STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385272	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tigard Rehabilitation and Care	14145 SW 105th Avenue Tigard, OR 97224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42270 Based on interview and record review it was determined the facility failed to ensure residents received communication in a language they could understand for 1 of 1 resident (#52) reviewed for behavior. This placed residents at risk for lack of involvement in care. Findings include: Resident 52 admitted to the facility in 10/2024 with diagnoses including diabetes. A 10/12/24 Admission MDS revealed Resident 52's preferred language was Spanish and she/he needed an interpreter to communicate with health care staff. A 10/28/24 care plan revealed Resident 52 spoke Spanish. A review of the medical record revealed the following English language documents were issued to and signed by Resident 52: - 10/14/24 Portable Orders for Life-Sustaining Treatment (POLST), - 10/22/24 Notice of Medicare Non-Coverage, - 10/29/24 Notice of Medicare Non-Coverage, - 1/9/25 SNF Discharge Instructions/Recapitulation of Stay. On 1/14/25 at 11:52 AM Witness 2 (Complainant) stated she visited with Resident 52 and she/he complained the facility provided documents to her/him in English only and requested she translated documents to Resident 52. Unable to interview Resident 52 due to her/his phone being disconnected. On 1/15/25 at 5:04 AM Staff 11 (CNA) stated Resident 52 spoke Spanish with very little English. On 1/15/25 at 12:00 PM Staff 18 (Social Services Director) stated Resident 52 had variable English skills and required a translator for communication. Staff 18 did not know if Resident 52 read English and stated she/he needed her/his Notice of Medicare Non-Coverage to be issued in Spanish. On 1/15/25 at 2:40 PM Staff 19 (LPN) confirmed Resident 52 spoke Spanish with very little English. (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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 10:42 AM Staff 2 (DNS) stated Resident 52 spoke Spanish and the facility failed to provide documents to her/him in a language she/he could understand.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 42270 Based on interview and record review it was determined the facility failed to ensure resident mail was delivered to residents on Saturdays for 1 of 1 facility reviewed for resident council. This placed residents at risk for lack of timely written communication. Findings include: A facility Mail and Electronic Communication policy, revised in 2017, stated, Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries). During the resident council meeting on 1/14/25 at 2:00 PM residents stated their mail was not delivered to them on Saturdays. On 1/15/25 at 10:04 AM Staff 20 (Activities Director) stated mail was delivered Monday through Friday only. Staff 20 stated mail delivered to the facility on Saturdays was not given to resdients until the next Monday morning. On 1/15/25 at 11:31 AM Staff 1 (Administrator) stated resident mail was to be delivered to the residents on the same day it was delivered to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42270 Based on interview and record review it was determined the facility failed to develop a comprehensive person-centered care plan for 1 of 1 sampled resident (#52) reviewed for behavior. This placed residents at risk for unmet needs. Findings include: Resident 52 admitted to the facility in 10/2024 with diagnoses including diabetes. An 10/16/24 Utilization Review assessment revealed Resident 52 had chronic suicidal ideation comments. An 10/26/24 Progress Note revealed Resident 52 yelled and swung at staff, was combatiative, and refused to have her/his vitals done. A 11/5/24 Progress Note with a licensed clinical social worker revealed Resident 52 was referred to her by the facility for a depressed mood. Resident 52 expressed feeling depressed following recent medical complications and loss of independence, had depressed mood, sadness, feelings of helplessness, difficulties concentrating, and some irritability. Resident 52 expressed recent suicidal ideation with no intent or plan. A review of Resident 52's medical record revealed no monitoring for mood or behaviors. A review of Resident 52's comprehensive care plan revealed nothing related to mood, history of suicidal ideation, adjustment, or behaviors. On 1/15/25 at 5:04 AM Staff 11 (CNA) stated Resident 52 was in a weird slump for a bit when asked about her/his mood. On 1/15/25 at 12:00 PM Staff 18 (Social Services Director) stated she was unaware of any mood issues for Resident 52. On 1/15/25 at 10:46 AM Staff 21 (CNA) stated Resident 52 complained about not having family support and expressed wanting to die. On 1/15/25 at 2:40 PM Staff 19 (LPN) stated Resident 52 expressed being tired of being sick and wanted to be done with life. Staff 19 referred her/him to Staff 18. On 1/16/25 at 12:42 PM Staff 4 (LPN Resident Care Manager) stated Resident 52 had a chronic low mood and had suicidal ideation without a plan or active suicidal behaviors. Staff 4 stated Resident 52 was seen by a licensed clinical social worker for her/his mood issues. On 1/17/25 at 7:32 AM Staff 18 stated Resident 52 had passive suicidal ideation and saw mental health support in the facility but that was about adjustment issues and not related to any suicidal behaviors. Staff 18 stated she did not feel Resident 52 had actual suicidal ideation or mood issues so she did not do a care plan related to it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 10:42 AM Staff 2 (DNS) stated Resident 52 had mood and behavior issues and she expected those issues to be addressed in her/his care plan.

