STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385275	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Rehabilitation and Care	411 SE Sheridan Road Sheridan, OR 97378

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review it was determined the facility failed to provide a clean and well-maintained homelike environment for 3 of 7 sampled residents (#s 5, 27, and 28) and 2 of 5 resident hallways reviewed for environment. This placed residents at risk for lack of a homelike environment. Findings include: 1. Resident 28 was admitted to the facility in 11/2025. On 6/1/26 at 12:10 PM, Witness 2 (Family Member) stated she/he was dissatisfied with the cleanliness and condition of Resident 28's room: the blinds were broken, there was a hole in the window frame leading directly to the outside, the floor was frequently dirty, and the resident's fall mat was dirty and sticky. Witness 2 stated the broken blinds and window frame hole were both present when the resident moved into the room, and she/he had spoken to the previous maintenance director about the need for repair. Resident 28's room was observed to have accumulated dirt and dust on the floor, particularly around the furniture and under the window. The window blinds were coated with dust and five of the slats were broken. There was a hole in the bottom left corner of the window frame that led directly to the outside, big enough for a fingertip to poke through. Resident 28's fall mat was soiled with large brown stains and sticky spots. On 6/2/26 at 3:54 PM Staff 12 (Housekeeping Manager) acknowledged Resident 28's room and fall mat were dirty and needed to be cleaned. Staff 12 stated the blinds were difficult to clean since they were broken. On 6/4/26 at 8:55 AM Staff 8 (Maintenance Director) stated he was aware of the broken blinds, but not the window frame hole in Resident 28's room. Staff 8 stated repairs such as broken blinds and a hole in the window frame required immediate repair. On 6/4/26 at 10:59 AM Staff 1 (Administrator) stated repairs to blinds and windows were to be made as soon as the damage occurred, and all staff members were responsible for reporting repair needs to maintenance. 2. Resident 5 was admitted to the facility in 2023. On 6/1/26 at 11:24 AM, Resident 5 stated several months ago she/he requested maintenance move the pictures hanging behind her/his bed to a location where she/he could see them, and the light next to the door was not working, but neither request was addressed. Observations of Resident 5's room revealed pictures were hung behind the resident's bed where she/he could not see them, and the light next to the door did not work. Resident 5's floor was dirty with accumulated dust and debris. Next to the resident's dresser on the floor was a dirty sock, a tube of cream, various pieces of plastic (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	packaging, and a pair of nail clippers. The resident's bed was angled away from the wall and the area between the wall and bed was dirty and dusty. The area under Resident 5's wheelchair had sticky red spots and visible dirt. On 6/2/26 at 3:54 PM Staff 12 (Housekeeping Manager) acknowledged Resident 5's room was dirty and needed to be cleaned. A 6/3/26 Work Order Report revealed a work order for moving Resident 5's pictures and fixing the light in her/his room was generated on 5/18/26 and closed on 5/22/26. On 6/4/26 at 9:13 AM Staff 8 (Maintenance Director) stated he was unaware of Resident 5's previous request to have her/his pictures moved or that the light in the room did not work. Staff 8 was unable to give a reason why the work order was closed when the work was not completed. 3. Resident was admitted to the facility in 12/2025. On 6/1/26 at 12:31 PM, Resident 27 stated the toilet in her/his room did not flush, would run continuously at times, and required manual adjustment. Resident 27 stated staff were aware of the issue, but it was not repaired. On 6/3/26 at 3:26 PM, Staff 11 (CNA) stated Resident 27's toilet was frequently clogged, and she had informed the prior maintenance director about the issue twice in the past. A 6/3/26 Work Order Report revealed a work order to address Resident 27's malfunctioning toilet was generated on 4/10/26 and closed on 5/27/26. On 6/4/26 at 9:00 AM, Staff 8 (Maintenance Director) stated he was unaware of an issue with Resident 27's toilet and was unable to give a reason why the work order was closed when the work was not completed. 