

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8643 NE Beech Street Portland, OR 97220	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. 51846 Based on observation, interview and record review it was determined the facility failed to honor a resident's preference for timing of wound care for 1 of 1 sampled resident (#42) reviewed for choices. This placed resident at risk for impaired sleep and reduced quality of life. Findings include: Resident 42 was admitted to the facility in 1/2025 with diagnoses including a stage four pressure ulcer and a non-pressure chronic ulcer with necrosis of the bone (non-healing open sore with loss of bone tissue). A review of Resident 42's physician orders indicated wound care was to be performed twice daily. A review of Resident 42's scheduled pain medication showed administration times to be at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. Resident 42 also had physician orders for two other separate pain medications every three hours, as needed. On 1/28/25 Resident 42's admissions assessment noted Resident 42 to be social and looked forward to activities and it was very important for her/him to do things with groups of people. On 2/10/25 at 10:41 AM and on 2/12/25 at 1:32 PM, Resident 42 stated it was inconvenient for her/him to receive wound care at lunch time and midnight because it caused her/him to miss scheduled activities and not sleep well at night. Resident 42 stated she/he requested to have her/his scheduled wound care changed to morning and evening, but nothing was changed. On 2/12/25 at 1:16 PM Staff 13 (CNA) stated Resident 42 received her/his pain medication for wound care. On 2/12/25 Resident 42 received wound care from 2:12 PM to 2:42 PM. During an interview on 2/13/25 at 8:18 AM, Staff 30 (RCM) stated Resident 42's wound care was coordinated around the time of her/his pain medication and when nurses could do the wound care. During an interview on 2/18/25 at 11:35 AM, Staff 1 (Administrator) and Staff 2 (DNS) stated treatment times were based on residents' preferences and could be customized. Staff 1 and Staff 2 acknowledged Resident 42's preferences were not honored related to her/his wound care treatments.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 385258	If continuation sheet Page 1 of 34

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47000 Based on interview and record review it was determined the facility failed to provide residents and their representatives with a baseline care plan and to ensure baseline care plans included care for an indwelling urinary catheter for 2 of 4 sampled residents (#s 46 and 254) reviewed for care planning and catheter care. This placed residents at risk for being uniformed of their plan of care and complications of catheter use. Findings include: The facility's 5/2024 Baseline Care Plan Policy indicated the following: -A baseline care plan was to be developed for each resident within 48 hours of admission and was to be used until an interdisciplinary, person-centered and comprehensive care plan was developed. -The baseline care plan was to include instructions needed to provide effective, person-centered care of the resident. -The resident and/or representative was to be provided a written summary of the baseline care plan. 1. Resident 46 was admitted to the facility in 12/2024 with diagnoses including cognitive and communication deficit. Review of Resident 46's clinical record revealed no evidence baseline care plan information was provided to the resident or her/his involved family member. On 2/10/25 at 3:04 PM, Witness 1 (Family member) stated she was never provided with a baseline care plan for Resident 46 and she wanted one. On 2/18/25 at 8:28 AM, Resident 46 stated she/he never received a copy of her/his baseline care plan, she/he wanted one and she/he wanted Witness 1 to have a copy. On 2/18/25 at 9:49 AM, Staff 2 (DNS) acknowledged a baseline care plan was not given to Resident 46 or Witness 1. 2. Resident 254 was admitted to the facility in 1/2025 with diagnoses including complications associated with an indwelling urinary catheter with the presence of an indwelling catheter. Resident 254's 1/30/25 Nursing Admission Assessment revealed the resident had an indwelling urinary catheter in place. Resident 254's Baseline Care Plan, initiated on 1/30/25, did not include information about the use of the resident's catheter. On 2/12/25 at 10:00 AM, Staff 2 (DNS) acknowledged Resident 254's baseline care plan did not include information regarding her/his catheter.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services in the area of communication for 1 of 2 sampled residents (#254) reviewed for communication. This placed residents at risk for diminished quality of life and potential decline in their ability to carry out activities of daily living. Findings include: Resident 254 was admitted to the facility in 1/2025 with diagnoses including dementia and hearing loss. Resident 254's 1/30/25 Baseline Care Plan indicated the resident was hard of hearing and wore bilateral hearing aids, and staff were to ensure the resident's hearing aids were in her/his ears or were to use a dry erase board in order to ensure proper communication. On 2/10/25 at 10:44 AM, Resident 254 was observed in her/his room and sat in her/his wheelchair. No dry erase board was visible in the resident's room and the resident's hearing aids were in her/his ears. The state surveyor greeted the resident and spoke at a loud volume to which the resident stated, I can't hear you. On 2/10/25 at 10:45 AM, Staff 32 (Agency CNA) stated when she started her shift at 6:00 AM, Resident 254's hearing aids were already in her/his ears. On 2/10/25 at 12:38 PM, Resident 254 was observed in the dining room accompanied by Witness 2 (Resident Representative). Resident 254 was unable to hear either the state surveyor or Witness 2, even at a loud volume. Witness 2 removed the resident's hearing aids and stated they were completely dead. Witness 2 returned to the dining room after she placed the resident's hearing aids on the charger in the resident's room and stated it was a constant battle to get staff to remove the resident's hearing aids at night and put them on the charger. Witness 2 stated she visited Resident 254 at the facility daily and there was always a problem with the hearing aids, including the resident's hearing aids not being charged, hanging out of the resident's ears, or just sitting on the charger. On 2/11/25 at 11:30 AM, Resident 254 was observed in the facility's common area and sat in her/his wheelchair. The state surveyor verbally greeted the resident in an elevated voice but the resident did not demonstrate comprehension in either words or actions. On 2/11/25 at 1:47 PM, Staff 27 (CNA) stated she noticed problems with [Resident 254's] hearing aids last week and they did not seem to work at all. On 2/11/25 at 3:04 PM, Staff 28 (CNA) stated Resident 254 could not hear anything without her/his hearing aids. Staff 28 stated Resident 254's hearing aids were pretty crucial because she/he was able to hear pretty good and able to understand more of what was going on when she/he wore them but, sometimes people forgot to charge them. Staff 28 further stated he had not seen a dry erase board in the resident's room until the previous day. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 8:39 AM, Staff 33 (SLP) stated Resident 254 was very hard of hearing and her/his ability to follow directions and answer questions was improved when they were written down. Staff 33 stated she talked to all of the CNAs about the resident's ability to respond better to visual commands but had not noticed anyone doing it. Staff 33 stated she brought her own dry erase board each time she worked with Resident 254 as there was never one available in her/his room. Staff 33 further stated it took staff maybe a week to realize [Resident 254] absolutely needed to have [her/his] hearing aids charged. On 2/12/25 at 9:45 AM, Staff 30 (LPN Resident Care Manager) stated she provided Resident 254 with a dry erase board on her/his day of admission to the facility, but was not sure if the board was transferred with the resident when she/he moved rooms on the second day of her/his stay at the facility. On 2/12/25 at 10:00 AM, Staff 2 acknowledged there were concerns around Resident 254's hearing aids and did not comment on the use of the dry erase board to improve communication.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 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 2 sampled residents (#21) reviewed for ADLs. This placed residents at risk for lack of personal hygiene. Findings include: Resident 21 was admitted to the facility in 3/2024 with diagnoses including Parkinson's disease and muscle weakness. Resident 21's Admission MDS dated [DATE] indicated the resident had moderate cognitive impairment and required one-person total assistance with personal hygiene and grooming. Resident 21 was observed on 2/10/25 at 12:28 PM, and on 2/12/25 at 1:10 PM, with a significant amount of chin hairs. On 2/10/25 at 12:28 PM, Resident 21 stated she/he did not want to have facial hair but was not able to look at herself/himself or touch her/his face due to lack of mobility in her/his arms from Parkinson's disease. Resident 21 stated she/he relied on staff to shave unwanted facial hair. On 2/12/25 at 3:33 PM, Staff 14 (CNA) stated she obtained information to care for Resident 21 from the Kardex (bedside care plan) and acknowledged Resident 21 had long chin hairs. On 2/13/25 at 9:58 AM, Staff 2 (DNS) stated she expected staff to implement and follow the care plan, ensuring Resident 21 was provided appropriate personal hygiene care, including the removal of facial hair.		

