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	08/15/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to ensure professional standards were followed for 1 of 1 RN (Staff 2) reviewed for medications and pressure ulcers. This placed residents at risk for adverse medication reactions and worsening of wounds. Findings include: The Oregon State Board of Nursing Scope of Practice Standards for Registered Nurses ([NAME] [PHONE NUMBER]) outlined standards related to the Registered Nurse's responsibility for nursing practice implementation. Applying nursing knowledge . the Registered Nurse shall implement the plan of care by: - Implementing treatments and therapy, appropriate to the context of care, including emergency measures, interpretation of medical orders, medication administration, independent nursing activities, nursing, medical and interdisciplinary orders, health teaching and health counseling; - Documenting nursing interventions and responses to care in an accurate, timely, thorough, and clear manner. The Oregon State Board of Nursing Conduct Derogatory to the Standards of Nursing ([NAME] [PHONE NUMBER]) outlined nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following: - Failing to develop, implement and/or follow through with the plan of care; - Accepting an assignment when individual competency necessary to safely perform the assignment has not been established or maintained; - Entering inaccurate, incomplete, falsified, fabricated or altered documentation into a health record. 1. Resident 164 readmitted to the facility on [DATE] with diagnoses including post-surgical care for a toe amputation. On 8/13/24 at 3:27 PM Staff 2 (DNS) stated he received Resident 164's admission physician orders on 8/2/24 and did not implement the orders prior to leaving the facility for the day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 3:49 PM Staff 1 (Administrator) stated on 8/2/24 around 9:00 AM she requested Staff 2 to review Resident 164's admission physician orders prior to the resident's arrival and to implement the orders. Staff 1 further stated Staff 2 left the building on 8/2/24 around 3:00 PM and she was unaware admission physician orders were not implemented. Staff 1 acknowledged admission physician orders were not implemented for three days after Resident 164 admitted to the facility. Refer to F684. 2. Resident 8 admitted to the facility on [DATE] with diagnoses including diabetes and a sacral fracture. On 8/10/24 Resident 8 was identified to have a new wound to her/his left buttock. On 8/14/24 at 12:34 PM Staff 2 (DNS) stated he was hired on 7/26/24 at the facility. Staff 2 stated Staff 3 (RNCM) completed skin assessments on 7/30/24, prior to her leaving for vacation and he had not completed skin assessments for any resident. On 8/15/24 at 11:59 AM Staff 2 assessed Resident 8's left buttock wound (five days after wound was identified.) On 8/15/24 at 3:18 PM Staff 3 (RNCM) stated she was in charge of completing skin assessments but had been on vacation since the end of July. Staff 3 further stated floor nurses did not usually complete skin assessments and the expectation was for Staff 2 to complete skin assessments. Refer to F686.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34324 Based on observation, interview, and record review it was determined the facility failed to provide nail care to dependent residents for 2 of 2 sample residents (#s 10 and 11) reviewed for ADLs. This placed residents at risk for lack of grooming and skin impairments. Findings include: 1. Resident 10 admitted to the facility in 2021 with diagnoses including kidney disease. The 7/26/21 Care Plan indicated Resident 10 required ADL assistance by staff for personal hygiene. Review of Resident 10's clinical medical record revealed no documented evidence for when the resident's nail care was to be provided. Observations made on 8/13/24 at 9:20 AM and on 8/14/24 at 9:30 AM revealed Resident 10 with long fingernails. Some of the fingernails were curved down, touching the nail bed. Resident 10 was unable to state when her/his fingernails were last trimmed. On 8/14/24 at 9:24 AM Staff 6 (CNA) stated resident nail care was to be done on shower days and as needed. Staff 6 stated nail care was documented in Tasks under personal hygiene and there was no specific place to document when nail care was completed. Staff 6 acknowledged Resident 10's nails were long and curved down. On 8/14/24 at 9;43 AM Staff 2 (DNS) stated the expectation was for nursing staff to complete nail care even for non-diabetic residents. Staff 2 acknowledged Resident 10's nails were long, curved and needed to be trimmed. 2. Resident 11 admitted to the facility in 2023 with diagnoses including dementia with moderate cognitive impairment. The 8/29/23 Care Plan indicated Resident 11 required assistance with ADL care related to her/his dementia. Interventions included to check nail length and trim and clean on bath days and as needed. Review of Resident 11's clinical record revealed no documented evidence for when the resident's nail care was to be provided. On 8/13/24 at 9: 20 AM Resident 11 stated her/his fingernails were not trimmed often enough and could not recall the last time her/his nails were trimmed. Resident 11 stated her/his fingernails were much longer than she/he was use too or normally had them. Resident 11 stated staff had not asked if she/he wanted her/his fingernails trimmed. On 8/14/24 at 9:24 AM Staff 6 (CNA) stated resident nail care was to be done on shower days and as needed. Staff 6 stated nail care was documented in Tasks under personal hygiene and there was no specific place to document when nail care was completed. Staff 6 acknowledged Resident 11's nails were on the longer side and staff were to be checking resident fingernails routinely. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 9:43 AM Staff 2 (DNS) stated the expectation was for nursing staff to complete nail care even for non-diabetic residents. Staff 2 acknowledged Resident 11's nails were long and needed to be trimmed.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to implement physician orders upon admission for 1 of 1 sampled residents (#164) reviewed for medications. This placed residents at risk for adverse medication reactions. Findings include: Resident 164 readmitted to the facility on [DATE] with diagnoses including post-surgical care for a toe amputation. The 8/2/24 hospital discharge orders indicated Resident 164 was to receive the following medications: -doxycycline (an antibiotic medication) 100 mg; 1 tablet BID. 8/3/24 PM dose was missed. -losartan (a hypertension medication) 25 mg; 1 tablet BID. 8/3/24 PM dose was missed. -pravastatin (a cholesterol medication) 40 mg; 1 tablet one time a day. 8/3/24 dose was missed. The MAR and 8/3/24 progress note indicated Resident 164 did not receive one dose of doxycycline, one dose of losartan, and one dose of pravastatin. An 8/3/24 at 4:58 PM progress note revealed Staff 5 (RN) was unable to resume many meds and documented in the progress note the medications given to the resident. An 8/4/24 at 6:10 AM progress note revealed there were no orders in the resident's chart. On 8/13/24 at 3:27 PM Staff 2 (DNS) stated he received Resident 164's admission physician orders on 8/2/24 and did not implement the orders prior to leaving the facility for the day. On 8/15/24 at 3:49 PM Staff 1 (Administrator) stated on 8/2/24 around 9:00 AM she requested Staff 2 to review Resident 164's admission physician orders prior to the resident's arrival and to implement the orders. Staff 1 further stated Staff 2 left the building on 8/2/24 around 3:00 PM and she was unaware admission physician orders had not been implemented. Staff 1 acknowledged admission physician orders were not implemented for three days after Resident 164 admitted to the facility and did not receive the identified medications.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48830

