

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Tigard Rehabilitation and Care		STREET ADDRESS, CITY, STATE, ZIP CODE 14145 SW 105th Avenue Tigard, OR 97224	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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>Based on interview and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 3 sampled residents (#5) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 5 admitted to the facility in 2011 with diagnoses including anxiety, mood and personality disorder. The 7/20/23 Care Plan indicated Resident 5 had behaviors of refusing cares, refusing all wound cares and other cares including bathing and hygiene tasks. Resident 5 was not easily directed and interventions by staff escalated the resident's agitation. Resident 5 had history of being verbally and physically aggressive toward staff. Interventions included: to not argue with the resident and to discontinue attempts to treat if she/he became agitated and reapproach later. A 1/6/25 Facility Reported Incident indicated the following:- - On 1/4/25 Resident 5 told Staff 21 (RN) to go to Hell when attempting to complete wound care. Staff 21 was heard by CNA Staff reply to Resident 5, I'm already in Hell. You're Satan's bitch, aren't you? Staff 21 also threatened to call the police on Resident 5 for assault because the resident grabbed the collar of Staff 21's isolation gown. - - Staff 19's (CNA) witness statement indicated she and Staff 20 (CNA) went to provide a brief change to Resident 5. Staff 19 indicated Resident 5 was not accepting cares, but they were able to start changing the resident's brief. Staff 21 came into the room to complete wound care. Resident 5 became upset because of the brand of cream being used. Resident 5 became agitated and grabbed Staff 21's gown, tore it and told her to Go to Hell. Staff 21 was heard replying, I'm already there and you're Satan's bitch. Staff 21 stated she was going to call the police and press charges on Resident 5 for assault. - - Staff 20's witness statement indicated she and Staff 19 went to change Resident 5's brief and Staff 21 also went into the room to complete wound care. Resident 5 did not want to be changed and was not calming down. Staff 21 informed her and Staff 19, it was fine, keep changing [her/him]. Resident 5 was upset about the cream being used and both Resident 5 and Staff 21 were yelling back and forth at each other. - - Staff 21 indicated Resident 5 was calling her names and told her to go to Hell. Staff 21 told the resident wound care had to be done, and she/he needed to be changed, the resident continued to yell. Staff 21 indicated Resident 5 grabbed her and she told the resident she could report her/him. Staff 21 indicated she stated she was in Hell but did not recall saying anything else. - - Resident 5 indicated she/he told Staff 21 to get out and Staff 21 told her/him she was going to call them to take her/him away. Resident 5 was unable to recall any other statements made by Staff 21. - - The investigation indicated Resident 5's care plan was not followed related to staff not discontinuing attempts to treat and provide care when the resident became agitated. No psychosocial harm was found, and Staff 21 was terminated. Abuse was unable to be ruled out related to the verbal abuse toward Resident 5. On 7/10/25 at 11:07 AM Resident 5 was unable to recall the incident that occurred between her/him and Staff 21. On 7/10/25 at 1:10 PM Staff 19 stated she and Staff 20 went into Resident 5's room with Staff 21 to change the resident's brief and complete wound care. Staff 19 stated they were all wearing gowns due to the resident being on Enhanced Barriers Precautions. Staff 19 stated Resident 5 lashed out and grabbed Staff 21's gown and told her to go to Hell. Staff 19 stated Staff 21 told the resident that she was already there, and she/he was Satan's bitch. Staff 19 stated they were able to change the resident, but she/he continued to lash out and Staff 21 threatened to call the police on the resident for assaulting staff. Staff 19 stated Resident 5 had a history of being resistive to care. Staff 19 stated when Resident 5 was being resistive to cares staff were to leave the room, reassess and reapproach. Staff 19 stated Staff 21 told her and Staff 20 to keep going with providing the brief change and to not worry about it even though Resident 5 was resistive. On 7/10/25 at 12:14 PM Staff 20 stated Resident 5 had known behaviors of refusing cares. Staff 20 stated her, and Staff 19 went into Resident 5's room to change her/his brief and Staff 21 was also in the room to complete wound care. Staff 20 stated Resident 5 was not complying with care and refusing to be changed. Staff 20 stated Staff 21 told her and Staff 19 to go ahead and change the resident even though she/he was freaking out and told them to get out. Staff 20 stated both Staff 21 and Resident 5 were yelling at each other. Staff 20 stated she heard Staff 21 telling Resident 5 she/he was Satan's bitch. Staff 20 stated when Resident 5 was resistive to cares, staff were to walk away and reapproach. On 7/10/25 at 12:57 PM Staff 21 stated Resident 5 was hateful and on 1/4/25 Resident 5 was calling her names, trying to hit and kick her and told her to go to Hell. Staff 21 stated she told Resident 5 that she was already there and then proceeded to say something under her breath. Staff 21 stated CNA staff overheard her and reported it. Staff 21 stated she did not argue about what she reportedly said. Staff 21 further stated she was directed by Staff 15 (Former DNS) to force brief changes at</p>		