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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. 41458 Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activity program for 3 of 4 sampled dependent residents (#s 28, 46 and 254) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's Activity Program Policy, last revised 6/2018, indicated the following: -Activity programs were designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. -The activities program included facility-organized group activities, independent individual activities and assisted individual activities. -The facility's activity programs were designed to encourage maximum individual participation and were geared to the individual resident's needs. -All activities were documented in the resident's medical record. 1. Resident 28 was admitted to the facility in 8/2023 with diagnoses including a brain stem stroke, severe dementia, Alzheimer's disease and dysphagia (difficulty swallowing). Resident 28's 8/28/24 Annual MDS revealed the resident had severely impaired cognition. Resident 28 liked doing things in groups of people, keeping up with the news, spending time outdoors, being around animals, listening to music and reading books/magazines and newspapers. Resident 28's Activity Care Plan, last revised 12/23/24, included giving the resident sensory supplies and helping him/her to use them and taking the resident outside when it was warm. The 1/6/25 Resident Council Meeting Minutes indicated residents wanted more in-room activities. The facility's Activity Calendar revealed the following scheduled activities: -2/10/25 10:30 AM: Clipper Cuts 2:00 PM: Farkle 3:30 PM: Stretching 4:00 PM: Charades -2/11/25 (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:40 AM: Bible Study 1:30 PM: Yahtzee 3:30 PM: Ladies Group 4:30 PM: Dominoes -2/12/25 11:00 AM: Coffee Cafe 1:30 PM: Bingo 3:15 PM: Mobile Scrabble 4:00 PM: Library Cart 4:45 PM Chair Yoga -2/13/25 10:30 AM: Resident Shopping 1:30 PM: Volleyball Thursday Therapy/Activities 2:30 PM: Chess 4:00 PM Meditation and Socialization -2/14/25 11:00 AM: Menu Planning 2:00 PM: Valentine's Prom Event 4:30 PM: Valentine's Trivia Resident 28's Activity Participation Logs from 1/10/25 through 2/10/25 indicated Resident 28 participated in a one-on-one exercise activity on 1/14/25 and was brought to group bingo on 1/29/25 with a guest. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Random observations of Resident 28 conducted from 2/10/25 through 2/12/25 between the hours of 4:45 AM and 4:15 PM revealed the resident was up in her/his wheelchair for hours at a time, sitting in the living area, in front of the television. Resident 28 sat with her/his eyes closed and was not observed to watch television or look out the window. Frequently, other residents and staff were in the living area but none were observed interacting with Resident 28. On 2/11/25, the resident was seen sitting in the living area in her/his wheelchair in front of the television from 11:36 AM until the surveyor left the facility at 4:15 PM. The resident was not engaged in any activities during any observations. When the resident was not up in her/his wheelchair in the living area, the resident was in bed, positioned on her/his left side facing the wall, in a dark room with no stimulation such as music. There were no books, newspapers, magazines or sensory supplies observed in Resident 28's room. On 2/12/25 at 9:17 AM, Staff 34 (CNA) reported Resident 28 usually got up around 10:00 AM or 11:00 AM and sat in her/his wheelchair in the living area, in front of the TV all day. Staff 34 stated she never saw Resident 28 doing anything other than sitting in her/his wheelchair including no group or one-on-one activities in the resident's room or while sitting in the living area. Staff 34 stated Resident 28 did nothing all day and when the resident was in her/his bed, the room was dark and there was no stimulation such as music, occurring. On 2/18/25 at 7:49 AM, Staff 6 (Activities Director) stated she had no programs developed to provide activities to residents with dementia or residents unable to verbalize. Staff 6 reported Resident 28 was not able to engage while in group activities, such as bingo, and could not converse except to occasionally respond to yes/no questions. Staff 6 stated she had no sensory activities for Resident 28 except holding her/his hand on occasion. Staff 6 stated Resident 28 was not being provided with activities to meet her/his preferences or ability level and she/he should be getting more activities. On 2/18/25 at 10:50 AM, Staff 1 (Administrator) stated he expected the facility to have an activities program for dementia residents and residents who were non-verbal and expected residents to have a person-centered activities program. 47000 2. Resident 46 was admitted to the facility in 12/2024 with diagnoses including cognitive and communication deficit. Resident 46's 12/31/24 Baseline Care Plan indicated the resident was not alert or oriented, enjoyed to play pool and listen to music and her/his daily routine consisted of caring for her/his cat and boat. Resident 46's 1/7/25 Activity Assessment indicated the resident's activity preferences included to sail, and she/he preferred activities to occur in her/his room. Resident 46's 1/7/25 Admission MDS revealed the resident was cognitively intact and she/he preferred to listen to music, go outside when the weather was nice, be around pets and to keep up with the news. The MDS also revealed books, magazines and newspapers were not very important activity preferences for the resident. The Activities CAA indicated a care plan was to be developed in order to achieve improvement in this area. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 46's 1/8/25 Activity Care Plan revealed the following: -The resident's activity preferences included being around pets. -Witness 1 (Family Member) was very involved. -Ask the resident about her/his cat and sailboat. -Provide the resident with the opportunity to go outdoors and to sit by windows. -Encourage the resident to explore activities that promoted autonomy and independence with preferred activity pursuits. -Provide the resident with activity materials like books, magazines, newspapers, television, radio, arts and crafts in accordance with the resident's interests. The facility's 2/2025 Activity Calendar revealed the following activities: -2/10/25: 10:30 AM Clipper Cuts 1:30 PM Dietary Meeting 2:00 PM Farkle 3:30 PM Stretching 4:00 PM Charades -2/11/25: 10:40 AM Bible Study 1:30 PM Yatzee 3:30 PM Ladies' Group 4:30 PM Dominos -2/12/25: 11:00 Coffee Cafe 1:30 PM Bingo 3:15 PM Mobile Scrabble (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4:00 PM Library Cart 4:45 PM Chair Yoga Review of Resident 46's 1/14/2025 through 2/12/2025 Activity Task Logs revealed the resident did not participate in any group activity outside of afternoon treats on 1/28/25 and her/his one-to-ones included four check ins, two family visits and one instance of conversation and reminiscing. Observations of Resident 46 from 2/10/25 through 2/12/25 between 5:27 AM to 4:03 PM revealed the resident to be in bed with her/his television on. On 2/10/25 at 3:04 PM, Witness 1 stated Resident 46 spent all day in her/his room in bed. Witness 1 stated she was never interviewed about the resident's