Based on interview and record review it was determined the facility failed to initially assess and monitor pressure ulcers for 2 of 2 sampled residents (#s 6 and 8) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers and unassessed treatment needs. Findings include:

1. Resident 8 admitted to the facility on ,d+[DATE] with diagnoses including diabetes and a sacral fracture.

The 5/20/24 Admission Nursing Database indicated Resident 8 did not have any wounds present.

The 5/20/24 care plan indicated the resident had a potential impairment to skin integrity related to diabetes and fragile skin. Interventions included to encourage and assist resident to change positions frequently; notify nurse of new skin issues; and follow facility protocols for treatment of injury.

The 8/2024 TAR revealed the facility implemented a standing order for wound care on 8/10/24 for a wound to Resident 8's left buttock.

The 8/11/24 at 4:36 AM progress note indicated wound care was completed to an open area on Resident 8's left buttock. It was noted there was no drainage, the area was cleaned and covered.

On 8/14/24 at 12:34 PM Staff 2 (DNS) stated he was hired on 7/26/24 at the facility. Staff 2 stated Staff 3 (RNCM) completed skin assessments on 7/30/24, prior to her leaving for vacation and he had not completed skin assessments for any resident.

The 8/15/24 at 11:59 AM progress note revealed Staff 2 assessed Resident 8's left buttock wound (five days after the wound was identified.) The progress note indicated Resident 8 had a Stage 2 pressure ulcer on the left inner gluteal (muscles that make up the buttock area) that measured 1.2 inches long, .5 inches wide, and 0 inches deep with no visual drainage or odor. Four Stage 2 pressure ulcers to the left forearm were also identified and measured.

The 8/15/24 at 12:49 PM Weekly Wound Observation Tool completed by Staff 2 indicated Resident 8 had a Stage 2 pressure ulcer on the left gluteal and left forearm, slough tissue was present (yellow/white material in the wound bed) and the wounds were facility acquired on 5/15/24. The measurements were 20 mm long, 13 mm wide, 02 mm deep and had minimal drainage with a slight odor. The measurements and wound appearance did not identify which wound it was for.

