

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/02/2024
NAME OF PROVIDER OR SUPPLIER  Pearl at Kruse Way, The		STREET ADDRESS, CITY, STATE, ZIP CODE 4550 Carman Drive Lake Oswego, OR 97035	

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50930</p> <p>Based on interview and record review it was determined the facility failed to notify a resident of a medication change for 1 of 5 sampled residents (#19) reviewed for unnecessary medications. This placed residents at risk for lack of participation in treatment decisions. Findings include:</p> <p>Resident 19 admitted to the facility in 7/2024 with diagnoses including depression.</p> <p>The Admission MDS dated [DATE] indicated Resident 19 was cognitively intact.</p> <p>The 7/2024 MAR indicated 40 mg of Citalopram was administered at bedtime from 7/7/24 through 7/19/24.</p> <p>Pharmacy recommendations dated 7/17/24 included a request to decrease Resident 19's Citalopram (anti-depressant medication) from 40 mg to 20 mg with a provider agreement and signature dated 7/18/24.</p> <p>A nursing note dated 7/19/24 indicated a gradual dosage decrease of Citalopram from 40 mg to 30 mg and then 20 mg per provider order.</p> <p>The 7/2024 MAR indicated 30 mg of Citalopram was administered from 7/20/24 through 7/22/24.</p> <p>Progress notes from 7/21/24 to 7/22/24 indicated the change to Resident 19's dosage of Citalopram was not discussed with the resident until 7/22/24 after the resident requested to speak with the provider. After that discussion, the dosage was changed back to 40 mg.</p> <p>On 8/1/24 at 10:21 AM Resident 19 stated, They treated me like I was brain dead, and she/he was outraged, incensed, and disgusted about the lack of communication regarding changes to the resident's Citalopram dose. Resident 19 stated she/he experienced no adverse reactions from changes to the Citalopram dosage.</p> <p>On 8/1/24 at 2:43 PM Staff 2 (DNS) indicated she usually followed up on pharmacy recommendations with residents prior to any changes to medications. Staff 2 reviewed the progress notes and verified the first communication with Resident 19 regarding changes to the resident's Citalopram dosage was on 7/22/24, four days after the dose was reduced.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50930</p> <p>Based on interview and record review it was determined the facility failed to provide a summary of the baseline care plan to 5 of 5 sampled residents (#s 19, 124, 125, 130, and 133) reviewed for pain, rehab services and unnecessary medication. This placed residents at risk for being uninformed of their plan of care. Findings include:</p> <p>1. Resident 19 admitted in 7/2024 with diagnoses including aftercare following joint replacement surgery and depression.</p> <p>The Admission MDS dated [DATE] indicated Resident 19 was cognitively intact.</p> <p>No information was found in the resident's clinical record to indicate a baseline care plan or summary was provided to the resident.</p> <p>On 7/29/24 at 11:26 AM Resident 19 stated she/he did not receive any care plan paperwork.</p> <p>On 8/1/24 at 11:24 AM Staff 2 (DNS) confirmed a copy of the resident's baseline care plan was not provided to Resident 19.</p> <p>41453</p> <p>2. Resident 124 admitted ,d+[DATE] with diagnoses including bone fractures and hearing loss.</p> <p>A 7/26/24 cognition assessment indicated Resident 124 was cognitively intact.</p> <p>A review of Resident 124's clinical record revealed no indication Resident 124 received a copy of the baseline care plan.</p> <p>On 8/1/24 at 11:24 AM Staff 2 (DNS) confirmed a copy of the resident's baseline care plan was not provided to Resident 124.</p> <p>3. Resident 125 admitted to the facility in 7/2024 with diagnoses including cognitive impairment and hypertension.</p> <p>A 7/25/24 cognition assessment indicated Resident 125 was cognitively intact.</p> <p>A review of Resident 125's clinical record revealed no indication Resident 125 received a copy of the baseline care plan.</p> <p>On 8/1/24 at 11:24 AM Staff 2 (DNS) confirmed a copy of the resident's baseline care plan was not provided to Resident 125.