4. Upon the 6/1/26 survey entrance, observed several handrail end cap pieces were missing from handrails in resident areas. On 6/3/26 the facility implemented an improvised repair by covering the handrail ends caps with a plastic foam material and black tape. The application of tape created crevices between the layers, and portions of the tape protruded at angles where it was folded. The handrail closest to the dining room was not fully covered with tape, leaving an exposed area of the plastic foam. On 6/3/26 at 2:28 PM Staff 12 (Housekeeping Manager) was observed wiping the handrails but not the taped areas. On 6/4/2026 at 9:17 AM observed taped areas were peeling. Staff 12 stated the peeling tape resulted in an uncleanable surface.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to ensure kitchen staff wore appropriate hair restraints during meal preparation, provide a sanitary kitchen environment and ensure proper hand hygiene practices were followed for 1 of 1 facility kitchen reviewed for sanitation. This placed residents at risk for unsanitary foods and food-borne illness. Findings include:The facility's undated Food Preparation and Service policy indicated:-Food preparation staff are to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illnesses.-Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and discarded after each use.-Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.1. On 6/3/26 at 11:29 AM, Staff 9 (Cook) was observed working in the kitchen without a hair restraint. Staff 9's hair was pulled back into a braid, which was observed swinging onto the front of her shoulder while she actively prepared food items for lunch.On 6/3/26 at 11:30 AM, Staff 7 (Dietary Director) stated Staff 9 forgot to replace her hair restraint after returning from lunch break. Staff 7 stated he believed a hair restraint was required only when the employee's hair was not pulled back and contained.On 6/4/25 at 10:35 AM, Staff 6 (Regional Dietary Director) stated hair restraints were to be worn at all times while working in the kitchen.2. Observation of the facility's kitchen on 6/3/26 between 12:00 PM and 12:30 PM, revealed the following:-Staff 9 (Cook) opened the refrigerator and removed a bag of salad. Staff 9 opened the bag without gloves and used her bare hands to dish out the salad. Staff 9 returned the bag of salad to the refrigerator.-Staff 9 picked up a biscuit with bare hands, cut into pieces, and placed them onto a plate.-Staff 9 picked up pre-made sandwiches with bare hands and placed them on plates.On 6/3/26 at 12:28 PM, Staff 7 (Dietary Director) acknowledged Staff 9 did not properly follow guidelines for handling ready to eat food.On 6/4/26 at 10:35 AM, Staff 6 (Regional Dietary Director) stated staff are expected to use utensils or gloves when handling ready-to-eat food items.3. On 6/4/26 at 10:20 AM, during interview with Staff 6 (Regional Dietary Director) and Staff 7 (Dietary Director), black tape was observed wrapped around the edge of the metal table used to hold clean dishes from the dishwasher. Staff 7 stated the tape was applied after the table was damaged. Staff 6 acknowledged the tape created a surface that could not be adequately cleaned and stated the tape needed to be removed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure the facility was free from pests for 1 of 1 sampled facility reviewed for environment. This placed residents at risk for a lack of sanitary conditions. Findings include: The facility's 5/2008 Pest Control policy indicated:-This facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents.-Windows are screened at all times.On 6/1/26 at 12:13 PM observed an open bathroom window without a screen in room [ROOM NUMBER]. No insects were observed at that time.On 6/1/26 from 5:47 PM to 6:21 PM, during dinner in the main resident dining room, a window without a screen was open and a mosquito, unidentified large bug, and a fly were observed. Staff 14 (Social Services Director) closed the window and stated it was due to insects getting in through the window. Five windows in the dining room did not have screens. On 6/2/26 at 9:36 AM, a fly was observed on the surveyor's computer while in the south hall.On 6/3/26 at 12:50 PM, a fly was observed in Staff 3's (LPN Resident Care Manager) office.On 6/4/26 at 9:00 AM, Staff 8 (Maintenance Director) stated he was aware several screens needed to be replaced or repaired and stated he was conducting an audit of all window screens the following week.On 6/4/26 at 1:22 PM, Staff 1 (Administrator) stated screens were required to be in place on all windows as part of the facility's pest control policy and acknowledged the facility had several missing or damaged screens.