accompany residents to their appointments as required. She acknowledged the provider note stating no facility staff escort was provided due to short staffing. 35855 2. On 7/25/24 the State Survey Agency received a public complaint which indicated the facility was short staffed, and when there were not enough staff the facility did not address the issue. On the 7/24/24 to 7/25/24 night shifts the facility only had one nurse and one CNA for 27 residents. On 8/1/24 the State Survey Agency received a public complaint which indicated Staff 20 (Former Administrator) terminated the employment of multiple staff, and half of the CNAs and CMAs voluntarily ended their employment before it was terminated. All shifts were short-staffed, and the administration brought in agency nurses but no agency CNAs. On 8/1/24 the State Survey Agency received a public complaint which indicated Staff 20 terminated the employment of a lot of the staff. The facility did not have enough staff to adequately care for the residents and the resident acuity was high. On 11/5/24 at 9:26 AM Witness 8 (Complainant) confirmed in 7/2024 the facility was short-staffed, and the facility did not meet minimum required staffing levels for all the shifts. Review of the Direct Care Staff Daily Reports for the months of 4/2024 through 7/2024, 10/2024, and 11/2024 revealed the following days when one or more shifts did not meet the state minimum CNA staffing requirements: - 4/10/24 - 4/26/24 through 4/29/24 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Myrtle Point Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 637 Ash Street Myrtle Point, OR 97458	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/3/24 through 5/6/24 - 5/8/24 - 5/11/24 - 5/13/24 - 5/15/24 - 5/18/24 - 5/20/24 through 5/23/24 - 5/26/24 - 5/29/24 - 5/31/24 - 6/1/24 through 6/7/24 - 6/10/24 - 6/22/24 through 6/23/24 - 6/26/24 - 6/29/24 through 6/30/24 - 7/1/24 - 7/24/24 through 7/26/24 - 10/18/24 Noc shift On 11/5/24 at 11:46 AM Witness 9 (Complainant) stated in 7/2024 lack of staff was horrible. Witness 9 stated one night there was only one CNA and one nurse. Witness 9 stated she was deathly concerned about residents falling on the night shift when there were only two staff in the facility. On 11/6/24 at 12:11 PM Resident 14's call light was activated, and Staff 8 (CMA) went into Resident 14's room and requested Resident 14 turn off her/his call light. At 12:51 PM Resident 14 stated she/he requested batteries for her/his television remote at 7:30 AM, then again at 12:11 PM, and had not yet received the batteries. At 1:11 PM Resident 14's lunch tray was delivered, and Staff 10 (RN) stated she would go check about the batteries. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 7:09 AM Witness 7 (Former Staff) stated in 7/2024 Staff 20 hindered staff in completing their work. At times she cut the scheduled staff hours and the CNAS were always running and doing their best to provide care to the residents. On 11/7/24 at 10:04 AM Resident 3 stated staff needed to answer call lights more quickly. At times she/he waited 30 to 45 minutes which usually occured on evening shift. On 11/7/24 at 10:50 AM Resident 22 stated in 7/2024 the facility was a nasty place. Resident 22 stated he went multiple hours without her/his antibiotic and pain medications. The Administrator made her/him make phone calls to try and find her/his own housing for when she/he discharged . On 11/7/24 at 9:05 AM Staff 13 (CNA) stated in 7/2024 there was a shortage of staff because of all the changes in the facility. Staff 13 stated CNA staff assisted the residents as quickly as possible. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated in 6/2024 and 7/2024 it was hit or miss on the evening shift and there were times evening shift was short of staff. On 11/8/24 at 8:44 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they expected staff to address an issue if a call light was turned on in a resident room.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50930 Based on interview and record review it was determined the facility failed to ensure nursing staff were able to demonstrate competency in skills and techniques necessary to care for residents for 3 of 5 staff (#s 18, 26, and 27) reviewed for competencies. This placed residents at risk for poor quality of care and lack of competent staff. Findings include: On 11/5/24 Staff 1 (Administrator) was asked to provide documentation of a completed competency checklist for Staff 17 (CNA), Staff 18 (CNA), Staff 26 (CNA), Staff 27 (CNA), and Staff 28 (CNA). On 11/6/24 at 10:00 AM Staff 1 provided completed competency checklists for Staff 17 and Staff 28. Staff 1 stated she did not have the requested completed competency checklists for Staff 18, Staff 26, and Staff 27.

