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	10/17/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, and record review it was determined the facility failed to ensure a licensed nurse was on duty for 1 of 2 days reviewed for licensed nurse staffing. This placed residents at risk for delayed and unmet medical needs. Findings include: On 10/14/25 at 6:07 PM Staff 17 (Former DNS) stated there was one occasion on 8/6/25 or 8/7/25 when there was no nurse working on night shift. On 10/15/25 at 9:43 AM a request was made from Staff 1 (Administrator) for the Direct Care Staff Daily Reports and the daily staff assignment sheets from 8/6/25 and 8/7/25.On 10/15/25 at 10:18 AM Staff 21 (Quality Coordinator) stated she was unable to locate the daily staff assignment sheets for 8/6/25 and 8/7/25. On 10/15/25 at 2:18 PM Staff 1 stated she was unable to locate the Direct Care Staff Daily Reports for 8/6/25 and 8/7/25.On 10/15/25 at 4:00 PM Staff 1 stated the facility did not have a nurse working night shift on 8/7/25.

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to ensure a registered nurse was available for at least eight consecutive hours for 3 of 17 days reviewed for RN coverage. This placed residents at risk for delayed nursing assessments. Findings include:A review of the Direct Care Staff Daily Reports for 9/1/25 and 10/1/25 through 10/16/25 revealed the following dates without the required RN coverage:-9/1/25-10/6/25-10/7/25On 10/16/25 at 4:53 PM Staff 1 (Administrator) acknowledged the identified dates without the required RN coverage.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to post accurate and complete staffing information and failed to retain required staff postings for 1 of 1 facility reviewed. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include:a. On 10/15/25 at 9:43 AM a request was made from Staff 1 (Administrator) for the Direct Care Staff Daily Reports from 8/1/25 through 10/14/25.On 10/15/25 at 2:18 PM Staff 1 stated she was unable to locate the Direct Care Staff Daily Reports for 8/1/25 through 8/31/25 and 9/2/25 through 9/30/25.b. A review of the Direct Care Staff Daily Reports from 10/1/25 through 10/16/25 revealed 16 of 16 days when portions of the form were left blank, crossed out, or were inaccurate. The incomplete or inaccurate information included the daily census, and the number of working staff.On 10/16/25 at 4:53 PM Staff 1 (Administrator) acknowledged the Direct Care Staff Daily Reports were incomplete and inaccurate for the identified dates.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review it was determined the facility administration failed to use resources effectively and efficiently to attain or maintain the residents' highest practicable physical, mental and psychosocial well being. Deficient practice was noted related to a lack of staffing, a failure to retain staff postings, infection control, physician visits, social services, and resident rights for 1 of 1 facility reviewed for effective administration. Findings include:1.The facility failed to offer the resident/representative opportunities to participate in their care planning process via care conference for four identified residents (#s 3, 4, 6, and 13). On 10/16/25 at 2:07 PM Staff 4 (SSD) acknowledged residents were not being offered an opportunity to participate in the care planning process for the identified residents.Refer to F553.2. The facility failed to report allegations of abuse to the State Agency (SA) and failed to thoroughly investigate the allegation of abuse for one identified resident (#10).On 10/16/25 at 3:26 PM Staff 1 (Administrator) stated she was unaware of what a FRI was. Staff 1 acknowledged Resident 10's allegation of abuse was not reported to the SA and acknowledged the allegation was not thoroughly investigated.Refer to F609 and F610.3.The facility failed to ensure face to face physician visits occurred as required for three identified residents (#s 1, 8, and 11). On 10/16/25 at 9:16 AM Staff 1 (Administrator) stated she believed tele-health (virtual, not in-person) physician visits were acceptable and acknowledged face to face physician visits did not occur for the identified residents.Refer to F712.4. The facility failed to have a qualified and trained infection preventionist in place.On 10/17/2025 at 8:16 AM Staff 1 (Administrator) stated she was unaware of the required qualifications and training for the infection preventionist and just learned on 10/16/25. Staff 1 confirmed the facility did not have a certified infection preventionist from 10/6/25 to present.Refer to F882.5. The facility failed to ensure sufficient staffing was in place to meet resident care needs, failed to post accurate and complete staffing information, and retain required staff postings.a. On 8/7/25 there was no nurse in the facility working on night shift.b. There was no RN coverage as required for 9/1/25, 10/6/25 and 10/7/25.c. The facility had insufficient state-mandated minimum CNA staffing on one or more shifts on 9/1/25, 10/4/25, 10/6/25, 10/12/25, and 10/16/25.d. The facility was unable to locate the August 2025 and September 2025 Direct Care Staff Daily reports. There were 16 days identified in October 2025 with inaccurate and incomplete Direct Care Staff Daily reports.On 10/15/25 at 4:00 PM and 10/16/25 at 4:53 PM Staff 1 (Administrator) acknowledged the identified findings related to the lack of nursing and CNA coverage, and the inaccurate and missing Direct Care Staff Daily reports.F725, F727, and F732.