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to ensure allegations of abuse were reported timely for 1 of 6 sampled residents (#45) reviewed for accidents and abuse. This placed residents at risk for continued abuse. Findings include: The facility's Abuse Prevention Policy and Procedure, dated 6/12/18, indicated:-All incidents, accidents, and injuries of unknow origins such as bruising or skin tears, and resident-to-resident contacts will be identified through the 24-hour report and an incident report in order to initiate an investigation. The Administrator and the Director of Nursing will be notified.-Mandated Reporters are to immediately report to their onside supervisor and the State Hotline number be they have reasonable cause to believe abuse, neglect, involuntary seclusion, abandonment, or financial exploitation has occurred, or when they have reason to suspect an incident is sexual or physical assaults. The Director of Nursing and/or Administrator shall be immediately notified of all allegations of abuse and neglect. Resident 45 was admitted to the facility in 7/2018 with a diagnosis of respiratory failure. Resident 45's 1/1/26 Progress Note revealed she/he alleged abuse and psychosocial harm. Resident 45 reported two CNAs assisted her/him to reposition in bed and her/his back was injured because the CNAs overdid it. Resident 45's 1/1/26 Event-Other investigation form revealed on 1/1/26 a handwritten note by Staff 17 (CNA) was found on the Resident Care Manager's floor. The note indicated on 12/30/25 Resident 45 was heard screaming in pain. Resident 45 reported staff caused her/him to be in pain by assisting her/him in bed when she/he did not need to be repositioned. On 6/4/26 at 2:38 PM Staff 17 stated if a resident reported abuse she/he notified the charge nurse. Staff 17 stated on 12/30/25 when Resident 45 reported abuse she/he reported to Staff 18 (Former RN) and also wrote a note to the Resident Care Manager. On 6/4/2026 9:59 AM Staff 1 (Administrator) stated staff should have reported Resident 45's allegation of abuse on 12/30/25 and the facility did not report to the state within the required time frame.On 6/5/26 at 10:37 AM Staff 18 stated on 12/30/25 she was not notified of Resident 45's allegation of abuse. Staff 18 stated if she/he was notified, she would have reported to management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review it was determined the facility failed to ensure the MDS was coded accurately related to oxygen and non-invasive mechanical ventilator for 1 of 3 sampled residents (#7) reviewed for respiratory care. This placed residents at risk for inaccurate assessments. Findings include:The facility's undated Quarterly Assessments policy revealed quarterly MDS assessments were conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status were monitored. Resident 7 was admitted to the facility in 7/2022 with diagnosis including obstructive sleep apnea, chronic respiratory failure with hypoxia and hypercapnia (the body's tissues do not receive enough oxygen and the lungs cannot effectively remove carbon dioxide leading to dangerous carbon dioxide buildup in the blood), and Chronic Obstructive Pulmonary Disease (COPD)A review of the 4/25/26 Quarterly MDS revealed the resident was not using oxygen or a BiPAP (Bilevel Positive Airway Pressure that delivers pressurized air through a mask providing two pressure levels: a higher pressure for inhaling and a lower pressure of exhaling). The physician order, last signed on 5/31/26, revealed an order with a start date of 2/5/26 indicating Resident 7 was to receive continuous oxygen at two Liters per minute through nasal cannula (NC) or bled into the BiPAP.On 6/1/26 at 1:38 PM Resident 7 was observed with a NC placed in her/his nostrils and received oxygen through a portable oxygen machine. Resident 7 stated she/he required the use of continuous oxygen. Resident 7 stated while she/he was in bed she/he received oxygen through the BiPAP machine bled through from the oxygen concentrator and while up in the wheelchair received oxygen through the portable oxygen machine and the NC.On 6/4/26 at 12:12 PM Staff 5 (MDS Coordinator) stated he was an offsite MDS Coordinator that went to the facility once a week. Staff 5 stated he collected information for each section of the MDS through the resident's physicians order, progress notes and any documentation uploaded into the resident's medical record. Staff 5 acknowledged Resident 7 required continuous oxygen, used a BiPAP and he coded the 4/25/26 Quarterly MDS inaccurately. On 6/4/26 at 2:08 PM Staff 2 (DNS) acknowledged Resident 7's 4/25/26 Quarterly MDS was coded inaccurately related to oxygen and BiPAP use.