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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. 42270 Based on interview and record review it was determined the facility failed to provide care to wounds for 1 of 1 sampled resident (#52) reviewed for non-pressure skin wounds. This placed residents at risk for worsening wounds. Findings Include: Resident 52 admitted to the facility in 10/2024 with diagnoses including diabetes. An 10/5/24 hospital progress note revealed Resident 52 had a a right foot ulcer. An 10/8/24 Clinical Admission revealed a right lateral (outer edge) foot diabetic foot ulcer was identified. Daily Skilled Evaluations completed 10/9/24 through 10/18/24, 10/20/24 through 11/1/24, 11/4/24, and 11/5/24, identified Resident 52's right lateral foot diabetic ulcer was not evaluated. 10/14/24, 10/17/24, 10/25/24, 11/1/24, and 11/19/24 Physician Progress Notes revealed no information related to Resident 52's right lateral foot diabetic ulcer. A 11/21/24 Skin Check assessment revealed Resident 52 was identified to also have a venous ulcer (a chronic wound that occurs when blood pools in the veins of the legs, damaging the skin and causing an open sore) on the left front lower leg and a venous ulcer on the left shin; both were indicated to have been identified on admission. A 11/26/24 Progress Note revealed Resident 52 had newly identified wounds to her/his left lower extremity, right foot, and buttocks. New wound orders were requested. A 11/26/24 Skin Integrity Issue investigation revealed Resident 52 had a wound noted on 10/8/24 but there were no orders for treatment. Staff 6 (Assistant DNS) completed a skin assessment of Resident 52 and discovered two additional wounds to her/his left lower leg and one pressure wound. Resident 52 stated the wound to the left leg was present for years. Orders for wound care were requested and obtained at that time for the four wounds. On 11/27/24 physician orders were received for wound care to Resident 52's wounds. On 1/16/25 at 11:10 AM Staff 6 stated she was aware of Resident 52's wounds. Staff 6 stated the facility identified Resident 52 had a wound on her/his right foot at the 10/8/24 admission, but orders for treatment were not obtained until 11/27/24. Staff 6 reviewed the 11/21/24 Skin Check assessment and confirmed the left front lateral lower leg wound and left shin venous ulcer wounds were identified as present on admission and Resident 52 stated the wounds were there for a long time. Staff 6 stated the facility failed to provide treatment for these wounds until 11/27/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34324 Based on interview and record review it was determined the facility failed to ensure residents were assessed after weight loss was identified for 1 of 3 sampled residents (# 34) reviewed for nutrition. This placed residents at risk continued weight loss. Findings include: Resident 34 admitted to the facility on [DATE] with diagnoses including malnutrition and type 1 diabetes. The 8/13/24 Care Plan indicated Resident 34 had a nutritional problem related to ongoing malnutrition and weight loss since admit. The goal was for Resident 34's weight to be within acceptable parameters set by the RD and Interdisciplinary team. Interventions included distant supervision, high protein foods and supplements. Review of Resident 34's Weight Summary report indicated the following: - 6/25/24 weight of 200.6 pounds. - 7/10/24 through 9/4/24 weight averaging 205.5 pounds. - 9/16/24 no weight taken. - On 9/23/24 Resident 34's weight was 174.6 pounds (32.5-pound weight loss). On 9/26/24 a progress note indicated the identified weight of 174.6 pounds and a reweigh was requested. Review of the Weight Summary Report indicated Resident 34 was not weighed again until 10/7/24 with a weight of 175.2 pounds (two weeks after the 9/26/24 reweigh request). Review of Resident 34's medical