</p> <p>4. Resident 130 admitted to the facility in 7/2024 with diagnoses including diabetes and seizures.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 7/22/24 cognition assessment indicated Resident 130 had moderate cognitive impairment.</p> <p>A review of Resident 130's clinical record revealed no indication Resident 130 received a copy of the baseline care plan.</p> <p>On 8/1/24 at 11:24 AM Staff 2 (DNS) confirmed a copy of the resident's baseline care plan was not provided to Resident 130.</p> <p>5. Resident 133 admitted to the facility in 7/2024 with diagnoses including hypertension and bone fractures.</p> <p>A 7/29/24 cognition assessment indicated Resident 133 was cognitively intact.</p> <p>A review of Resident 133's clinical record revealed no indication Resident 133 received a copy of the baseline care plan.</p> <p>On 8/1/24 at 11:24 AM Staff 2 (DNS) confirmed a copy of the resident's baseline care plan was not provided to Resident 133.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41453</p> <p>Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 4 of 8 sampled residents (#s 125, 135, 181, and 228) reviewed for medications. This placed residents at risk for reduced medication efficacy and adverse medication side effects. Findings include:</p> <p>1. Resident 228 admitted to the facility in 7/2024 with diagnoses including hypertension and prostate cancer.</p> <p>An 8/2/24 facility audit of Resident 228's medication administrations from 7/27/24 through 8/1/24 revealed the following:</p> <ul style="list-style-type: none"> <li>- On 7/31/24 seven medications were administered one hour and 38 minutes to two hours and 49 minutes late.</li> <li>- On 8/1/24 four medications were administered one hour and 30 minutes late.</li> </ul> <p>On 8/2/24 Staff 2 (DNS) confirmed the medications were not administered timely.</p> <p>2. Resident 135 admitted to the facility in 7/2024 with diagnoses including paralysis and depression.</p> <p>An 8/2/24 facility audit of Resident 135's medication administrations from 7/27/24 through 8/1/24 revealed the following:</p> <ul style="list-style-type: none"> <li>- On 7/31/24 four medications were administered 47 minutes to two hours and 47 minutes late.</li> <li>- On 8/1/24 five medications were administered two hours and 30 minutes late.</li> </ul> <p>On 8/2/24 Staff 2 (DNS) confirmed the medications were not administered timely.</p> <p>3. Resident 125 admitted to the facility in 7/2024 with diagnoses including cognitive impairment and hypertension.</p> <p>An 8/2/24 facility audit of Resident 125's medication administrations from 7/27/24 through 8/1/24 revealed the following:</p> <ul style="list-style-type: none"> <li>- On 7/31/24 six medications were administered 48 minutes to three hours late.</li> <li>- On 8/1/24 four medications were administered two hours and 30 minutes late.</li> </ul> <p>On 8/2/24 Staff 2 (DNS) confirmed the medications were not administered timely.</p> <p>4. Resident 181 admitted to the facility in 7/2024 with diagnoses including diabetes and heart failure.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An 8/2/24 facility audit of Resident 181's medication administrations from 7/27/24 through 8/1/24 revealed the following:</p> <ul style="list-style-type: none"> <li>- On 7/27/24 one medication was administered one hour and 21 minutes late</li> <li>- On 7/28/24 three medications were administered 30-55 minutes late</li> <li>- On 7/29/24 seven medications were administered one hour and 45 minutes to 3 hours and 46 minutes late</li> <li>- On 7/30/24 three medications were administered one hour and 25 minutes late</li> <li>- On 8/1/24 four medications were administered one hour and 9 to one hour and 16 minutes late.</li> </ul> <p>On 8/2/24 Staff 2 (DNS) confirmed the medications were not administered timely.