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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. Based on interview and record review it was determined the facility failed to provide PRN insulin per physician orders for 1 of 5 sampled residents (#4) reviewed for unnecessary medications. This placed residents at risk for elevated blood sugars. Findings include: Resident 4 was admitted to the facility in 12/2023 with a diagnosis of diabetes. Resident 4's 6/24/25 Physician Orders revealed Insulin Lispro (fast acting insulin) was to administer every two hours PRN CBG greater than 400. Resident 4's PRN Insulin Lispro was not to be administered within two hours of her/his scheduled Lispro which was to be administered after meals. Resident 4's 5/2026 DAR (Diabetic Administration Record) revealed her/his CBG was greater than 400 on 5/1/26 at 1:00 PM, 5/7/26 at 9:00 AM, 5/12/26 at 12:00 PM and 6:26 PM, and 5/26/26 at 8:25 AM. Resident 4's DAR revealed staff did not administer the PRN Insulin Lispro. Resident 4's clinical record did not have documentation to indicate on 5/1/26, 5/7/26, 5/12/26, and 5/26/26 her/his CBG was rechecked after the CBGs were greater than 400. On 6/4/26 at 2:04 PM Staff 4 (RN Regional Consultant) verified in 5/2026 Resident 4's CBG was greater than 400 on four occasions and there was no documentation to indicate her/his CBG was rechecked or PRN insulin Lispro was administered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to ensure aspiration precautions were followed for 2 of 5 sampled resident (#s 38 and 44) reviewed for accidents. This placed residents at risk for adverse outcomes related to aspiration. Findings include: 1. Resident 38 was admitted to the facility in 9/2025 with a diagnosis of dysphagia (difficulty swallowing). Resident 38's 9/10/25 Speech Therapy Evaluation and Plan of Treatment revealed she/he had minimal signs of dysphagia but due to her/his cognitive status and confusion, she/he was not able to follow instructions for swallowing strategies. Resident 38 was assessed to not have signs of aspiration. Recommendations included she/he was to have close supervision for oral intake and be upright for meals. Resident 38's 9/10/25 in-room Aspiration Precautions Information sheet (posted above Resident 38's head of bed) did not instruct staff to provide supervision for meals. Resident 38's 2/23/26 Aspiration Precautions information sheet (located in the dining room in a binder) revealed she/he was to be provided 1:1 monitoring while eating. Resident 38's 3/25/26 Order Details revealed she/he was to have 1:1 supervision for meals with small bites and sips. On 6/1/26 at 4:20 PM Resident 38 was observed in bed with her/his eyes shut. Two cups of fluids within arm's reach were observed on Resident 38's bedside table. On 6/1/26 at 4:22 PM Staff 20 (CNA) stated Resident 38 was able to eat independently. Staff 20 reviewed Resident 38's in-room Aspiration Precautions Information sheet and stated Resident 38 was able to eat and drink without supervision. If Resident 38 was assessed to need 1:1 supervision staff would need to be with the resident while she/he consumed food and fluids. On 6/1/26 at 4:52 PM and 6:02 PM Staff 3 (LPN Resident Care Manager) stated a resident's in-room Aspiration Precautions Information sheet and the sheet located in the dining room should contain the same information. Staff 3 stated 1:1 supervision meant there should not be drinks within reach in a resident's room and staff were to be present with all intakes. On 6/1/26 at 5:32 PM Staff 25 (CNA) stated if a resident had aspiration precautions a sign was placed in a resident's room with instructions. Staff 25 stated Resident 38 was able to eat and drink independently and did not require 1:1 supervision. On 6/2/26 at 11:27 AM Staff 2 (DNS) stated the most current information for residents' aspiration precautions was located in the dining room. If a resident's Aspiration Precautions Information sheet indicated a resident was to be provided 1:1 supervisor, no food or drinks were to be left within reach at the bedside unless specified on the form. 2.Resident 44 was admitted to the facility in 5/2026 with diagnoses including pneumonia. Resident 44's health record indicated resident had a BIMS score of nine, indicating a moderate cognitive deficit. Resident 44's 5/22/26 care plan and admission orders indicated Resident 44 was a high aspiration risk and required one on one supervision for all eating and drinking. On 6/1/26 at 1:42 PM, Resident 44 was observed asleep in bed. Two cups were located on the bedside table within reach of the resident. One cup without a lid contained juice, and a second cup with a lid contained water. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/1/26 at 2:55 PM, Staff 16 (Restorative Aide) stated Resident 44 required one to one supervision during all meals, and Resident 44 was not to be left unsupervised, were to cue the resident during meals and assist with all food and liquid intake as needed. Staff 16 stated she never witnessed the resident chocking or coughing during meals. On 6/1/26 at 3:41 PM, Resident 44 stated she/he did not have a history of choking while consuming liquids. On 6/1/26 at 3:56 PM, Staff 3 (LPN Resident Care Manager), stated Resident 44 required one to one supervision during all meals and required staff to be present to monitor and assist with eating and liquids as needed. Staff 3 stated fluids should not be left at the bedside unless the fluids were well out of reach of the resident. On 6/1/26 at 4:16 PM, Resident 44 was observed awake in bed. Two cups were located on the bedside table within reach of the resident. One cup without a lid contained juice, and a second cup with a lid which contained water. The resident did not reach for any fluids on his bedside table. On 6/1/26 at 3:55 PM Staff 27 (CNA) stated she worked with the resident who had poor vision and was to be taken to the dining room for assistance with all meals. Staff 27 stated she would refer to the Kardex (a quick guide for CNAs to provide care to residents) but was unaware the resident required one to one supervision and was not to have liquids at bedside. On 6/1/26 at 4:22 PM, Staff 26 (CNA) stated she was aware Resident 44 was not to drink from a straw but was unaware the residents required one to one supervision and was not to have fluids at her/his bedside. On 6/2/26 at 11:27 AM, Staff 2 (DNS) and Staff 4 (RN Regional Consultant) stated Resident 44 required one to one supervision which meant staff to be present for all food and liquid intake and fluids were not to be kept at the bedside unless they were placed out of reach.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review it was determined the facility failed to maintain oxygen equipment for 1 of 3 sampled residents (#7) reviewed for oxygen therapy. This placed residents at risk for increased risk for respiratory failure. Findings include: Resident 7 was admitted to the facility in 7/2022 with diagnosis including obstructive sleep apnea, chronic respiratory failure with hypoxia and hypercapnia (the body's tissues do not receive enough oxygen and the lungs cannot effectively remove carbon dioxide leading to dangerous carbon dioxide buildup in the blood), and Chronic Obstructive Pulmonary Disease (COPD)A review of the 7/23/26 Annual MDS revealed Resident 7 had a BIMS of 15 indicating she/he was cognitively intact and it revealed Resident 7 utilized oxygen.The physician order, last signed on 5/31/26, revealed an order with a start date of 2/5/26 indicating Resident 7 was to receive continuous oxygen at two Liters per minute through nasal cannula (NC) or bled into the BiPAP.A review of 6/2026 TAR revealed to clean the oxygen concentrator and filter every Tuesday night shift starting on 2/10/26. On 6/2/26 this task was documented as completed by Staff 15 (LPN).Observations on 6/1/26 at 1:23 PM, 6/2/26 at 3:27 PM, and 6/3/26 at 8:50 AM revealed the external vent on the back of the oxygen concentrator to have a layer of dust when touched with a finger.On 6/1/26 at 1:38 PM Resident 7 stated she/he required the use of continuous oxygen. Resident 7 stated while she/he was in bed she/he received oxygen through the BiPAP machine bled through from the oxygen concentrator and while up in the wheelchair received oxygen through the portable oxygen machine and the NC.On 6/2/26 at 3:48 Staff 24 (CNA) stated Resident 7 received continuous oxygen and only the nurses cleaned the exterior of the oxygen concentrator machines. On 6/3/26 at 8:56 AM Staff 15 stated Resident 7's oxygen concentrator did not have a filter to clean, and she did not clean the exterior of the oxygen concentrator as nursing didn't do that.On 6/3/26 at 9:28 AM Staff 2 (DNS) stated she expected the charge nurse to wipe down the exterior of the oxygen concentrator, including the vent on the back. Staff 2 observed Resident 7's oxygen concentrator and acknowledged it had a layer of dust that should not be there.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure a resident had transporation for dialysis for 1 of 1 sampled residents (#4) reviewed for dailysis. This placed residents at risk for fluid retention. Findings include: Resident 4 was admitted to the facility in 12/2023 with a diagnosis of kidney disease. Resident 4's [DATE] Annual MDS revealed she/he was cognitively intact. On [DATE] at 11:09 AM Resident 4 stated she/he did not go to dialysis on [DATE] because the facility did not set up transportation. On [DATE] at 4:12 PM Staff 14 (Social Services Director) stated the company that provided Resident 4 transportation to dialysis had a contracted schedule which needed to be renewed every 90 days. The contract was not renewed prior to expiration and Resident 4 missed dialysis on [DATE]. On [DATE] at 4:16 PM DNS stated the facility should always ensure the transportation contract was renewed before it expired to ensure a resident did not miss dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385275	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Rehabilitation and Care	411 SE Sheridan Road Sheridan, OR 97378