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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. 50930 Based on interview and record review it was determined the facility failed to ensure the required annual CNA training and annual performance reviews were completed for 2 of 5 sampled CNA staff (#s 26 and 28) reviewed for staffing. This placed residents at risk for unmet needs and lack of competent staff. Findings include: On 11/5/24 at 1:00 PM Staff 1 (Administrator) was asked to provide annual performance reviews and documentation of annual in-service training for Staff 26 and Staff 28. No annual performance reviews or in-service training documentation were provided for the identified staff members. On 11/6/24 at 10:00 AM Staff 1 (Administrator) stated in-service training was completed for CNA staff during staff meetings and via internet-based services. She stated she was recently hired and was not sure when or how evaluations were completed for staff. She acknowledged the identified CNA staff records did not show 12 hours of annual in-service training and did not include annual performance reviews. She stated the facility was not able to access the previous internet-based training service records, and the facility had not started the new internet-based training service.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35855 Based on interview and record review it was determined the facility failed to provide accurate and timely pharmaceutical services for 1 of 2 sampled residents (#14) reviewed for pain management. This placed residents at risk for medication errors. Findings include: Resident 14 admitted to the facility in 5/2023 with diagnoses including arthritis and intervertebral disc degeneration (one or more discs in the spine deteriorate). A 11/6/23 Care plan indicated Resident 14 had chronic pain with interventions including to administer pain medications as ordered by the physician. A 2/2024 MAR instructed staff to administer Methadone (to treat moderate to severe pain) three times a day for chronic pain with a start date of 1/11/24. On 2/7/24 at 4:00 AM, 2/20/24 at 8:00 PM and 2/21/24 at 4:00 AM the MAR referred the reader to review Medication Administration Notes. A 2/7/24 Medication Administration Note indicated Methadone was not administered to Resident 14 because the facility was waiting on the delivery from the pharmacy. No documentation was found in Medication Administration Note for 2/20/24 why Resident 14 did not receive her/his Methadone. A 2/21/24 Medication Administration Note indicated Resident 14's Methadone was not delivered to the facility yet. On 3/6/24 the State Survey Agency received a public complaint which indicated Resident 14's pain medication was not re-ordered timely and as a result she/he did not receive the medication timely. A 3/7/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. Resident 14 was on scheduled pain medication and was almost always in constant pain, which frequently affected sleep and day to day activities. A 3/2024 MAR instructed staff to administer Methadone three times a day for chronic pain. On 3/17/24 at 12:00 PM, 8:00 PM and 3/18/24 at 4:00 AM the MAR referred the reader to review Medication Administration Notes. A 3/17/24 11:44 AM Medication Administration Note indicated Methadone was not administered because the facility was waiting on a physician order. A 3/17/24 8:08 PM Medication Administration Note indicated Methadone was not administered because the medication was unavailable, and the facility was waiting for the medication. A 3/18/24 4:39 PM Medication Administration Note indicated Methadone was not administered to Resident 14 because the facility was waiting on a delivery from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/30/24 MDS revealed Resident 14's BIMS score was 15 which indicated she/he was cognitively intact. On 11/6/24 at 9:34 AM Resident 14 stated almost every month her/his pain medications were late or missed. On 11/7/24 at 9:24 AM Witness 7 (Complainant) stated the facility consistently mismanaged Resident 14's medications. On 11/7/24 at 9:24 AM Witness 2 (Complainant) stated the facility mismanaged Resident 14's medications, and it was a hardship for her/him. On 11/8/24 at 8:39 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated Resident 14 was frequently out in the community away from the facility. Staff 2 stated she expected the physician to be notified if Resident 14 missed a dose of pain medication.