| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385269 | A. Building<br>B. Wing | 07/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village at Hillside | 400 NW Hillside Park Way<br>McMinnville, OR 97128 |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>50897<br><br>Based on interview and record review it was determined the facility failed to inform the resident's representative of the risks and benefits of psychotropic medication for 1 of 5 sampled residents (#8) reviewed for unnecessary medications. This placed residents at risk for not being informed of adverse side effects of medications. Findings include:<br><br>Resident 8 was admitted to the facility in 7/2023 with diagnoses including dementia and anxiety.<br><br>Resident 8's 5/5/24 Quarterly MDS indicated Resident 8 had severe cognitive impairment.<br><br>Resident 8's Profile Sheet, reviewed on 7/18/24, listed a resident representative (Witness 1).<br><br>Resident 8's record included a Physician Order dated 7/27/23 for citalopram hydrochloride (an antidepressant) 10 MG oral tablets daily.<br><br>The 7/2023 MAR indicated Resident 8 began receiving the citalopram on 7/28/23.<br><br>Resident 8's health record revealed a consent for citalopram signed by Witness 1 (Family) on 10/5/23 (more than two months after the resident began receiving citalopram). No evidence was found to indicate Resident 8 and Witness 1 were provided with risks and benefits of citalopram prior to the start of administration in 7/2023.<br><br>In an interview on 7/17/24 at 2:30 PM Staff 2 (Resident Care Manager/MDS Coordinator) acknowledged the lack of timely notification of risks and benefits of citalopram. |

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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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>50897<br><br>Based on interview and record review it was determined the facility failed to include the resident's representative in care planning for 1 of 1 sampled resident (#8) reviewed for care planning. This placed residents at risk for lack of resident-centered care planning. Findings include:<br><br>Resident 8 was admitted to the facility in 7/2023 with diagnoses including dementia and anxiety.<br><br>Resident 8's 5/5/24 Quarterly MDS indicated Resident 8 had severe cognitive impairment.<br><br>Resident 8's Profile Sheet, reviewed on 7/18/24, indicated she/he had a resident representative.<br><br>A 1/14/24 Collaborative Care document indicated Resident 8 had a care conference on 1/14/24.<br><br>In an interview on 7/15/24 at 3:01 PM Witness 1 (Family) stated they did not participate in a care conference in the past year. He said he did not get medical information unless he asked for it and Witness 1 said he was not notified of updates/changes to the resident's care plan or outcomes of healthcare provider visits.<br><br>A review of Resident 8's clinical record revealed no indication that the resident representative was contacted regarding the resident's care plan.<br><br>In an interview on 7/17/24 at10:40 AM Staff 3 (Social Service Coordinator) stated Resident 8's family was not offered a care conference since 1/2024. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>50897<br><br>Based on interview and record review it was determined the facility failed to use the services of a registered nurse for at least eight consecutive hours a day for 19 of 46 days reviewed for staffing. This placed residents at risk for lack of RN oversight including comprehensive assessments. Findings include:<br><br>A review of the Direct Care Staff Daily Reports for dates from 6/1/24 through 7/16/24 revealed no RN coverage during the 24-hour period on the following dates:<br><br>- 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/10/24, 6/11/24, 6/12/24, 6/16/24, 6/18/24, 6/19/24, 6/22/24, 6/23/24, 6/25/24, 6/26/24, 7/2/24, 7/3/24, 7/6/24, 7/7/24, 7/10/24<br><br>In a follow up interview on 7/18/24 at 10:00 AM Staff 1 (Administrator) was informed of the identified dates when the staffing sheets indicated there was a lack of RN coverage. Staff 1 acknowledged there was no RN working as a charge nurse for at least 8 hours on the identified dates. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>34324<br><br>Based on interview and record review it was determined the facility failed to follow up on pharmacist recommendations for 1 of 5 sampled residents (#11) reviewed for unnecessary medications. This placed residents at risk for unnecessary medication administration. Findings include:<br><br>Resident 11 admitted to the facility in 2023 with diagnoses including migraines and pain.<br><br>Review of the 7/1/24 physician orders indicated Resident 11 received Depakote (anticonvulsant) BID for migraines and Miralax (laxative) as needed for constipation.