activity preferences, which included to listen to music or a podcast, visit with her/his cat and socialize with others. Witness 1 further stated the resident did not enjoy television. On 2/11/25 at 10:59 AM, Resident 46 was observed in her/his room in bed with the television on. Resident 46 stated she/he loved to sail her/his boat, play pool and be around animals. On 2/12/25 at 9:05 AM, Staff 20 (CNA) stated Resident 46 spent most of her/his time in bed and slept a lot. Staff 20 stated the resident liked to fish but we don't have fishing stuff here so she/he could not engage in this activity interest. Staff 20 stated the resident also enjoyed to talk about her/his boat and cat but she was unaware of any additional activity interests or preferences. On 2/18/25 at 8:28 AM, Resident 46 was observed in her/his room in bed with the television on. Resident 46 stated she/he was interested to go outside and get fresh air and to receive in-room visits, and she/he loved animals and music, especially rock and roll. Resident 46 further stated she/he did not prefer to watch television but may look at it if it was on. On 2/18/25 at 7:49 AM, Staff 6 (Activities Director) stated Resident 46 slept most of the time but was always pleasant whenever she went into her/his room. Staff 6 stated she had not offered the resident an opportunity to participate in any of the activities she/he indicated were preferred on her/his Admission MDS, including to go outside, listen to music or receive a pet visit. Staff 6 stated the only activity she offered the resident was to talk about cats and boats. Staff 6 stated she did not have any idea how activity improvement as indicated in the resident's Activity CAA would be achieved and stated many of the resident's activity care plan interventions were not resident-specific but were canned. On 2/18/25 at 10:50 AM and at 11:08 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 4 (Regional Nurse Consultant) were present for an interview. Staff 1, Staff 2 and Staff 4 acknowledged the lack of activities offered for Resident 28. Staff 1 stated he expected the facility to have an activities program for residents with dementia and expected residents to have a person-centered activities program. 3. Resident 254 was admitted to the facility in 1/2025 with diagnoses including dementia. Resident 254's 1/30/25 Baseline Care Plan indicated the resident was not able to make her/his needs known, she/he liked games and her/his routine included to watch television with other residents. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 254's 2/6/25 Activity Assessment revealed the resident was unable to communicate what activities she/he enjoyed in the present or past and her/his preferred location for activities was anywhere in the facility. Resident 254's Activity Care Plan indicated the following: -Meaningful activities for the resident included participation in festive meals and snacks, television and visits with friends and family. -Assist the resident to-and-from activity locations as needed. -Provide one-to-one room visits for socialization if needed. The facility's 2/2025 Activity Calendar revealed the following activities: -2/10/25: 10:30 AM Clipper Cuts 1:30 PM Dietary Meeting 2:00 PM Farkle 3:30 PM Stretching 4:00 PM Charades -2/11/25: 10:40 AM Bible Study 1:30 PM Yatzee 3:30 PM Ladies' Group 4:30 PM Dominos -2/12/25: 11:00 Coffee Cafe 1:30 PM Bingo 3:15 PM Mobile Scrabble 4:00 PM Library Cart 4:45 PM Chair Yoga (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 254's 1/2025 and 2/2025 Activity Task Logs revealed the resident did not participate in a group activity and her/his one-to-ones included a check in on 1/30/25, calendar delivery on 1/31/25 and filling out menu on 2/7/25. On 2/10/25 at 10:44 AM, Resident 254 was observed in her/his room and sat in her/his wheelchair. No activity or personal items were observed in the resident's room. The televisions of the resident's roommates to both her/his right and left were on and the resident did not watch either. Resident 254 was unable to answer any questions regarding her/his activity interests or preferences at this time. On 2/10/25 at 1:47 PM, Witness 2 (Resident Representative) stated Resident 254 spent her/his day in between two beds in jail with no involvement in activities. Witness 2 stated the resident enjoyed to go outside, golf and listen to music, especially music from the 1940s. Witness 2 stated the resident enjoyed to be around people and she had repeatedly requested staff to allow her/him to participate in activities, and if she/he declined participation, it was likely on account of her/his hearing loss and difficulty with comprehension because of her/his diagnosis of dementia. Witness 2 further stated she was not interviewed about the resident's activity interests or preferences. On 2/11/25 from 10:50 AM to 12:42 PM, Resident 254 was observed in the facility's common area. The resident sat in her/his wheelchair and positioned her/his body away from the television which aired the news and a daytime talk show during this time period. The resident was not observed to watch the television or interact with other residents or staff. On 2/11/25 at 1:47 PM, Staff 27 (CNA) stated she had not seen Resident 254 participate in any activities and did not know the resident's activity interests. On 2/11/25 at 3:04 PM, Staff 28 (CNA) stated he did not know Resident 254's activity interests, the resident was confused a lot of the time and the only time he saw the resident up and in her/his wheelchair was when family visited. On 2/12/25 at 8:51 AM, and 10:52 AM, Resident 254 was observed in her/his room in bed. The televisions of the resident's roommates to both her/his right and left were on and the resident did not watch either. On 2/12/25 at 8:55 AM, Staff 13 (CNA) stated he had not seen Resident 254 participate in any activities, did not know the resident's activity interests and stated if he was curious about her/his activity interests, he would consult the resident's family as they come in enough. On 2/18/25 at 8:00 AM, Staff 6 (Activities Director) stated Resident 254's activity participation consisted primarily of meals in the dining room. Staff 6 stated she had not attempted any sensory activities with Resident 254 and the meaningful activities she included on the resident's care plan were not activity interests expressed by the resident or family but just things I saw [her/him] doing so I included them as meaningful activities. Staff 6 stated the resident had not participated in any group activities at the facility outside of Bingo on one occasion and her check in with the resident consisted of her asking the resident if there was anything [she/he] wanted to do and [she/he] said no. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Evergreen Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8643 NE Beech Street Portland, OR 97220	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/25 at 10:50 AM and at 11:08 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 4 (Regional Nurse Consultant) were present for an interview. Staff 1, Staff 2 and Staff 4 acknowledged the lack of activities offered for Resident 254. Staff 1 stated he expected the facility to have an activities program for residents with dementia and expected residents to have a person-centered activities program.		