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review it was determined the facility failed to submit mandatory staffing information based on the payroll data journal and other verifiable and auditable data as required. This placed residents at risk for inaccurate staffing information. Findings include:A review of the Payroll Based Journal Staffing Data for Fiscal Year Quarter 1 and Quarter 2 of 2025 (April 1-June 30) indicated the facility failed to submit required data for the two quarters.On 10/15/25 at 2:40 PM Staff 1 (Administrator) confirmed the Payroll-Based Journal was not submitted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to ensure a community use glucometer was properly cleaned and sanitized between resident uses, and the facility failed to develop and conduct a risk analysis assessment for potential areas of growth and spread of water-borne pathogens. This placed residents at risk for exposure to water-borne and blood-borne pathogens. Findings include:1.The blood glucose monitoring system manufacturer instructions indicated to disinfect the meter with EPA-registered wipes. The 4/4/25 facility policy and procedure for blood glucose monitoring machines indicated to clean glucometers according to manufacturer's instructions and/or using an EPA approved germicidal disposable cloth. a. On 10/14/25 at 1:56 PM Staff 3 (LPN) was observed to administer insulin to Resident 11, and stated she checked the resident's CBG previously. On 10/14/25 at 2:09 PM Staff 3 stated she sometimes used alcohol wipes to clean glucometers. b. On 10/16/25 at 11:51 AM Staff 16 (RN) was observed to check Resident 5's CBG using a community use glucometer. Staff 16 placed the glucometer in a basket in the medication cart without cleaning it. On 10/16/25 at 12:09 PM Staff 16 proceeded to Resident 11's table using the same glucometer. The State Surveyor intervened. Staff 16 went back to the medication cart and used an EPA approved wipe to clean the glucometer. Staff 16 acknowledged she did not clean the community use glucometer between resident uses and stated was unaware of the cleaning policy. 2. The Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality/Safety and Oversight Group letter 17-30, revised on 7/6/18, on Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease stated, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. A review of the facility's 8/7/25 Legionella Water Management Policy revealed the following: -The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. On 10/15/2025 at 11:00 AM Staff 18 (Maintenance Director) and Staff 19 (Maintenance) stated they both started at the facility six months ago. Staff 18 and Staff 19 stated the facility did not develop and conduct a risk analysis assessment for potential areas of growth and spread of water-borne pathogens, such as Legionella, in the facility's main water system. On 10/17/2025 at 8:35 AM Staff 1 (Administrator) stated she was unaware the facility did not have a risk analysis assessment in place for the facility's water system.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review it was determined the facility failed to have a qualified and trained infection preventionist in place for 1 of 1 facility reviewed for infection prevention and control. This placed residents at risk for inadequate infection control. Findings include:On 10/13/25 surveyors requested documentation to indicate the facility had an infection preventionist in place.On 10/16/25 at 12:30 PM Staff 14 (IP) stated she started the IP role in October 2024 and did not complete the required training to become qualified. Staff 14 stated Staff 15 (Former IP) was assisting with the facility's Infection Prevention and Control Program until recently.On 10/16/25 at 2:47 PM Staff 5 (Human Resources) provided documentation to indicate Staff 15's last day working in the facility was on 10/5/25.On 10/17/2025 at 8:16 AM Staff 1 (Administrator) stated she was unaware of the required qualifications and training for the infection preventionist and just learned on 10/16/25. Staff 1 confirmed the facility did not have a certified infection preventionist from 10/6/25 to present.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to obtain information related to advance directives and health care decisions for 4 of 4 sampled residents (#s 3, 5, 6 and 12) reviewed for advance directives. This placed residents at risk for not having their health care decisions honored. Findings include: The facility's 2/2009 Philosophy Statement form located in the admission packet included information related to advance directives. The form included questions related to if the resident already had an advanced directive in place or if information was provided and was accepted or declined. The form included a signature for the resident or responsible party to sign. 1. Resident 5 admitted to the facility on [DATE] with diagnoses including diabetes. A review of the resident's clinical record revealed no indication an advanced directive was reviewed or offered. On 10/15/25 at 1:35 PM Resident 5 stated she/he did not know what an advance directive was and was never offered or provided with any information about it. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated a POLST (Physician Orders for Life-Sustaining Treatment) was completed upon admission and there was no one to ask regarding the process for offering and completing an advance directive with residents. Staff 4 was informed there was no information found in Resident 5's clinical record of an advance directive being reviewed or offered. No further information was provided. 2. Resident 6 admitted to the facility on [DATE] with diagnoses including depression. A review of the resident's clinical record revealed no indication an advanced directive was reviewed or offered. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated a POLST (Physician Orders for Life-Sustaining Treatment) was completed upon admission and there was no one to ask regarding the process for offering and completing an advance directive with residents. Staff 4 was informed there was no information found in Resident 6's clinical record of an advance directive being reviewed or offered. No further information was provided. 3. Resident 3 admitted to the facility in 9/2024 with diagnoses including heart failure. The facility's 2/2009 Philosophy Statement form located in the clinical record indicated Resident 3 had an advance directive. There was no indication the facility obtained a copy of the advance directive. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated a POLST (Physician Orders for Life-Sustaining Treatment was completed upon admission and there was no one to ask regarding the process for offering and completing an advance directive with residents. Staff 4 was informed no information was located in Resident 3's clinical record for the advance directive. No further (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information was provided. 4. Resident 12 admitted to the facility in 2015 with diagnoses including heart failure and depression. A review of the 9/5/23 care plan revealed staff were to offer education to Resident 12 and her/his legal representative regarding an Advance Directive quarterly with the Care Conference, and as needed. A review of the resident's clinical record, including Care Conferences, revealed no indication an advanced directive was reviewed or offered quarterly. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated a POLST (Physician Orders for Life-Sustaining Treatment) was completed upon admission and there was no one to ask regarding the process for offering and completing an advance directive with residents. Staff 4 was informed no information was found in Resident 12's clinical record of an advance directive being reviewed or offered quarterly. No further information was provided.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review it was determined the facility failed to ensure long term residents received physician visits every 90 days for 3 of 4 sampled residents (#s 1, 8 and 11) reviewed for unnecessary medications and nutrition. This placed residents at risk for unassessed needs. Findings include:1. Resident 1 admitted to the facility in 8/2023 with diagnoses including dementia and muscle weakness. A review of the clinical record indicated Resident 1 received telehealth (virtual, not in-person) physician visits and the last in-person physician visit was on 2/18/25. On 10/15/25 at 9:16 AM Staff 13 (Former Administrator) stated physician visits were completed via telehealth. On 10/16/25 at 9:16 AM Staff 1 (Administrator) stated she believed only telehealth physician visits were acceptable. Staff 1 acknowledged Resident 1's last face to face physician visit was on 2/18/25. 2. Resident 8 admitted to the facility in 11/2024 with diagnoses including dementia and hypertension. A review of the clinical record indicated Resident 8 received telehealth physician visits and the last face to face physician visit was on 1/21/25. On 10/15/25 at 9:16 AM Staff 13 (Former Administrator) stated physician visits were completed via telehealth. On 10/16/25 at 9:16 AM Staff 1 (Administrator) stated she believed telehealth physician visits were acceptable. Staff 1 acknowledged Resident 8's last face to face physician visit was on 1/21/25. 3. Resident 11 admitted to the facility in 2023 with diagnoses including diabetes and dementia. Review of the clinical record indicated Resident 11 received telehealth physician visits and the last face to face physician visit the resident was on 1/21/25. On 10/15/25 at 9:16 AM Staff 13 (former Administrator) stated physician visits were completed via telehealth. On 10/16/25 at 9:16 AM Staff 1 (Administrator) stated she believed telehealth physician visits were acceptable. Staff 1 acknowledged Resident 11's last face to face physician visit was on 1/21/25.