On 8/15/24 at 2:47 PM Staff 2 was asked about the discrepancy of wound measurements between Resident 8's progress note and the Weekly Wound Observation Tool note. Staff 2 stated the 8/15/24 at 11:59 AM progress note was the most accurate. Staff 2 stated he had wound care training, but it had been about ten years since he had assessed wounds.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 8/15/24 at 3:18 PM Staff 3 (RNCM) stated she was in charge of completing skin assessments but had been on vacation since the end of July. Staff 3 further stated floor nurses did not usually complete skin assessments and the expectation was for Staff 2 to complete skin assessments.

34702

2. Resident 6 readmitted to the facility in 2023 with diagnoses including a Stage 4 pressure ulcer of the sacral region.

On 8/14/24 a review of Resident 6's clinical record indicated the Weekly Wound Observation Tool was completed on 7/30/24. There was no indication additional weekly wound assessments were completed after 7/30/24.

On 8/14/24 at 11:51 AM Staff 2 (DNS) stated Staff 3 (RNCM) completed skin assessments on 7/30/24, prior to her leaving for vacation and he had not completed skin assessments for Resident 6.

The 8/15/24 12:16 PM progress note by Staff 5 (RN) indicated Resident 6 had a dressing change to the coccyx and the wound measured 2.4 cm long, 1.2 cm wide and 1 cm deep.

The 8/15/24 2:01 PM Weekly Wound Observation Tool completed by Staff 5 indicated Resident 6 had a Stage 4 pressure ulcer on the coccyx measured 20 mm long, 20 mm wide, and 1 mm deep.

On 8/15/24 at 2:34 PM Staff 5 (RN) was asked about the discrepancy of wound measurements between Resident 6's progress note and the Weekly Wound Observation Tool note. Staff 5 reviewed the progress note and Weekly Wound Observation Tool and stated she completed the dressing change and measurements for Resident 6. Staff 5 then reviewed her handwritten notes and stated the measurements of the wound from her notes were 19 cm long, 20 cm wide, and 0.9 cm deep. Staff 5 acknowledged there were discrepancies between the progress note, the Weekly Wound Observation Tool note and her handwritten notes. Staff 5 stated she had not completed wound measurements at this facility previously.