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure a resident's bowel care was held per physician orders and labs were monitored for 2 of 5 sampled residents (#2 and 4) This placed residents at risk for dehydration. Findings include: 1. Resident 2 was admitted to the facility in 7/2023 with a diagnosis of a genetic disorder characterized by chronic constipation. Resident 2's 7/2/24 Order Details revealed she/he was to be administered MiraLAX (laxative) every morning for constipation hold for loose stools. Resident 2's bowel care record from 5/5/26 through 6/3/26 revealed on 5/23/26 and 5/24/26 she/he had two loose each day. Resident 2's 5/2026 MAR revealed MiraLAX (was not held on 5/23/24, 5/24/26, or 5/26/26. On 6/3/26 atn12:34 PM Staff 21 (CMA) stated if a resident had an order to hold bowel medications for loose stools the medication should not be administered if a resident had a loose stool. Staff 21 stated CNAs notified her if a resident had a loose stool. On 6/3/26 at 3:43 PM Staff 2 (DNS) verified bowel care was not held when Resident 2 had loose stools. The information for loose stools was also on the bowel list which was printed daily and staff were to review the list prior to administering bowel care medications. 2. Resident 4 was admitted to the facility in 12/2023 with a diagnosis of kidney disease. Epocrates.com (web-based pharmacy resource) revealed interactions included the use of torsemide and sertraline. The combination of these two medications could increase the risk of low sodium levels and sodium levels should be monitored. National Library of Medicine defines low blood sodium as levels lower than 135. Resident 4's Labs report from 2/2025 through 3/15/25 revealed on 3/5/25 her/his sodium level was low at 130. Resident 4's 6/2026 MAR included she/he was administered torsemide (removes excess fluid) and sertraline (antidepressant) daily. On 6/4/26 at 2:20 PM Staff 3 (LPN Resident Care Manager) stated Resident 4 often had her/his laboratory tests obtained during dialysis. Staff 3 verified Resident 4's last documented sodium level was on 3/5/25. On 6/4/26 at 4:16 PM Staff 2 (DNS) stated each resident's physician provided standing orders for routine laboratory tests. Staff 2 stated Resident 4 did not have standing orders for routine laboratory tests, verified on 3/5/25 her/his sodium was low, and no additional sodium levels were ordered or obtained after 3/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385275	A. Building B. Wing	06/05/2026

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review it was determined the facility had a medication error rate of greater than 5%. The facility error rate was with 32 percent with 8 errors in 25 opportunities. This placed resident at risk for adverse medication regimen. Findings include: Resident 16 was admitted to the facility in 4/2026 with a diagnosis including diabetes. Resident 16's 4/27/26 admission MDS revealed she/he was cognitively intact On 6/2/26 at 8:56 AM Staff 19 (CMA) was observed to prepare Resident 16's medications, enter Resident 16's room, place her/his medicine cup with the prepared medications on her/his computer table, then Staff 19 exited her/his room. The medications which were left on the bedside table included: -amlodipine (treats high blood pressure)-atorvastatin (anti-lipid)-disulfiram (treats alcohol use disorder)-Biktarvy (anti-viral medication)-vitamin B12 (Supplement)-Farxiga (treats heart failure)-metformin (treats diabetes)-multvitamin (supplement)-Omeprozole (treats reflux disease)After Staff 19 left the room, this surveyor asked if Resident 16 was assessed to self-administer medications. Staff 19 stated Resident 16 did not have an assessment to leave medications at bedside, returned to her/his room, and requested Resident 16 to consume the medications. On 6/3/26 at 3:43 PM Staff 2 (DNS) stated medications were not to be left at the bedside unless a resident was assessed to be safe, had orders to leave at the bedside, and was reflected on the care plan. Staff 2 acknowledged leaving medications at the bedside was considered a medication error.