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 26991 Based on observation, interview and record review it was determined the facility failed to ensure a follow-up dental appointment was made for 1 of 2 sampled residents (#18) reviewed for dental. This placed residents at risk for dental pain. Findings include: Resident 18 admitted to the facility in 4/2023 with a diagnosis of diabetes. A 3/19/24 dental Clinical Notes Report revealed an oral exam was performed and findings included cavities. Recommendations included a referral for treatment and a full crown. A 5/15/24 Clinical Notes Report revealed Resident 18 was seen for a dental visit. X-rays were not able to be performed due to the resident's mental capacity. Resident 18's clinical record did not indicate she/he was referred to another dental provider. On 11/8/24 at 10:16 AM Staff 1 (Administrator) stated Resident 18 was not setup for a dental referral related to the treatment recommendations from the previous dental appointments.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35855 Based on interview and record review it was determined the facility failed to employ a director of food and nutrition services with the required certification for 1 of 1 facility reviewed for qualified dietary staff. This placed residents at risk for unmet dietary needs. Findings include: On 11/7/24 at 3:12 PM Staff 23 (Dietary Manager) stated she would be certified in 2/2025 as a dietary manager. No documentation was provided for Staff 23's certification as a dietary manager. On 11/8/24 at 11:17 AM and 12:14 PM Staff 1 (Administrator) was informed Staff 23 currently lacked the required certification, and also did not have the required certification in 2023 which was identified during the annual recertification survey that year. Staff 1 stated Staff 23 was coming in on Sundays and working on the classes. Staff 1 stated since Staff 23's preceptor passed away, she did not complete the training. Staff 1 stated she was not aware the facility was cited previously for the same issue. Review of 2022 and 2023 recertification surveys revealed the facility was cited because Staff 23 did not possess the required certification.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35855 Based on observation, interview, and record review it was determined the facility failed to ensure residents' food preferences were honored for 1 of 3 sample residents (#14) reviewed regarding food. This placed residents at risk for unmet needs. Findings include: On 7/24/24 the State Survey Agency received a public complaint which indicated Resident 14 was not getting enough food and did not always get what other residents were served. On 11/6/24 at 9:42 AM and 1:13 PM Resident 14 stated the facility served their largest meal at lunch and in her/his culture the largest meal of the day was at dinner time. Resident 14 stated the facility did not provide choices during meals and residents received what was served. At times Resident 14 was served beets or Brussels sprouts, and she/he did not like those types of vegetables. Resident 14 stated when a request for a salad was honored it was very small and with hardly anything on the salad. Resident 14 received her/his lunch meal tray with mashed potatoes and gravy, vegetables, and a pork chop. Resident 14 stated the pork chop was dry. A review of an undated Alternative Meal Item list revealed the following choices: 1. Cottage cheese and fruit 2. All beef hotdog with bun 3. Corndogs 4. Grilled cheese sandwich 5. Egg salad sandwich 6. Tuna sandwich 7. Bowl of cereal. A 9/3/24 Likes and Dislikes Interview sheet stated Resident 14 went to bed hungry and CNAs refused to provide a bowl of cereal. On 11/7/24 at 3:12 PM Staff 23 (Dietary Manager) stated the alternative meal menu was comprised of items continuously asked for by residents. Staff 23 stated there were only a few residents that wanted salad, and when they did they asked the CNAs and then CNAs passed the request on to the kitchen. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated a couple of instances she saw meal portions super small. Staff 18 stated there used to be an alternative meal menu, but when Staff 20 (Former Administrator) worked in the facility in 7/2024 and 8/2024 she took away the alternative menu. Staff 18 stated the alternative menu did not come back when Staff 20 no longer worked at the facility. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 9:05 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed the alternative meal item list was not nutritionally equivalent to the main menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677 Based on observation and interview it was determined the facility failed to ensure food was stored appropriately and was discarded in a timely manner for 1 of 1 resident refrigerator reviewed for food storage and handling. This placed residents at risk for food-borne illness and cross-contamination. Findings include: On [DATE] at 11:34 AM the resident refrigerator located in the sunroom contained the following food items that were labeled with expired dates: - Applesauce was dated [DATE] (expired for 7 days). - A sandwich was dated [DATE] (expired for 5 days). - A dish of pineapple was dated [DATE] (expired for 5 days). - A plastic bag of carrots was dated [DATE] (expired