On 8/15/24 at 3:18 PM Staff 3 (RNCM) stated she was in charge of completing skin assessments but had been on vacation since the end of July. Staff 3 further stated floor nurses did not usually complete skin assessments and the expectation was for Staff 2 to complete skin assessments.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to obtain ordered medications timely for 2 of 6 sampled residents (#s 1 and 7) reviewed for medications. This placed residents at risk for not receiving prescribed medications. Findings include: 1. Resident 1 admitted to the facility in 2018 with diagnoses including chronic kidney disease. The 8/9/24 physician order indicated Resident 1 had a UTI and to start Keflex (antibiotic) 500 mg TID for seven days. The 8/2024 MAR indicated Resident 1 did not receive Keflex on the following dates and times: -8/10/24 8:00 PM -8/11/24 7:00 AM -8/11/24 12:00 PM -8/11/24 8:00 PM -8/12/24 7:00 AM -8/12/24 12:00 PM On 8/15/24 at 12:29 PM Staff 2 (DNS) acknowledged Resident 1 did not receive Keflex as ordered on the identified dates. Staff 2 was observed to check the electronic medication dispensing system for availability of Keflex and stated he was unsure of how to check for inventory and availability of medication. Staff 2 stated he thought the medications were automatically refilled by the pharmacy. Staff 1 (Administrator) stated there was a breakdown in the reordering process for medications by nursing staff. 2. Resident 7 admitted to the facility in 2023 with diagnoses including diabetes. The 8/12/24 hospital discharge summary indicated Resident 7 had a UTI and was to start cephalexin (antibiotic) 500 mg four times daily for 7 days. The 8/2024 MAR indicated Resident 7 was to receive cephalexin at 7:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. Resident 7 did not receive the first dose of cephalexin until 8/13/24 at 5:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 12:29 PM Staff 2 (DNS) acknowledged Resident 7 readmitted to the facility on [DATE] and did not receive the first dose of cephalexin until 8/13/24 at 5:00 PM. Staff 2 was observed to check the electronic medication dispensing system for availability of cephalexin and stated he was unsure of how to check for inventory and availability of medication. Staff 2 stated he thought the medications were automatically refilled by the pharmacy. Staff 1 (Administrator) stated there was a breakdown in the reordering process for medications by nursing staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to address pharmacist recommendations in a timely manner for 3 of 5 sampled residents (#s 6, 8 and 12) reviewed for unnecessary medications. This placed residents at risk for unnecessary medication administration. Findings include: 1. Resident 8 admitted to the facility on ,d+[DATE] with diagnoses including depression. A 7/8/24 Pharmacy Review indicated Resident 8 received mirtazapine (an antidepressant) 7.5 mg at bedtime. The recommendation was to discontinue this medication. On 8/6/24, (29 days later), the physician agreed with the pharmacy recommendation. A review of the 8/2024 MAR indicated Resident 8 received the last dose of mirtazapine 7.5 mg at bedtime on 8/6/24. On 8/15/24 at 3:11 PM Staff 3 (RNCM) stated the expectation was for the physician to address the pharmacy recommendations within two weeks and implement the recommendations. Staff 3 acknowledged Resident 8 had a pharmacy recommendation on 7/8/24 and it was not signed by the physician until 8/6/24. 34702 2. Resident 6 readmitted to the facility in 2023 with diagnoses including anxiety disorder. Resident 6's 6/26/24 pharmacy recommendation indicated the following: -Resident 6 received trazodone (antidepressant) 100 mg at bedtime, diazepam (antianxiety) 2 mg at bedtime and duloxetine (antidepressant) 60 mg daily. -Consider changing diazepam to lorazepam 1 mg at bedtime. Diazepam is long lasting and considered potentially inappropriate medication for use in older adults and should be avoided due to the high risk of adverse reactions. The recommendation was not signed by the physician until 7/31/24 (35 days later) and indicated to discontinue diazepam and start lorazepam 1 mg QHS PRN. On 8/14/24 at 10:54 AM and 8/15/24 at 3:18 PM Staff 3 (RNCM) stated the expectation was for the physician to follow up on pharmacy recommendations within two weeks. Staff 3 acknowledged Resident 6 had a pharmacy recommendation on 6/26/24 and it was not signed by the physician until 7/31/24. 34324 3. Resident 12 admitted to the facility in 2024 with diagnoses including heart disease, bipolar and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/26/24 Pharmacy Review indicated Resident 12 received Quetiapine (antipsychotic), Citalopram (anti-depressant) and trazodone (anti-depressant). The medications had a potential to prolong the QT interval (heart rhythm) and put the resident at risk for torsade de pointes (fast heart rhythm), ventricular tachycardia (quick beats in the lower heart chambers) and ventricular fibrillation (fast, inadequate heartbeat). A recommendation to monitor for heart palpitations, shortness of breath, chest pain, lightheadedness and fainting as well as an EKG every six months was recommended. On 7/3/24 the physician responded and agreed with the recommendations. Review of Resident 12's clinical record revealed no documented evidence the resident's recommendations were addressed. On 8/15/24 at 3:15 PM Staff 3 (RNCM) acknowledged she had not followed up with the physician and addressed the agreed upon pharmacy recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34702 Based on observation, interview and record review it was determined the facility failed to maintain a medication error rate of less than five percent. There were five errors in 26 opportunities resulting in a 19 percent error rate. This placed residents at risk for adverse medication side effects. Findings include: 1. Resident 164 admitted to the facility in 8/2024 with diagnoses including diabetes. The 6/5/24 physician order indicated Resident 164 was to receive Novolin R (insulin) seven units before meals. The manufacturer instructions for Novolin R indicated to prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/13/24 at 12:18 PM Staff 4 (RN) was observed to administer seven units of Novolin R via insulin pen to Resident 164. Staff 4 did not prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/13/24 at 12:55 PM Staff 4 acknowledged she did not prime the insulin pen prior to administration and stated she was not aware the Novolin R insulin pen needed to be primed. 2. Resident 8 readmitted to the facility in 2024 with diagnoses including diabetes. The 7/11/24 and 8/2/24 physician orders indicated Resident 8 was to receive the following: -insulin lispro five units before meals. -insulin lispro sliding scale if CBG: 0-149 zero units and 250-299 five units before meals. The manufacturer instructions for the insulin lispro pen indicated to prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/13/24 at 12:37 PM Staff 4 (RN) was observed to check Resident 8's CBG and it was 254. Staff 4 was observed to administer ten units of insulin lispro via insulin pen to Resident 8. Staff 4 did not prime the insulin pen with the two units recommended by the manufacturer prior to administering the insulin lispro. On 8/13/24 at 12:55 PM Staff 4 acknowledged she did not prime the insulin pen prior to administration and stated she was not aware the insulin lispro pen needed to be primed. On 8/15/24 at 8:16 AM Staff 5 (RN) was observed to check Resident 8's CBG and it was 117. Staff 5 was observed to administer five units of insulin lispro via insulin pen to Resident 8. Staff 5 did not prime the insulin pen with the two units recommended by the manufacturer prior to administering the insulin lispro. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/15/24 at 8:29 AM Staff 5 acknowledged she did not prime the insulin pen prior to administration and stated she was not aware the insulin lispro pen needed to be primed. 3. Resident 1 admitted to the facility in 2018 with diagnoses including chronic kidney disease. The 7/19/24 diagnoses were updated to included diabetes. The 8/2/24 physician order indicated Resident 1 was to receive Lantus (insulin) 15 units once daily. The manufacturer instructions for the Lantus insulin pen indicated to prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/15/24 at 7:48 AM Staff 5 (RN) was observed to administer 15 units of Lantus insulin via insulin pen to Resident 1. Staff 5 did not prime the insulin pen with the two units recommended by the manufacturer prior to administering the Lantus insulin. On 8/15/24 at 8:29 AM Staff 5 acknowledged she did not prime the insulin pen prior to administration and stated she was not aware the Lantus insulin pen needed to be primed. 4. Resident 3 admitted to the facility in with diagnoses including atrial fibrillation (irregular heart rhythm). The 7/31/24 physician order indicated Resident 3 was to receive diltiazem (antiarrhythmic heart medication) 240 mg once daily for atrial fibrillation and to hold the medication if the blood pressure was less than 100/60 or the heart rate was less than 60. On 8/15/24 at 8:14 AM Staff 5 (RN) was observed to administer morning medications to Resident 3. Staff 5 stated Resident 3's blood pressure and heart rate were taken at approximately 7:10 AM and she/he had a blood pressure of 127/63 and a pulse of 70. Staff 5 stated she held the diltiazem even though the blood pressure and pulse were within the parameters to administer the medication.