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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. Based on interview and record review it was determined the facility failed to inform residents and/or resident's responsible party of the risks and benefits, and to ensure consent was obtained, for the use of psychotropic medications for 1 of 5 sampled residents (#6) reviewed for unnecessary medications. This placed residents at risk for lack of informed consent of psychotropic medications. Findings include:Resident 6 admitted to the facility in 2025 with diagnoses including depression and insomnia.An 8/19/25 and 9/25/25 physician order indicated the following medications to be administered to Resident 6:- Trazadone (antidepressant) for insomnia- Sertraline (antidepressant) for depression- Bupropion ((antidepressant) for depressionA review of the clinical record revealed no indication the risks and benefits of the antidepressant medication was reviewed, or consent was obtained from Resident 6.On 10/15/25 at 12:00PM Staff 1 (Administrator) stated she was unable to locate any information to indicate the risks and benefits was reviewed, or a consent was obtained by Resident 6, for the three identified medications.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer the resident/representative the opportunity to participate in the care planning process for 4 of 5 sampled residents (#s 3, 5, 6 and 13) reviewed for care planning. These failures placed residents at risk for lack of knowledge and input for the care planning process. Findings include:1. Resident 5 admitted to the facility on [DATE] with diagnoses including diabetes. Review of Resident 5's clinical record revealed no indication a care conference was offered or completed since admission. On 10/15/25 at 1:35 PM Resident 5 stated she/he had never had a care conference to review her/his care plan and was interested in having a care conference if it was offered. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated she was unable to locate in the clinical records any indication care conferences were completed to review a residents' care plan. Staff 4 stated there was no process in place to involve residents in their plan of care. Staff 4 acknowledged Resident 5 was not involved in her/his plan of care. 2. Resident 6 admitted to the facility on [DATE] with diagnoses including depression. Review of Resident 6's clinical record revealed no indication an initial care conference was offered or completed since admission. On 10/14/25 at 12:33 PM Resident 5 stated she/he did not know what a care conference was and stated she/he had never been offered one to go over her/his care plan. Resident 5 stated she/he would be interested in having a care conference if it as offered. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated she was unable to locate in the clinical records any indication care conferences were completed to review the resident's care plan. Staff 4 stated there was no process in place to involve residents in their plan of care. Staff 4 acknowledged Resident 6 was not involved in her/his plan of care. 3. Resident 3 admitted to the facility in 9/2024 with diagnoses including heart failure. There was no indication in the clinical record to indicate Resident 3 was offered a care conference since admission. On 10/14/2025 at 9:26 AM Resident 3 stated she/he would like to attend a care conference and did not recall attending one in the past. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated she was unable to locate in the clinical records any indication care conferences were completed to review the resident's care plan. Staff 4 stated there was no process in place to involve residents in their plan of care. Staff 4 acknowledged Resident 3 was not involved in her/his plan of care. 4. Resident 13 admitted to the facility in 11/2024 with diagnoses including heart failure. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no indication in the clinical record to indicate Resident 13 was offered a care conference since admission. On 10/14/25 at 9:43 AM Resident 13 stated the facility did not offer care conferences and she/he wished to attend a care conference. On 10/16/25 at 2:07 PM Staff 4 (Social Services) stated she was unable to locate in the clinical records any indication care conferences were completed to review the resident's care plan. Staff 4 stated there was no process in place to involve residents in their plan of care. Staff 4 acknowledged Resident 13 was not involved in her/his plan of care.

