

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Regency Hermiston Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 970 W Juniper Avenue Hermiston, OR 97838	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>38140</p> <p>Based on observation, interview, and record review it was determined the facility failed to protect the resident's right to be free from sexual and physical abuse by other residents for 4 of 5 sampled residents (#s 12, 29, 128 and 279) reviewed for abuse. This placed residents at risk for mental anguish and abuse. Findings include:</p> <p>Review of the facility's revised 10/2022 Abuse/Neglect/Misappropriation/Exploitation Policy and Procedures revealed the purpose of the policy was to define how the facility will prevent, identify, report and investigate abuse. Sexual abuse was defined as any form of non-consensual contact including unwanted or inappropriate touching. The facility must evaluate whether the resident has the capacity to consent to sexual activity. Physical abuse included hitting, slapping, pinching, striking with an object and shoving.</p> <p>1. Resident 12 admitted to the facility in 2020 with a diagnoses including dementia with behavioral disturbance.</p> <p>Resident 12's 7/6/24 Quarterly MDS revealed, Resident 12 had a BIMS score of 3, which indicated the resident had severe cognitive impairment.</p> <p>Resident 22 admitted to the facility in 2019 with diagnoses including schizophrenia (mental disorder that affects a person's ability to think, feel and behave clearly), sexual disorders and depression.</p> <p>Resident 22's 9/15/24 Quarterly MDS revealed, Resident 22 had a BIMS score of 4, which indicated the resident had severe cognitive impairment.</p> <p>A 9/19/24 at 1:00 PM Alleged Abuse incident report written by Staff 2 (DNS) revealed Staff 19 (CNA) observed Resident 22 in Resident 12's room. Resident 22 sat in her/his wheelchair at Resident 12's bed side. Staff 19 saw Resident 22's hands on Resident 12's breasts and over her/his clothing. The residents were immediately separated and neither recalled the incident minutes later.</p> <p>A 9/19/24 at 1:34 PM Progress note revealed Staff 4 (Resident Care Manager/LPN) spoke with Resident 12 related to Resident 22's physical contact with her/him and she/he could not recall anyone coming into her/his room.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 11:55 AM Resident 12 was observed in her/his room in bed coloring. Resident 12 was able to state some needs, but she/he was not able to recall ever being abused or touched by another resident.</p> <p>On 4/7/25 at 6:49 PM Staff 19 stated when staff walked down the facility hallways, they always looked into resident's room to ensure residents were safe. Staff 19 stated she recalled when she walked past and looked into Resident 12's room she observed Resident 12 in bed while Resident 22 sat in her/his wheelchair at the head of Resident 12's bed. Resident 22's hands were grabbing and touching all over Resident 12's breasts. Staff 19 removed Resident 22 from Resident 12's room and told management staff.</p> <p>On 4/9/25 at 11:15 AM Staff 4 confirmed she wrote the 9/19/24 at 1:34 PM progress note and she interviewed Resident 12 after the incident. Staff 4 stated Resident 12 was on alert charting, did not recall the physical abuse and did not experience any changes in behavior after the incident.</p> <p>On 4/9/25 at 11:27 AM Staff 2 confirmed she wrote the 9/19/24 at 1:00 PM Alleged Abuse incident report for Resident 12 and Resident 22. Staff 2 confirmed Staff 19 reported she witnessed Resident 22 with her/his hands on Resident 12's breast and the facility investigation confirmed abuse. Staff 2 acknowledged both residents were assessed as severely cognitively impaired, both were often confused and neither resident recalled the incident after it occurred.</p> <p>40774</p> <p>2. Resident 29 was admitted to the facility in 3/2022 with diagnoses including personality disorder (long-term pattern of thoughts, feelings, and behaviors that are unhealthy) and anxiety.</p> <p>Resident 29's 8/29/23 Annual MDS revealed she/he had moderate cognitive impairment and was able to understand others.</p> <p>Resident 128 was admitted to the facility in 6/2024 with diagnoses including dementia and anxiety.