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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. 18073 Based on interview and record review it was determined the facility failed to follow physician orders for daily wound care for 1 of 1 resident (#50) reviewed for discharge. This placed the resident at risk for complications related to chronic wounds. Findings included: Resident 50 was admitted to the facility in 11/2024 for wound care with diagnoses including lower extremity venous stasis ulcers. Admission orders dated 11/18/24 included silver sulfadiazine cream 1 %: Apply to right leg topically one time a day and as needed for wound care. Review of the 11/2024 TAR and nursing notes dated 11/20/24 revealed wound care was not provided on 11/20/24 due to the silver sulfadiazine cream not being available. There was no documentation on the TAR or in nursing notes to indicate if wound care was completed on 11/21/24, however, a physician progress note dated 11/22/24 revealed the resident complained to the provider she/he had not received wound care while in the facility. The resident left the facility AMA (against medical advise) later that day. An attempt was made to contact the resident on 2/14/25 without success. On 2/18/25 at 8:03 AM, Staff 2 (DNS) explained the process for obtaining ordered medications and wound care supplies. Staff 2 stated the facility could have contacted the pharmacy to have the silver sulfadiazine cream delivered the day it was needed. Staff 2 stated these instructions were available to agency nurses or the nurses could have contacted her for assistance. Staff 2 confirmed the facility did not have the silver sulfadiazine cream and resident did not receive wound care as ordered until 11/22/24 the day Resident 50 left the facility.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41458 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to maintain and prevent a potential decrease in ROM or mobility for 2 of 2 sampled residents (#s 5 and 28) reviewed for restorative services. This placed residents at risk for loss of ROM and mobility. Findings include: The facility's Restorative Nursing Policy, dated 8/1/24, indicated the following: -It is the policy of this facility to ensure that a resident's communication, mobility, range of motion, performance of ADLs, eating and toileting do not deteriorate unless the deterioration is unavoidable. Residents evaluated with deficits in communication, mobility, range of motion, performance of ADLs, eating or toileting received necessary care and services to attain and maintain their highest practicable physical, mental and psychosocial well-being. -Residents with the need to improve functional status were re-evaluated monthly to determine effectiveness of the current interventions and need to revise goals or interventions. -Residents with the need to maintain current functional status were re-evaluated at least quarterly to determine effectiveness of current interventions and need to revise goals or interventions. 1. Resident 5 was admitted to the facility in 7/2016 with diagnoses including non-traumatic brain hemorrhage (bleed), epilepsy and Wernicke's encephalopathy (a brain injury caused by a lack of vitamin B1). Resident 5's Restorative Nursing Range of Motion Care Plan, last revised 10/29/24 with a target date of 5/8/25, indicated the resident was at risk for a decline and/or complications with ROM in her/his joints. The resident was to receive RA services two times per week. The 1/6/25 Resident Council Meeting Minutes indicated residents requested to have the Restorative Program re-instated because residents wanted help with walking and ROM. Review of Resident 5's ROM RA task logs indicated the last time the resident received RA services was on 11/17/24. Random observations from 2/10/25 through 2/12/25 between the hours of 4:45 AM and 4:15 PM revealed Resident 5 was not observed doing any ROM exercises. Resident 5 was mostly seen in her/his bed with the lights off, sleeping. A sign was observed over Resident 5's bed which indicated the resident received RA services two times a week; on Monday and Saturday. On 2/10/25 at 11:11 AM Resident 5 stated she/he was not currently doing any exercises. On 2/11/25 at 2:53 PM Staff 11 (Director of Rehabilitation) stated there was currently no active RA program in place since at least 12/1/24 due to the facility having no dedicated RA staff. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 11:47 AM Staff 1 (Administrator) confirmed the facility did not currently have an active RA program thus Resident 5 did not receive RA services. Staff 1 stated CNAs did not carry-out a resident's RA program because those programs were specialized to each resident and required trained RA staff to complete each resident's individualized program. 2. Resident 28 was admitted to the facility in 8/2023 with diagnoses including a brain stem stroke, severe dementia, Alzheimer's disease and dysphagia (difficulty swallowing). Resident 28's Restorative Nursing Mobility Care Plan, last revised 9/20/24 with a target date of 3/1/25, indicated the resident was to complete five sit to stand exercises in the parallel bars with one person assist using a gait belt. No weekly frequency of RA services was identified. The 1/6/25 Resident Council Meeting Minutes indicated residents requested to have the Restorative Program re-instated because the residents wanted help with walking and ROM. A review of Resident 28's mobility RA task logs indicated the last time the resident received RA services was on 2/24/24. Random observations from 2/10/25 through 2/12/25 between the hours of 4:45 AM and 4:15 PM revealed Resident 28 was either in her/his bed or was up in a wheelchair sitting in the common area. The resident was not observed doing restorative services during observations. On 2/11/25 at 2:53 PM Staff 11 (Director of Rehabilitation) stated there was currently no active RA program in place since at least 12/1/24 due to the facility having no dedicated RA staff. On 2/12/24 at 11:47 AM Staff 1 (Administrator) confirmed the facility did not currently have an active RA program thus Resident 28 did not receive RA services. Staff 1 stated CNAs did not carry-out a resident's RA program because those programs were specialized to each resident and required trained RA staff to complete each resident's individualized program.