<br><br>Review of Resident 11's pharmacist reviews indicated the following recommendations:<br><br>- 5/2024 recommended to clarify the order to administer Miralax with food/meals. There was no indication of follow up or a response by the physician.<br><br>- 7/2024 recommended a gradual dose reduction (GDR) of the Depakote from BID to once a day at bedtime. The physician was noted to indicate yes and accepted the recommendation on 7/3/24.<br><br>Review of the 7/2024 MAR from 7/4/24 through 7/16/24 indicated Resident 11 was still receiving Depakote BID.<br><br>Review of the 5/2024, 6/2024 and 7/2024 MAR revealed no indication the use of Miralax was updated to include direction to be administered with food/meals.<br><br>On 7/17/24 at 9:33 AM Staff 2 (LPN Resident Care Manager) stated she assisted with monthly pharmacist reviews. Staff 2 stated pharmacist recommendations were faxed to the physician and the facility typically received a response promptly. Staff 2 stated when a response was received, orders were either changed or updated. Staff 2 stated she misread the 7/2024 pharmacist recommendation for the Depakote and the recommendation to reduce Resident 11's Depakote was not implemented. Staff 2 also acknowledged there was no information to indicate the Miralax recommendation was followed up on. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>50926<br><br>Based on interview and record review, it was determined the facility failed to ensure residents did not receive unnecessart blood pressure medication for 1 of 5 sampled residents (#3) reviewed for medications. This placed the resident at risk for low blood pressure. Findings include:<br><br>Resident 3 was admitted to the facility in 2/2022 with diagnoses including essential hypertension.<br><br>A review of Resident 3's medication orders revealed an order dated 3/14/24 for verapamil HCl tablet 120 mg (an antihypertensive medication) to be given 1 time a day related to hypertension with instructions to hold for blood pressure less than 100 systolic or 60 diastolic. The order also indicated to hold the medication for pulse less than 60.<br><br>A review of Resident 3's MARs dated 6/1/24 through 7/15/24 revealed six instances that the verapamil was administered when the resident's blood pressure or pulse were outside of ordered parameters: 6/8/24, 6/9/24, 6/21/24, 6/24/24, 6/26/24 and 7/6/24.<br><br>During an interview with Staff 8 (RN) on 7/18/24 at 10:28 AM she stated stated she would expect the medication to be held when blood pressure or pulse was not within the ordered parameters. She confirmed that the medications were documented as administered on those dates. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>36494<br><br>Based on observation and interview it was determined the facility failed to provide a sanitary kitchen environment, document food temperatures and ensure staff wore appropriate hair restraints during meal preparation for 1 of 2 kitchens reviewed for sanitation. This placed residents at risk for unsanitary food and cross contamination. Findings include:<br><br>1. On 7/15/24 at 9:23 AM and 7/17/24 at 7:21 AM, the inside of the refrigerator in the kitchen was observed to have three small fans circulating air, and each fan had approximately a quarter-inch buildup of dust particles. The ceiling of the refrigerator above the three fans had multiple visible dust particles. Adjacent to the three fans was a black insulated tubing which had visible dust particles on the exterior of the insulated tubing.<br><br>On 7/17/24 at 10:18 AM Staff 6 (Certified Dietary Manager) and Staff 7 (Registered Dietician) both observed and acknowledged the three fans, the ceiling and the black insulated tubing were dirty and had a visible build-up of dust particles.<br><br>2. On 7/15/24 at 9:43 AM and 7/17/24 at 10:16 AM Staff 5 (Executive Chief) was observed in the kitchen prepping meals without a hair restraint or a beard restraint.<br><br>On 7/17/24 at 10:18 AM Staff 6 (Certified Dietary Manager) and Staff 7 (Registered Dietician) observed Staff 5 without a hair or a beard restraint in the kitchen. Staff 7 stated she expected Staff 5 to have a hair and beard restraint whenever he was in the kitchen.<br><br>3. On 7/17/24 at 7:34 AM Staff 4 (Cook) was observed checking temperatures for hot breakfast items but she did not write down or log the food temperatures. Staff 4 stated they were out of the temperature log sheets and she was not able to record the temperatures.<br><br>On 7/17/24 at 10:18 AM food temperature logs were requested. At 12:46 PM, Staff 7 provided one Dietary Food Temperature Log dated 7/16/24, which had nine breakfast items with temperatures listed on the form. Staff 7 stated she could not locate any other food temperature logs. Staff 7 stated staff were checking food temperatures but not recording them on the temperature log form. Staff 7 stated she expected staff to complete temperature checks for each meal and record the temperature on the temperature log form. |