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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 report an allegation of abuse to the State Agency (SA) within the mandated timeframe for 1 of 1 sampled resident (#10) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 10 admitted to the facility in 2/2021 with diagnoses including stroke and weakness.The 7/28/25 Quarterly MDS indicated Resident 10 had a BIMS of 15, which indicated she/he was cognitively intact.On 10/16/25 between 10:50 AM and 11:16 AM Witness 1 (Anonymous Staff), Witness 2 (Anonymous Staff) and Witness 3 (Anonymous Staff) indicated there were concerns when Staff 12 (LPN) locked the door when Resident 10 went out of the facility and did not allow her/him to re-enter the building. Witness 3 stated Staff 12 told Resident 10, You are not the most important resident here. We can't stop what we are doing and open the door. Witness 3 indicated Resident 10 started crying, and the incident was reported to Staff 2 (DNS).On 10/16/25 at 11:07 AM Resident 10 stated about a month ago Staff 12 was working night shift and when the resident left the facility at 4:40 AM, Staff 12 did not allow her/him back in and she/he had to wait until day shift arrived at 7:00 AM to re-enter the building. Resident 10 stated she was upset after the incident and Staff 12 was rude to her/him. On 10/16/25 at 12:47 PM Staff 2 (DNS) stated it was reported to her by staff that Staff 12 did not let Resident 10 in the door when she/he knocked and called, and the incident happened on night shift a couple weeks ago. Staff 12 stated it seemed like a former staff was involved. Staff 2 stated she did not specifically ask Resident 10 about being locked out of the facility, did not interview the resident, did not complete an investigation, and did not report this incident to the State Agency. Staff 2 stated she was unaware she needed to report this incident and any allegation of verbal abuse to the State Agency.On 10/16/25 3:26 PM Staff 1 (Administrator) stated she was aware of Resident 10 having concerns about getting in and out of the facility when Staff 12 worked. Staff 1 stated the incident was not reported to the State Agency and she was not aware of what a facility reported incident was.

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	38E040	A. Building B. Wing	10/17/2025

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to thoroughly investigate allegations of abuse for 1 of 1 sampled resident (#10) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 10 admitted to the facility in 2/2021 with diagnoses including stroke and weakness.The 7/28/25 Quarterly MDS indicated Resident 10 had a BIMS of 15, which indicated she/he was cognitively intact.On 10/16/25 between 10:50 AM and 11:16 AM Witness 1 (Anonymous Staff), Witness 2 (Anonymous Staff) and Witness 3 (Anonymous Staff) indicated there were concerns when Staff 12 (LPN) locked the door when Resident 10 went out of the facility and did not allow her/him to re-enter the building. Witness 3 stated Staff 12 told Resident 10, You are not the most important resident here. We can't stop what we are doing and open the door. Resident 10 started crying and the incident was reported to Staff 2 (DNS).On 10/16/25 at 11:07 AM Resident 10 stated about a month ago Staff 12 was working night shift and when the resident left the facility at 4:40 AM, Staff 12 did not allow her/him back in and she/he had to wait until day shift arrived at 7:00 AM to re-enter the building. Resident 10 stated she was upset after the incident and Staff 12 was rude to her/him. On 10/16/25 at 12:47 PM Staff 2 (DNS) stated it was reported to her by staff that Staff 12 was not letting Resident 10 in the door when she/he knocked and called, and the incident happened on night shift a couple weeks ago. Staff 12 stated it seemed like a former staff was involved. Staff 2 stated she did not specifically ask Resident 10 about being locked out of the facility, did not interview Resident 12, and did not complete an investigation. On 10/16/25 3:26 PM Staff 1 (Administrator) stated she was aware Resident 10 had concerns about getting in and out of the facility at night when Staff 12 worked. Staff 1 stated the incident was not investigated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure expired biologicals were discarded and temperatures of medication refrigerators were monitored for 1 of 1 treatment cart and 1 of 1 medication room reviewed for medication storage. This placed residents at risk for reduced efficacy of medication. Findings include:1. On [DATE] at 1:56 PM Staff 3 (LPN) was observed to prepare Humalog insulin for Resident 11. The open date was [DATE]. The manufacturer's instructions indicated the medication was to be discarded 28 days after opening.On [DATE] at 1:56 PM Staff 3 acknowledged the Humalog was expired and was not discarded 28 days after opening.2. On [DATE] at 2:09 PM the medication refrigerator logs were reviewed with Staff 3 (LPN). There were no recorded temperatures for [DATE] or [DATE]. The medication refrigerator was observed to contain insulin and medications.On [DATE] at 2:09 PM Staff 3 stated night shift was responsible for completing the temperature logs and the expectation was for the temperature logs to be completed the morning prior to night shift leaving the facility. Staff 3 acknowledged the temperature logs were blank for [DATE] and [DATE].