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents received treatment and services related to the use of an indwelling urinary catheter for 1 of 2 sampled residents (#254) reviewed for catheter care. This placed residents at risk for complications of catheter use. Findings include: The facility's 8/2024 Indwelling Urinary Catheter Policy and Procedure revealed a resident with a catheter was evaluated for the ongoing need for an indwelling catheter following their admission. If the resident did not have appropriate indications for continuing its use, the physician was to be contacted to determine if the catheter could be discontinued. If there was an appropriate indication for use, then orders were to be reviewed to include the medical justification for the catheter use, catheter size, frequency of catheter, bag and tubing changes and catheter irrigations if appropriate. Resident 254 was admitted to the facility in 1/2025 with diagnoses including complications associated with an indwelling urinary catheter with the presence of an indwelling catheter and dementia. Resident 254's 1/30/25 Nursing Admission Assessment revealed the resident had an indwelling urinary catheter in place. No evidence was found in Resident 254's clinical record to indicate the need for her/his catheter or treatment and services related to the resident's catheter was provided. Additionally, no orders were received that included detailed information about the resident's catheter On 2/10/25 at 10:44 AM, Resident 254 was observed in her/his room and sat in her/his wheelchair. The tubing and bag of her/his catheter was visible underneath her/his wheelchair. Resident 254 was unable to answer any questions related to her/his catheter at this time. On 2/10/25 at 1:38 PM, Witness 2 (Resident Representative) stated she did not think Resident 254 received regular catheter care, and on one occasion, she observed the resident's catheter to be improperly secured. On 2/11/25 at 1:47 PM, Staff 27 (CNA) stated she did not provide catheter care for Resident 254, which included to empty the resident's catheter bag, from the start of her shift at 6:00 AM until the resident left the facility at 1:45 PM for a medical appointment. Staff 27 further stated she did not know the facility's expectation regarding catheter care for residents and thought this information was found in a resident's care plan. On 2/11/25 at 4:08 PM, Staff 29 (LPN) stated she did not know any information about Resident 254's catheter, including its size or type, or how often the resident received catheter care because the resident did not have any related physician orders. Staff 29 further stated she had not done anything with regards to the resident's catheter because of the lack of physician orders. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 4:15 PM, Resident 254 returned to the facility from her/his medical appointment and her/his catheter bag was filled with 600 cubic centimeters of dark yellow urine. On 2/12/25 at 9:45 AM, Staff 30 (LPN Resident Care Manager) stated she was not aware Resident 254 had a catheter until 2/11/25. Staff 30 further stated resident catheter care was to be completed every shift and residents were to have orders in place to reflect catheter indications, specifications and care.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43690 Based on observation, interview and record review it was determined the facility failed to ensure dialysis services were in place including monitoring and communication with the dialysis provider for 1 of 1 sampled resident (# 27) reviewed for dialysis. This placed residents at risk for dialysis complications and delayed treatment. Findings include: The facility's Dialysis policy, dated 8/1/24, indicated the following: a. The licensed nurse completes the Dialysis Center Communication Form prior to the resident leaving for dialysis. Weights are obtained from Dialysis Communication Center Form. b. Upon return, the post dialysis assessment portion of the form is completed and attached to the resident's medical record. ***Note-Residents who require hemodialysis are provided ongoing assessment and monitoring of the resident's condition before and after dialysis treatments including for complications and interventions as part of nursing standard of practice. Issues are documented, as noted, by the licensed nurse and medical providers are notified. Resident 27 was admitted to the facility in 2/2023 with diagnoses including end stage renal disease and PTSD (Post-traumatic stress disorder). Resident 27's 11/22/24 Quarterly MDS indicated the resident was cognitively intact. Resident 27's 10/29/24 Dialysis Care Plan indicated the resident received dialysis on Monday, Wednesday and Friday at 11:00 AM. From 12/27/24 through 2/12/25, Resident 27 had 18 dialysis treatments. A review of Resident 27's clinical record revealed no evidence nursing staff contacted the dialysis center to obtain a verbal or electronic report due to missing pre-dialysis and post-dialysis information on any of the resident's 18 dialysis visits since 12/27/24 including Resident 27's weights. The clinical record revealed the last documented weight for Resident 27 was on 2/3/25. On 2/11/25 at 11:16 AM, Resident 27 stated she/he went to dialysis on Monday, Wednesday and Friday around 10:30 AM and usually returned to the facility sometime after 5:00 PM. Resident 27 stated when she/he left the for her/his dialysis appointments she/he was not provided a Dialysis Center Communication Form. On 2/12/25 at 10:22 AM, Resident 27 was observed in her/his wheelchair leaving the facility for her/his dialysis appointment. Resident 27 did not have a Dialysis Center Communication Form when she/he left for her/his dialysis appointment. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 11:31 AM, Staff 21 (Agency LPN) stated she was not given any instructions on any of the residents prior to starting her shift on 2/12/25. Staff 21 stated she was not aware Resident 27 was on dialysis nor was she aware the resident had a dialysis appointment the morning of 2/12/25. Staff 21 stated the Dialysis Center Communication Form was not filled out or sent with the resident to her/his dialysis appointment. On 2/12/25 at 12:25 PM, and on 2/13/25 at 9:50 AM, Staff 2 (DNS) confirmed the last Dialysis Center Communication Form for Resident 27 was dated 12/24/25 and the last documented weight for Resident 27 was on 2/3/25. Staff 2 stated she expected staff to complete the Dialysis Communication Form and to reach out to the dialysis clinic if there was missing information on the dialysis form.		