for 4 days). On [DATE] at 11:46 AM Staff 23 (Dietary Manager) confirmed the food items should have been discarded by the expiration dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35855 Based on interview and record review it was determined the facility failed to ensure resident records were complete and accessible for 2 of 2 sampled residents (#s 11 and 18) whose records were reviewed. This placed residents at risk for unmet needs. Findings include: 1. Resident 11 admitted to the facility in 6/2019 with diagnoses including blindness and dementia. On 8/1/24 the State Survey Agency received a public complaint which indicated Staff 20 (Former Administrator) disposed of residents' medical records which included tuberculosis (TB) testing records. The nurse had to re-do residents' TB testing. Resident 11 stated staff attempted to poke her/him to re-do the TB test. No documentation was found in Resident 11's clinical records she/he was offered or received TB testing prior to 6/2024. A review of Resident 11's Immunization Details revealed on 8/2/24 Resident 11 refused a TB skin test. On 11/5/24 at 12:31 PM Staff 9 (LPN) stated she remembered a concern with lost medical documents and having to re-do TB testing on some residents. On 11/8/24 at 11:57 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed some TB testing medical documents were lost and the facility had to do their due diligence and complete the testing again. 2. Resident 18 admitted to the facility in 4/2023 with diagnoses including anxiety and dementia. On 8/1/24 the State Survey Agency received a public complaint which indicated Staff 20 (Former Administrator) disposed of residents' medical records which included tuberculosis (TB) testing records. The nurse had to re-do residents' TB testing. No documentation was found in Resident 18's clinical records she/he was offered or received TB testing prior to 8/2024. A review of Resident 18's Immunization Details revealed on 8/1/24 Resident 18 received a TB skin test on the right forearm. On 11/5/24 at 12:31 PM Staff 9 (LPN) stated she remembered a concern with lost medical documents and having to re-do TB testing on some residents. On 11/8/24 at 11:57 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed some TB testing medical documents were lost and the facility had to do their due diligence and complete the testing again.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50930 Based on interview and record review it was determined the facility failed to submit Payroll Based Journal staffing data and other verifiable and auditable data as required for 1 of 1 facility reviewed. This placed residents at risk for inaccurate staffing data reporting. Findings include: Review of the Payroll Based Journal Staffing Data for fiscal year 2024, quarter three (4/1/24 through 6/30/24), revealed the facility failed to submit required data for the quarter. On 11/6/24 at 12:22 PM Staff 1 (Administrator) stated she was unaware the data was not submitted until the survey team alerted her to the omission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 7 sampled residents (#27) reviewed for infection control. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: Resident 27 admitted to the facility in 2/2024 with a diagnosis of a fracture to the right hip. A 5/20/24 Nursing Note indicated Resident 27 discharged from the facility to the hospital because she/he had copious amounts of pus drainage from her/his surgical site. A 6/6/24 hospital transfer orders indicated Resident 27 had active infection of Methicillin Resistant Staphylococcus Aureus (MRSA, a bacterium which can cause serious infections in humans, is multi-drug resistant, and carriers could spread the infection even if they are not sick themselves). A 6/11/24 Nursing Note indicated Resident 27 had IV antibiotic treatment for an infected wound. No documentation was found in Resident 27's clinical record she/he was placed on precautions after readmitting to the facility on [DATE]. On 7/25/24 the State Survey Agency received a public complaint which indicated multiple residents admitted with MRSA and the biohazard receptacles were removed and Resident 27 developed a MRSA infection. On 11/5/24 at 11:58 AM Witness 9 (Complainant) confirmed the allegation Resident 27 developed MRSA in the facility due to lack of infection control. On 11/8/24 at 7:25 AM Staff 18 (CNA) stated Resident 27 readmitted from the hospital with MRSA. Staff 18 stated staff did not know Resident 27 had MRSA and she/he was not on any type of infection control precautions. On 11/8/24 at 9:16 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they would review the information. Staff 2 provided a 7/3/24 care plan which indicated Resident 27 was placed on precautions 27 days after she/he readmitted to the facility. No further information or documentation was provided.