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	08/15/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to ensure medical records were accurate for 2 of 2 sampled residents (#s 6 and 8) reviewed for pressure ulcers. This placed residents at risk for inaccurate wound measurements. Findings include: 1. Resident 8 admitted to the facility on ,d+[DATE] with diagnoses including diabetes and a sacral fracture. The 8/15/24 at 11:59 AM progress note by Staff 2 (DNS) indicated Resident 8 had a Stage 2 pressure ulcer on the left inner gluteal (muscles that make up the buttock area) that measured 1.2 inches long, .5 inches wide, and 0 inches deep with no visual drainage or odor. Four Stage 2 pressure ulcers to the left forearm were also identified and measured. The 8/15/24 at 12:49 PM Weekly Wound Observation Tool completed by Staff 2 indicated Resident 8 had a Stage 2 pressure ulcer on the left gluteal and left forearm, slough tissue was present (yellow/white material in the wound bed), and the wounds were facility acquired on 5/15/24. The measurements were 20 mm long, 13 mm wide, 02 mm deep and had minimal drainage with a slight odor. The measurements and wound appearance did not identify which wound it was for. On 8/15/24 at 2:47 PM Staff 2 was asked about the discrepancy of wound measurements between Resident 8's progress note and the Weekly Wound Observation Tool note. Staff 2 stated the 8/15/24 at 11:59 AM progress note was the most accurate. 34702 2. Resident 6 readmitted to the facility in 2023 with diagnoses including a Stage 4 pressure ulcer of the sacral region. The 8/15/24 12:16 PM progress note by Staff 5 (RN) indicated Resident 6 had a coccyx wound that measured 2.4 cm long, 1.2 cm wide and 1 cm deep. The 8/15/24 2:01 PM Weekly Wound Observation Tool indicated Resident 6 had a Stage 4 pressure ulcer on the coccyx that measured 20 mm long, 20 mm wide, and 1 mm deep. On 8/15/24 at 2:34 PM Staff 5 (RN) was asked about the discrepancy of wound measurements between Resident 6's progress note and the Weekly Wound Observation Tool note. Staff 5 reviewed the progress note and Weekly Wound Observation Tool and stated she completed the dressing change and measurements for Resident 6. Staff 5 then reviewed her handwritten notes and stated the measurements of the wound from her notes were 19 cm long, 20 cm wide, and 0.9 cm deep. Staff 5 acknowledged there were discrepancies between the progress note, the Weekly Wound Observation Tool note and her handwritten notes.