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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. 43690 Based on observation, interview and record review it was determined the facility failed to ensure residents received trauma informed care for 2 of 7 sampled residents (#s 27 and 46) reviewed for behavioral-emotional care and abuse. This placed residents at risk for re-traumatization. Findings include: The facility's 8/2024 Trauma-Informed Care Policy and Procedure revealed the following: -The facility screened newly admitted resident for indications of trauma as part of the comprehensive care plan process, accomplished through interview with the resident and/or her/his representative as appropriate. -The center developed an appropriate plan of care and interventions based upon the screening responses and observations of the resident. 1. Resident 27 was admitted to the facility in 2/2023 with diagnoses including end stage renal disease and PTSD (Post-traumatic stress disorder). Resident 27's 11/22/24 Quarterly MDS revealed the resident was cognitively intact, able to make herself/himself understood and understood others without difficulty. On 2/10/25 at 10:16 AM, and on 2/11/25 at 12:52 PM, Resident 27 was observed in her/his room in her/his wheelchair facing the door without the lights or TV on. Resident 27 stated she/he suffered from PTSD as a result of an accident she/he was involved in that left her/him paralyzed. Resident 27 stated no one at the facility discussed the cause of her/his PTSD or potential triggers for re-traumatization. No evidence was found in Resident 27's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 2/12/25 at 9:09 AM, Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents. Staff 5 stated she did not develop a care plan related to Resident 27's history of trauma or potential triggers. On 2/12/25 at 3:25 PM, Staff 14 (CNA) stated she thought Resident 27 might have PTSD but wasn't sure and was unaware if she/he had any triggers. On 2/18/25 at 10:07 AM, Staff 2 (DNS) acknowledged Resident 27's trauma and nothing was implemented related to her/his trauma triggers. 47000 2. Resident 46 was admitted to the facility in 12/2024 with diagnoses including hemiparesis (partial weakness on one side of the body) and hemiplegia (complete paralysis on one side of the body). (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 46's 1/7/25 Admission MDS indicated the resident was cognitively intact and it was very important to the resident to have family or a close friend involved in discussions about her/his care. Resident 46's 1/7/25 Social History Assessment listed numerous traumatic events the resident either witnessed or experienced. Resident 46's 1/8/25 Activity Care Plan indicated Witness 1 (Family Member) was very involved and helpful in answering questions. No evidence was found in Resident 46's clinical record to indicate a care plan was developed to address the resident's trauma history, the resident was asked specific questions related to triggers of her/his traumas or involved family members were interviewed in order to provide information about the resident's trauma history and potential triggers. On 2/18/25 at 8:28 AM, Resident 46 was observed in her/his room in bed. Resident 46 stated a staff person spoke to her/him a little bit about her/his trauma history but no one spoke with her/him about her/his trauma triggers. Resident 46 further stated she/he saw things that people should never have to see. On 2/13/25 at 9:48 AM, Staff 5 (Social Services Director) stated all residents were screened for trauma, and any resident with a positive trauma screen received a trauma care plan so staff could be aware of behaviors and to avoid re-traumatization. Staff 5 stated Resident 46 listed several traumas during her/his trauma screen, but she did not develop a care plan related to the resident's history of trauma and potential trauma triggers or interview Witness 1 about the resident's trauma history. On 2/18/25 at 11:08 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 4 (Regional Nurse Consultant) acknowledged Resident 46's trauma and nothing was implemented related to her/his trauma triggers.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 51846 Based on observation, interview and record review it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include: On 2/10/25 at 9:49 AM the Direct Care Staff Daily Report (DCSDR) posted for 2/10/25 was incomplete for the morning shift. On 2/12/25 at 5:40 AM the DCSDR posted for 2/11/25 was incomplete for the morning, evening, and night shift. On 2/12/25 at 12:43 PM, there was a DCSDR posted by the front entrance of the facility and another DCSDR posted next to where staff clocked in and out. The information on the two forms did not match. On 2/12/25 at 3:40 PM the DCSDR posted for 2/12/25 was incomplete for the morning shift. During an interview on 2/18/25 at 10:59 AM, Staff 31 (Staffing Coordinator) stated the DCSDR were expected to be complete and accurate by 8:00 AM for the morning shift, 4:00 PM for the evening shift, and 12:00 AM for the night shift. Staff 31 stated the DCSDR was to be posted in the area next to where staff clocked in and out. During an interview on 2/18/25 at 11:31 AM, Staff 1 (Administrator) stated that the DCSDR were expected to be complete and accurate by 8:00 AM for the morning shift, 4:00 PM for the evening shift, and 12:00 AM for the night shift. Staff 1 stated the DCSDR was to be posted near the front entrance.		

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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 provide necessary behavioral health care and services for 1 of 5 sampled residents (#46) reviewed for abuse. This placed residents at risk for unaddressed behavioral and emotional needs and a decrease in their quality of life. Findings include: The facility's 8/2024 Behavior Monitor Policy and Procedure directed the following: -Residents who resided in the facility who developed behavior symptoms received a comprehensive assessment completed by social services to identify potential precipitating factors as possible causes for behavior. -Target behavior was to be described as specifically as possible and interventions developed based on the resident's targeted behaviors. -If all behavior interventions were attempted and not effective, the charge nurse was to be notified. -The charge nurse was to further evaluate the resident and take further action to manage the behavioral symptoms. -The RNCM and DNS were to be notified through the 24-Hour Report of effectiveness or ineffectiveness of behavioral interventions and use of pharmacological intervention. Resident 46 was admitted to the facility in 12/2024 with diagnoses including hemiparesis (partial weakness on one side of the body) and hemiplegia (complete paralysis on one side of the body). Resident 46's 1/7/25 Admission MDS revealed the resident was cognitively intact and she/he felt little interest or pleasure in doing things and felt down, depressed or hopeless over the previous two weeks. The Psychosocial Well-Being CAA indicated activity staff was made aware of the resident's report of little interest in doing things and the resident's psychosocial well-being was to be addressed in her/his care plan with the goal of improvement in this area. Review of Resident 46's Progress Notes from 1/7/25 through 2/3/25 indicated the resident was aggressive, combative, refused care, agitated, uncooperative, irritable, frustrated and was not adjusting well to the facility. Observations of Resident 46 from 2/10/25 to 2/12/25 between 5:27 AM through 4:03 PM revealed the resident to be in her/his room in bed. The television was turned on but the resident frequently had her/his eyes closed or looked out her/his window. A staff member was always present in the resident's room. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/25 at 3:04 PM, Witness 1 (Family Member) stated Resident 46 spent her/his entire day in bed and was constantly supervised by a staff person in order to prevent falls. Witness 1 stated the resident had a temper and was often mad at herself/himself because her/his body did not work. On 2/11/25 at 11:02 AM, Staff 27 (CNA) stated Resident 46 did not like men to touch her/him, and if they did, the resident was combative. Staff 27 stated she was told by another CNA to make sure to have another staff person assist her when she provided care to Resident 46 on account of her/his behaviors. On 2/11/25 at 4:23 PM, Staff 36 (CNA) stated Resident 46's behaviors were too much. Staff 36 stated the resident was physically and verbally abusive, frequently refused care and would throw her/his bowel movements at staff. Staff 36 stated the resident called him names, told him to go back to the forest, hit and punched him. Staff 36 stated he reported these behaviors to the nurses but was told that this was [the resident's] behavior and was not provided with any assistance or interventions to help mitigate or avoid the behaviors. On 2/12/25 at 5:15 AM, Staff 37 (Agency CNA) stated Resident 46 was frequently verbally and physically abusive and made racist and disparaging comments. Staff 37 stated he reported these behaviors to the nurse who did not seem to care too much. On 2/12/25 at 5:35 AM, Staff 38 (CNA) stated Resident 46 had very bad behavior and no one has given any help or interventions to make care better. Staff 38 stated she no longer reached out to management staff about resident behaviors because they don't reach back. On 2/12/25 at 5:57 AM, Staff 39 (Agency LPN) stated Resident 46 was verbally and physically aggressive to the point staff could not complete care and he was unaware of any behavioral interventions to use with the resident outside of reapproaching her/him at a later time. On 2/13/25 at 9:48 AM, Staff 5 (Social Services Director) stated she initiated a mood and behavior care plan for a resident as soon as she was aware of any mood or behavior issues, which included depression, physical and verbal aggression. Staff 5 stated she was not aware of Resident 46's verbal and physical aggression, racist comments or her/his resistance to care and the resident did not have a care plan in place for these behaviors. Staff 5 stated she did make a referral to a mental health agency following the resident's depressive comments on her/his Admission MDS but was unsure of the status of the referral. Staff 5 stated she did not create a care plan related to the resident's depressed mood or psychosocial well-being. On 2/13/25 at 11:40 AM, Staff 30 (LPN Resident Care Manager) stated Resident 46 was very agitated, physically and verbally aggressive and frustrated by the loss of her/his independence. Staff 30 stated she was not made aware the resident reported feeling down, depressed or hopeless or experienced little interest or pleasure in doing things on her/his Admission MDS but thinks she spoke with the resident's provider at one point about the resident's depression. On 2/18/25 at 7:49 AM, Staff 6 (Activities Director) stated she was not made aware of Resident 46's report of feeling little interest or pleasure in doing things. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 8:28 AM, Resident 46 was observed in her/his room in bed. Resident 46 stated she/he did not feel great since her/his admission to the facility. Resident 46 stated no one at the facility spoke to her/him about her/his mood and she/he was open to having this conversation. Resident 46 stated she/he did not want to work with a couple of guys who were staff at the facility. Resident 46 stated no one spoke with her/him regarding how to honor her/his care preferences or make her/his care better. On 2/18/24 at 9:32 AM, Staff 2 (DNS) acknowledged Resident 46's mood and behaviors needed to be addressed, evaluated, and a care plan developed to address the residents emotional needs.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51846 Based on observation and interview it was determined the facility failed to ensure meals served to residents in their rooms were served at palatable temperatures for 1 of 2 carts reviewed for food quality. This placed residents at risk for decreased enjoyment of food. Findings include: On 2/10/25 at 10:00 AM Resident 40 stated the food temperature for breakfast was cold if she/he wanted to eat in her/his room. On 2/10/25 at 10:10 AM Resident 24 stated breakfast was cold when she/he wanted to eat in her/his room due to it sitting out there for too long. On 2/11/25 at 8:06 AM Resident 40 had breakfast in her/his room and stated, It's cold again. On 2/11/25 at 8:08 AM Resident 24 stated breakfast was served in her/his room and the breakfast was cold. On 2/11/25 at 8:16 AM Resident 15 stated breakfast served in her/his room was cold. An observation on 2/12/25 at 7:13 AM revealed kitchen staff obtained the temperature of the scrambled eggs, which was 188 degrees Fahrenheit. On 2/12/25 at 8:22 AM staff began delivering trays. On 2/12/25 at 8:40 AM the last tray was served. On 2/12/25 at 8:42 AM a test tray was obtained by the survey team. On 2/12/25 at 8:43 AM the breakfast test tray had eggs, toast, oatmeal, juice and milk. The eggs were cold and the toast was cold and soft. During an interview on 2/18/25 at 12:01 PM, Staff 12 (Dietary Director) acknowledged resident complaints regarding cold food served in rooms and stated meals served in residents' rooms were expected to be palatably warm. During an interview on 2/18/25 at 12:25 PM, Staff 1 (Administrator) stated he was aware and acknowledged resident complaints regarding cold food being served in resident rooms.		

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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. 47000 Based on observation, interview and record review it was determined the facility failed to accommodate resident dietary preferences for 1 of 2 sampled residents (#46) reviewed for nutrition. This placed residents at risk for not receiving preferred food. Findings include: Resident 46 was admitted to the facility in 12/2024 with diagnoses including dysphagia (difficulty swallowing) and cognitive and communication deficit. Resident 46's 1/21/25 Physician Orders directed the resident to receive a regular diet with a minced and moist texture. Resident 46's 1/24/25 Nutrition At Risk Evaluation revealed weight gain was desirable for the resident. A 1/24/25 Social Service Note revealed Witness 1 (Family Member) was informed Resident 46's meal portion size would be increased after she reported to Staff 5 (Social Services Director) the resident was hungry all of the time. On 2/10/25 at 3:04 PM, Witness 1 stated Resident 46 was hungry all of the time. Witness 1 stated she spoke with a staff member at the facility a few weeks ago and requested the resident to receive double portions at mealtimes but she/he still received regular portions. On 2/12/25 at 7:43 AM, Resident 46's breakfast was observed to be plated in the facility's kitchen. The resident's meal ticket did not indicate the resident was to receive double portions and the resident received a regularly portioned meal. On 2/13/25 at 9:48 AM, Staff 5 stated she informed Staff 2 (DNS) about Witness 1's request to increase Resident 46's meal portion size. On 2/13/25 at 10:59 AM, Staff 35 (Cook) stated Resident 46 received regularly portioned meals and he was unaware of any request for the resident to receive large or double portions at meal times. On 2/18/25 at 9:32 AM, Staff 2 stated she requested the kitchen to provide Resident 46 with double portions at every meal on 1/24/25 and was unaware her request had not been completed.		

