STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E040	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Mountain Care Center	112 East Fifth Street Prairie City, OR 97869

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record it was determined the facility failed to follow a comprehensive care plan related to transfers for 1 of 4 sampled residents (#4) reviewed for transfers. This placed residents at risk for unsafe transfers. Findings include: Resident 4 admitted to the facility in 2026 with diagnoses including hip fracture. The 4/13/26 Care Plan indicated Resident 4 required a [NAME]-steady (sit to stand transfer device) for transfers. A 5/12/26 email from Staff 6 (OT) to Staff 3 (RNCM) indicated Resident 4 reported that Staff 5 (LPN) transferred her/him from the recliner to the wheelchair without using the [NAME]-steady. The resident did not report any injury. The resident's Care Plan indicated she/he was to be transferred using the sara0steady. The email further indicated Resident 4 was not to be transferred any other way than by using the [NAME]-steady. On 5/27/26 at 10:39 AM Staff 6 stated Resident 4 reported to her that she/he was transferred by stand pivot instead of the [NAME]-steady by nursing staff. On 5/27/26 at 1:09 PM Resident 4 stated she/he used the [NAME]-steady for transfers. Resident 4 stated on the day of the incident she/he was getting ready go to lunch when Staff 5 offered to assist her/him. The resident stated Staff 5 grabbed her/him and the resident put her/his hands on his shoulders while Staff 5 transferred her/him from the recliner to the wheelchair. Resident 4 stated she/he was not used to being transferred that way and no injury occurred. The resident further stated Staff 5 did not ask what her/his transfer status was and just did it. On 5/27/26 at 2:16 PM Staff 5 stated he did assist Resident 4 with a transfer from the recliner to the wheelchair by giving the resident like a bear hug and had the resident stand and pivot on her/his own. Staff 5 stated he assumed Resident 4 was a one person assist with transfers because he saw the resident work with one person in therapy and the resident was able to stand on her/his own. Staff 5 stated he was not aware Resident 4 required a [NAME]-steady for transfers. Staff 5 stated if the Care Plan indicated the resident used a [NAME]-steady for transfers then it should be followed. Staff 5 acknowledged he did not follow Resident 4's care plan for transfers. On 5/28/26 at 10:06 AM Staff 2 (DNS) and Staff 3 acknowledged Staff 5 did not follow Resident 4's Care Plan for transfers.

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to implement interventions related to substance use disorder for 1 of 1 sampled resident (#3) reviewed for safety. This placed residents at risk for uncontrolled substance use disorder. Findings include: Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke and malnutrition.A review of the 3/4/26 signed physician orders revealed Resident 3 received tube feeding through a gastrostomy tube (liquid nutrition, fluids, and medications are delivered directly into the stomach through a small, surgically created opening in the abdomen) and Resident 3's current diet order was NPO (nothing by mouth).The 3/17/26 admission MDS revealed Resident 3 had a BIMS of 15 indicating she/he was cognitively intact. A 4/14/26 Progress Note revealed Resident 3 was observed by Staff 14 (RN) ambulating down the hallway with unsteady gait, red/glossy eyes, odor of alcohol present, and increased drooling from baseline. Resident 3 denied she/he drank alcohol however Staff 14 observed a bottle of whiskey that was about 60% gone in her/his room. Resident 3 stated, I have been sneaking alcohol every day since I got here. Staff 14 educated Resident 3 on the risks of intoxication and aspiration as the resident's current diet order was NPO. Resident 3 refused to go to the hospital for further evaluation and was monitored hourly to ensure her/his safety.A 4/15/26 Physician Progress Note revealed Resident 3 admitted she/he was an alcoholic and was sneaking alcohol into the facility. Resident 3 stated she/he consumed alcohol daily since admission despite facility policies prohibiting that behavior and despite the current NPO diet order, which significantly increased the resident's risk of aspiration. The risks were reviewed with Resident 3.A review of the 4/15/26 Deviation of Care/Risk vs. Benefits revealed Resident 3 admitted to drinking alcohol at the facility despite the NPO diet order in place. Resident 3 was educated on the risks and complications of aspiration, understood the risks and gave consent to proceed.A review of Resident 3's care plan revealed no information related to the resident's current noncompliance of the NPO diet order with alcohol consumption. No interventions were implemented including monitoring for signs and symptoms of substance use disorder.On 5/27/26 at 11:28 AM Staff 5 (LPN) stated Resident 3 was noncompliant with her/his diet order and drank alcohol in the facility. Staff 5 stated he found three empty alcohol containers in Resident 3's room under the sink. Staff 5 said there were no interventions in place related to monitoring the resident's alcohol use.On 5/27/26 at 1:40 PM Staff 10 (CNA) stated she never saw Resident 3 with alcohol in her/his possession and was unaware of any interventions related to the resident's alcohol use.On 5/27/26 at 1:52 PM Staff 12 (CNA) stated about one month ago she observed Resident 3 possibly under the influence of alcohol as Resident 3's gait was more unstable compared to her/his baseline, and the resident smelled of alcohol, so she reported the information to the charge nurse. Staff 12 said there were no interventions in place related to the resident's alcohol use.On 5/27/26 at 1:57 PM Staff 13 (CNA) stated she found empty alcohol bottles in Resident 3's room about three weeks ago and reported it to the charge nurse. Staff 13 said there were no interventions in place related to the resident's alcohol use.On 5/27/26 at 3:17 PM Resident 3 stated she/he consumed alcohol in the facility and stored alcohol in her/his room. Resident 3 stated the facility spoke to her/him about the risks and she/he understood the risks.On 5/27/26 at 4:59 PM Staff 15 (RN) stated she found three empty alcohol bottles in Resident 3's room. Staff 15 stated staff were educated verbally on interventions when Resident 3 was found intoxicated, however the interventions were not documented in the resident's medical record.On 5/27/26 at 5:39 PM Staff 14 stated Resident 3 consumed alcohol in the facility and was found to be intoxicated on her shift. Staff 14 stated she found alcohol in the resident's room that was about a quarter empty. Staff 14 stated Resident 3 was placed on alert charting and monitored hourly; however, there were no interventions in place related to the resident's alcohol use.On 5/28/26 at 12:32 PM Staff 16 (SSD) stated Resident 3 was identified to (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consume alcohol in the facility after her/his admission and exhibited behaviors including sneaking alcohol into the facility and manipulation of staff. Staff 16 stated she was unsure how staff were made aware of Resident 3's behaviors. Staff 16 acknowledged there were no interventions in place related to the resident's alcohol use.On 5/28/26 at 1:51 PM Staff 2 (DNS) stated Resident 3's medical record needed to include interventions such as signs and symptoms of intoxication and acknowledged interventions were not implemented related to the resident's alcohol use and potential substance use disorder.