record indicated no new nutritional interventions were implemented between 9/26/24 and 10/7/24. Review of Resident 34's progress notes indicated she/he was sent to the hospital on 10/14/24 related to diabetes and returned to the facility on [DATE]. A 10/15/24 nutritional progress note indicated a reweigh was previously requested. Resident 34 was due for review by the Nutritional at Risk (NAR) group but left to the hospital and would be reviewed in NAR upon return. Review of NAR Assessments indicated no review of Resident 34 was completed between 9/26/24 (first identified weight loss) and 10/14/24 (two and a half weeks later) when the resident discharged to the hospital. The first noted NAR assessment was completed on 10/22/24 (three days after readmission to the facility). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations made from 1/13/25 through 1/15/25 revealed Resident 34 was able to feed himself with adaptive equipment. Resident 34 was observed to eat 100% of her/his meals. On 1/16/25 at 9:39 AM and 3:22 PM Staff 13 (RD) stated she reviewed the weight report weekly and determined who needed to be further assessed for being at risk for weight loss. Staff 13 stated a re-weigh request was to be completed by the following morning to determine accuracy. Staff 13 stated a resident was to be reviewed in NAR within a week of being identified for weight loss. Staff 13 acknowledged Resident 34's re-weigh recommendation was not completed timely, and Resident 34 was not reviewed in NAR until 10/22/24 resulting in a delay in nutritional interventions.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 34324 Based on interview and record review it was determined the facility failed to ensure CNAs received annual performance reviews for 4 of 4 randomly selected CNA staff (#s 7, 8, 9 and 10) reviewed for staffing. This placed residents at risk for lack of care by competent staff. Findings include: On 1/14/25 at 1:30 PM Staff 2 (DNS) was asked for the annual performance reviews for Staff 7 (CNA), Staff 8 (CNA), Staff 9 (CNA), and Staff 10 (CNA). No performance reviews were provided. On 1/15/25 at 10:40 AM Staff 15 (Staffing Coordinator) acknowledged no performance reviews were completed for the identified CNA staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50897 Based on observation, interview and record review the facility failed to ensure refrigerator temperatures were monitored, and food was labeled and dated for 2 of 2 refrigerators reviewed for food storage. This placed residents at risk for potential foodborne illnesses. A review of the facility policy Refrigerator and Freezer policy revealed refrigerator and freezer temperatures were to be checked daily and all food items were to be marked with dates. Responsibility for implementating the policy was assigned to supervisors or their designee. On 1/13/25 at 8:25 AM the refrigerator used to store resident food items, located in the resident dining room, was observed to have a temperature recording log, however, the temperature was only recorded on 1/10/25. On 1/14/25 at 1:09 PM Staff 16 (Dietary Manager) stated he was not aware of the process for monitoring the resident foods refrigerator utilized by the care team. He stated he had taken the temperature of the refrigerator on 1/10/25 when he placed the log on the front of the refrigerator. On 1/15/25 at 9:59 AM foods were observed with no dates or names in both compartments of the resident refrigerator in the dining room. Staff 17 (CNA) stated she was not sure what the policy was for labeling and dating foods. The resident snack refrigerator behind the nurses station was also observed. The temperature log only had one recorded temperature, dated 1/14/15. In an interview on 1/16/25 at 1:00 PM Staff 16 acknowledged refrigerator temperatures were to be monitored and recorded daily, and refrigerator food was to be labeled and dated.