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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** 41458 Based on observation, interview and record review it was determined the facility failed to ensure food and beverages were labeled and stored in a manner to minimize spoilage and cross contamination for 1 of 2 unit refrigerators reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include: Review of the US FDA 2022 Food Code indicated the following: -Food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded. -Food must be labeled with a use-by-date if stored for at least 24 hours. -Food could be stored up to seven days. The facility's Resident Food from Outside Source Policy, dated [DATE], indicated the following: -Refrigerated food items from an outside source was stored in a container with the date the product was received, the name of the product and the resident's name and room number. -Unlabeled and undated foods would be discarded. On [DATE] at 3:50 PM Staff 3 (Administrator in Training) and Staff 12 (Dietary Director) reviewed the residents' refrigerator which contained numerous food and beverage items. The following food and beverages were observed to be stored as follows: -meatballs in a plastic to-go container were unlabeled and undated; -pretzel bites in a plastic to-go container were unlabeled and undated; -shredded meat in a plastic to-go container was unlabeled and undated; -a container of smoked [NAME] cheese dip was unlabeled and undated; -a resident's open bag of burritos had no open date; -a container of chocolate fudge was unlabeled and undated; -a container of fruit cubes was unlabeled and undated; -a pitcher of brown liquid was unlabeled and undated; -a pitcher of purple liquid was unlabeled and dated [DATE]; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-a pitcher of red liquid was unlabeled and undated; -three previously opened, one liter bottles of soda pop were unlabeled and undated. On [DATE] at 3:50 PM, Staff 3 and Staff 12 confirmed the above mentioned food and beverage items located in the residents' refrigerator were not properly labeled, dated or thrown out when expired. Staff 3 and Staff 12 stated they expected the residents' food and beverage items to be labeled and dated or discarded if the items were expired or not properly stored.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on observation, interview and record review it was determined the facility failed to provide physical therapy services as ordered for 4 of 4 sampled residents (#21, 154, 254 and 303) 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 Therapy Services Policy, last revised 7/2013, indicated therapy services were scheduled in accordance with the resident's treatment plan. 1. Resident 154 was admitted to the facility on [DATE] with diagnoses including contusion (injury caused by trauma) to the right thigh and abnormality of gait. Resident 154's 1/28/25 hospital transfer orders indicated the resident was prescribed PT to assess and treat. Resident 154's 1/30/25 Medicare PT Evaluation and Plan of Treatment indicated the resident needed PT three times a week for eight weeks. Resident 154's 1/2025 and 2/2025 Rehabilitation Service Log Matrix indicated PT assessed the resident on 1/30/25 and she/he did not receive PT treatment until 2/10/25, 11 days after her/his PT evaluation was completed. On 2/10/25 at 10:18 AM Resident 154 stated she/he was admitted to the facility two weeks ago to receive PT services so she/he could be discharged home. Resident 154 stated she/he was assessed soon after admission but, to date, she/he received no PT treatments. On 2/11/25 at 1:56 PM Staff 11 (Director of Rehabilitation) confirmed Resident 154 did not receive PT treatment per her/his treatment plan due to the facility's PT being on vacation and no PT coverage was available during that time. On 2/18/25 at 10:50 AM Staff 1 (Administrator) confirmed Resident 154 did not receive PT services due the facility not having PT coverage. 43690 2. Resident 21 was admitted to the facility in 3/2024 with diagnoses including Parkinson's disease and muscle weakness. Resident 21's 1/16/25 Physician Orders revealed PT to be provided as indicated. Resident 21's Admission MDS dated [DATE] indicated the resident had moderate cognitive impairment. On 2/10/25 at 12:32 PM, Resident 21 stated she/he was supposed to be getting more therapy than she/he was for her/his diagnosis of Parkinson's Disease. Resident 21 stated she/he had not received PT the previous week. (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 11:30 AM, Staff 15 (PT) stated Resident 21 did not receive three days of PT the previous week because she was out of town and there wasn't coverage. On 2/11/25 at 11:41 AM, Staff 11 (Director of Rehabilitation) stated Resident 21 was receiving PT for functional maintenance program and contracture management. Staff 11 confirmed Resident 21 had not received therapy the week prior due to lack of PT coverage. Staff 11 stated it was his expectation that residents were seen for therapies as scheduled. On 2/11/25 at 1:07 PM, Staff 1 (Administrator) and Staff 4 (Regional Nurse Consultant) were informed of the findings of this investigation. Staff 1 stated it was his expectation that residents continuously received therapies according to the orders. 47000 3. Resident 254 was admitted to the facility in 1/2025 with diagnoses including traumatic subdural hemorrhage (a serious brain injury that occurs when blood pools beneath the brain's outermost membrane). Resident 254's 1/31/25 Physician Orders directed the resident to receive physical therapy three times weekly for four weeks. Review of Resident 254's 1/2025 and 2/2025 Physical Therapy Encounter Notes revealed the resident received physical therapy on 1/31/25. On 2/10/25 at 1:38 PM, Resident 254 was observed in the dining room accompanied by Witness 2 (Resident Representative). Witness 2 stated the resident was here for rehab but was not sure the resident received any. On 2/11/25 at 2:57 PM, Staff 11 (Director of Rehab) confirmed Resident 254 was to receive physical therapy three times weekly and had not received any physical therapy since 1/31/25. 51846 4. Resident 303 admitted to the facility in 2/2025 with diagnoses including severe chest pain due to reduced blood flow to the heart muscle. Resident 303's 2/4/25 Physician Orders revealed PT and OT to be provided as indicated. Resident 303 was evaluated on 2/5/25 by the facility to begin PT four times per week. On 2/10/25 at 10:25AM Resident 303 reported she/he had not been receiving therapy. On 2/12/25 at 1:09PM Staff 11 (Director of Rehabilitation) confirmed Resident 303 was scheduled to have physical therapy four times per week and she/he did not receive therapy. Staff 11 stated there was no physical therapist available to work with Resident 303 and there was no plan in place for coverage when therapy staff were out.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41458 Based on observation, interview and record review it was determined the facility failed to ensure enhanced barrier precautions (EBPs) were followed for 1 of 2 sampled residents (#45) reviewed for catheter care. This placed residents at risk for infections, communicable disease and cross-contamination. Findings include: The CDC webinar titled Enhanced Barrier Precautions in Skilled Nursing Facilities, dated 11/15/22, indicated the following: -EBPs were a risk based approach to PPE use designed to reduce the spread of multidrug-resistant organisms (MDROs). -EBPs involved use of gown and gloves during high-contact resident care activities with residents known to be colonized or infected with a MDRO as well as, residents with wounds, indwelling catheters, central lines, feeding tubes, tracheostomies (a surgical opening in the neck where a tube is inserted to provide an artificial airway) and ventilators (a machine that helps people breath). The facility's Transmission Based Precautions Policy, dated 8/1/24, indicated the following: -When a resident was colonized with a MDRO, enhanced barrier precautions were utilized to reduce the risk of spread of a MDRO. -Personnel caring for residents on EBPs wore gloves and a gown. This included residents with tracheostomies, wounds, enteral tubes (feeding tubes), central lines and urinary catheters. Resident 45 was admitted to the facility in 12/2024 with diagnoses including hydronephrosis (a backup of urine into the kidney) with renal and ureteral calculous obstruction (a blockage in the tubes that carry urine from the kidneys to the bladder). Resident 45's 12/19/24 hospital transfer orders indicated the resident had an indwelling catheter. Urinary catheter management was per facility nursing protocol. Resident 45's 12/26/24 Admission MDS indicated the resident had an indwelling catheter. Observations from 2/10/25 through 2/11/25 between the hours of 8:00 AM and 4:00 PM revealed Resident 45 had an indwelling catheter, an isolation cart with PPE was not observed outside of the resident's room and no EBP signage was noted on the resident's door or wall outside of her/his room. On 2/11/25 at 12:21 PM, Staff 23 (CNA) stated Resident 45 was not on any infection control precautions and there was no signage or PPE outside the resident's door. At 1:47 PM, Staff 23 stated Resident 45 should have been on EBPs because she/he had a catheter. Staff 23 stated staff should have worn a gown and gloves when caring for Resident 45 and reported Staff 25 (Assistant Director of Nursing) stated the resident should have been on EBPs. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 1:50 PM, Staff 24 (CNA) stated she was assigned to care for Resident 45 today and was unaware Resident 45 required EBPs and had not been following any infection control precautions when caring for the resident. On 2/11/25 at 1:52 PM, Staff 25 confirmed Resident 45 had an indwelling catheter, was not currently on isolation precautions but should have been on EBPs. Staff 25 stated her expectation was any resident with a catheter should be placed on EBPs.		