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41453</b></p> <p>Based on observation and interview it was determined the facility failed to ensure medications were secured and only accessible to authorized persons for 1 of 2 sampled medication carts and 1 of 1 treatment cart reviewed for medication storage. This placed residents at risk for drug diversion. Findings include:</p> <p>1. On 8/1/24 at 7:53 AM a medication cart on [NAME] Hall was observed to be unlocked and unattended outside of room [ROOM NUMBER].</p> <p>On 8/1/24 at 7:55 AM Staff 10 (LPN) confirmed the medication cart was left unlocked and unattended.</p> <p>50897</p> <p>2. On 7/31/24 between 3:40 PM and 3:53 PM a treatment cart was observed in the East Hall unattended and unlocked. During the continuous observations both staff and visitors were seen walking past the cart.</p> <p>On 7/31/24 at 3:53 PM Staff 3 (RN) confirmed the cart contained insulin and other treatment supplies and was supposed to be locked when not in use.</p> <p>On 8/2/24 at 9:55 AM Staff 2 (DNS) confirmed treatment carts were to be locked when unattended.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50930</p> <p>Based on observation and interview it was determined the facility failed to ensure food was labeled and stored in a manner to prevent food spoilage, expired food was discarded, staff used appropriate hand hygiene, and staff used hair restraints properly for 1 of 1 kitchen and 1 of 2 unit refrigerators reviewed for food storage and handling. This placed residents at risk for food contamination and food-borne illnesses. Findings include:</p> <p>The facility's Food Safety and Sanitation Policy, revised ,d+[DATE], indicated food was to be labeled and dated. The policy also indicated hair restraints were required to cover all head hair.</p> <p>1. On [DATE] at 9:48 AM during an initial tour of the facility's walk-in refrigerator and freezer the following were observed:</p> <p>Refrigerator:</p> <ul style="list-style-type: none"> <li>- dark liquid in a clear dispenser with a spigot had no label or date</li> <li>- bagged grapes sitting in brown liquid in a cardboard tray</li> <li>- three plastic clamshell packs of strawberries were mushy and had white fuzz</li> <li>- small metal container labeled, Ham, with a use by date of [DATE]</li> <li>- to go container with a use by date of [DATE]</li> <li>- an undated to go container with no name</li> <li>- cooked bacon in a metal pan with a plastic lid and no label or date</li> <li>- clear bag of shredded fresh purple vegetable with no label</li> <li>- partially consumed carton of ricotta with no date</li> </ul> <p>Freezer:</p> <ul style="list-style-type: none"> <li>- open inner bag and outer box of frozen hamburger patties with ice crystals</li> <li>- partially open bag of chicken tenders with ice crystals</li> <li>- metal container labeled casserole with a tin foil lid with holes in it and visible ice crystals</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 2:00 PM Staff 4 (Executive Chef) stated the food storage process required a label and date for all food items, all expired items were to be thrown away, and all storage containers were to be kept closed. Staff 4 acknowledged the identified items in the refrigerator and freezer were not labeled, stored, and discarded correctly.</p> <p>2. Observation of the facility's unit refrigerators on [DATE] at 2:14 PM revealed the [NAME] Hall resident refrigerator contained:</p> <ul style="list-style-type: none"> <li>- wrapped sandwich with a use by date of [DATE]</li> <li>- partially consumed jug of 1% milk with no date</li> </ul> <p>On [DATE] at 2:18 PM Staff 8 (CNA) verified the identified items in the refrigerator and freezer were not stored and labeled properly.</p> <p>3. During a kitchen observation on [DATE] at 12:14 PM Staff 6 (Prep Cook) was noted wearing the same pair of gloves to touch the refrigerator door, food cart, food containers, utensils, bread slices, tomato slices, lettuce slices, portions of meat and chips. Staff 5 (Chef), Staff 7 (Dietary Aide), and Staff 6 (Prep Cook) were noted to have hair not completely covered by hair restraints.</p> <p>On [DATE] at 12:24 PM Staff 3 (Dietary Manager) verified staff were not using gloves and hair restraints properly.</p>		