</p> <p>Resident 128's 6/9/24 Admission MDS revealed she/he had moderate cognitive impairment.</p> <p>The facility's incident investigation completed on 11/29/24 by Staff 18 (Former Administrator in Training) indicated Resident 128 struck Resident 29 twice as the resident moved past her/him. Resident 29 grabbed Resident 128's right forearm with both hands, shook her/him and stated, Don't hit me. Staff intervened and separated the residents. Staff 17 (CNA) witnessed Resident 29 and Resident 128 strike each other and assisted in separating them.</p> <p>On 4/10/25 at 8:25 AM Staff 17 stated both residents had a history of hitting other residents.</p> <p>On 4/10/25 at 8:55 AM Resident 29 stated she/he did not remember the incident.</p> <p>On 4/11/25 at 11:04 AM Staff 2 (DNS) acknowledged the physical interaction between Resident 29 and Resident 128. Staff 2 stated both residents were monitored and kept at a distance to prevent this type of incident from occurring.</p> <p>46053</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>50930</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 2 of 4 sampled residents (#s 11 and 40) reviewed for ADLs. This placed residents at risk for a lack of personal hygiene and loss of dignity. Findings include:</p> <p>1. Resident 11 admitted to the facility in 12/2024 with diagnoses including weakness and kidney disease.</p> <p>A 4/4/25 quarterly MDS revealed Resident 11 had a BIMS score of three which indicated severe cognitive impairment and was dependent on staff for grooming.</p> <p>A review of Resident 11's 3/13/25 through 4/10/25 health record revealed CNA staff documented grooming was completed daily, a shower was provided six times, and the resident refused a shower two times.</p> <p>Random observations from 4/7/25 through 4/11/25 revealed Resident 11 had long white hairs hanging approximately two inches from her/his chin in multiple locations.</p> <p>On 4/10/25 at 2:42 PM, Staff 28 (CNA) stated she was not sure if Resident 11 had long chin hairs. She stated grooming for residents occurred at least twice a day and included shaving. She stated shaving was offered to residents during showers but was not sure if Resident 11 was offered during her/his showers.</p> <p>On 4/10/25 at 2:50 PM, Staff 4 (Resident Care Manager/LPN) stated she did not know Resident 11 had long chin hairs and acknowledged it was not proper ADL care. She stated the expectation was for residents to be offered shaving twice daily, with showers, and as needed.</p> <p>38140</p> <p>2. Resident 40 admitted to the facility in 2022 with diagnoses including Type 2 Diabetes (body's trouble with blood sugars) and vascular disease (body's circulatory system).</p> <p>Resident 40's 2/26/25 Quarterly MDS revealed Resident 40 had a BIMS score of 10 which indicated moderate cognitive impairment. The resident was dependent on staff to complete personal hygiene</p> <p>Review of Resident 40's health care record revealed the following:</p> <p>-From 3/12/25 through 4/8/25 indicated the resident received assistance from staff with personal hygiene daily.</p> <p>-From 3/13/25 through 4/9/25 no evidence was found indicating whether the resident was offered or refused assistance to trim chin hair.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/8/25 at 9:23 AM Resident 12 used her/his left hand, rubbed her/his chin, pulled the hairs together into a point and stated she/he wanted the chin hairs cut.</p> <p>Resident 12 was observed with long chin hairs, about two inches long, on the following dates and times:</p> <p>-4/8/25 at 9:23 AM and 2:20 PM;</p> <p>-4/9/25 at 7:45 AM and 5:12 PM.</p> <p>On 4/10/25 at 4:13 PM Staff 10 (CNA) acknowledged Resident 40 required assistance with her/his ADLs. Staff 10 stated they were aware of Resident 40's long chin hairs and the resident asked several times in the past to get them cut.</p> <p>On 4/10/25 at 4:16 PM Staff 4 (Resident Care Manager/LPN) stated she was aware of Resident 12's long chin hairs. She expected staff to offer Resident 12 to shave her/his chin hairs PRN, at least two times a week during bathing and if she/he refused it should be documented as refused in her/his medical record.</p>		