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review it was determined the facility failed to ensure routine dental services were provided for 1 of 2 sampled residents (#3) reviewed for dental care needs. This placed residents at risk for unmet dental needs. Findings include:Resident 3 admitted to the facility in 9/2024 with diagnoses including heart failure.On 10/14/25 at 9:27 AM Resident 3 stated it had been one year since she/he had a dentist appointment and there were issues finding a dentist that accommodated residents who required wheelchairs.No evidence was found in the clinical record to indicate a dental appointment was made since the resident's admission.On 10/16/25 at 2:08 PM Staff 4 (Social Services) stated she started at the end of September 2025 and was just now learning what her role was supposed to be. She stated she was not involved in dental services and provided no additional information regarding when Resident 3's dental status was reviewed.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review it was determined the facility failed to provide dental services for 1 of 2 sampled residents (#12) reviewed for dental services. This placed residents at risk for unmet dental needs. Findings include:Resident 12 admitted to the facility in 2015 with diagnoses including heart failure and diabetes.A review of the 7/28/25 Quarterly MDS indicated Resident 12's BIMS score was a four, indicating severe cognition impairment.On 10/14/25 at 9:40 AM Witness 5 (Family) stated she was involved in Resident 12's care at the facility. Witness 5 stated Resident 12 had three natural teeth remaining and did not receive routine dental cleaning in the past year. Witness 5 stated she wanted Resident 12 to receive routine dental cleanings.No evidence was found in the clinical record regarding Resident 12's dental cleaning history.On 10/16/25 at 2:08 PM Staff 4 (Social Services) stated she started at the end of September 2025 and was just now learning what her role was supposed to be. She stated she was not involved in dental services and provided no additional information regarding Resident 12's last routine dental service.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review it was determined the facility failed to provide therapy services for 1 of 1 sampled resident (#1) reviewed for nutrition. This placed residents at risk for functional decline. Findings include:Resident 1 admitted to the facility in 8/2023 with diagnoses including dementia and muscle weakness.A review of the 9/12/25 Annual MDS indicated Resident 1's BIMS score was a four, indicating severe cognition impairment. The MDS also indicated Resident 1 had swallowing issues including loss of liquids and/or solids from the mouth when eating and/or drinking along with coughing or choking during meals.A review of the 7/29/25 Nutrition at Risk (NAR) notes revealed concerns for increased risk of choking. The notes indicated Resident 1 was waiting for insurance authorization for a SLP evaluation. A review of the 8/7/25 Tele-Health Physician Provider Note revealed the resident had a recent diagnosis of lung cancer, was experiencing dysphagia and weight loss, and was awaiting a SLP evaluation.A review of the 8/28/25 Tele-Health Physician Provider Note revealed a free initial SLP evaluation was conducted and indicated a need for further follow up. The Physician Provider Note also indicated Resident 1 had a change in medical providers which caused a delay in obtaining speech therapy.A review of Resident 1's medical record revealed no notes related to the free initial speech therapy evaluation that was indicated in the 8/28/25 Physician Provider Note.On 10/16/25 from 9:01 AM through 9:30 AM Staff 22 (RD) stated Resident 1 was discussed during the weekly NAR meetings due to Resident 1's recent lung cancer diagnosis, weight loss and dysphagia. Staff 22 stated the facility did not have a speech therapist on-site and utilized one through the local hospital as outpatient therapy, however we don't have a good process for the setup of a speech therapist and it is not consistent services. Staff 22 stated on 8/26/25 a speech therapist from the local hospital performed a screening note with Resident 1, however it was not a full SLP evaluation and was not documented in Resident 1's medical record. Staff 22 stated she was unsure who at the facility oversaw therapy insurance authorizations.On 10/16/25 at 10:02 AM Staff 5 (HR) provided an email chain between Witness 6 (Hospital Speech Therapist) and Staff 13 (Former Administrator). The email chain revealed the following:-On 8/26/25 at 6:41 PM Witness 6 recommended a Modified Barium Swallow Study (an x-ray exam that uses barium to visualize and assess swallowing function in real time) to be scheduled for Resident 1 to determine the least restrictive diet to help determine ways to prevent aspiration pneumonia and to recommend quality of life measures.-On 9/3/25 at 3:29 PM Witness 6 emailed Staff 13 indicating it was a follow up email as Witness 6 had time in the schedule to provide SLP services to address Resident 1's dysphagia.-On 9/3/25 at 4:50 PM Staff 13 replied to Witness 6's email stating the facility was still waiting on Resident 1's insurance approval.On 10/16/25 at 10:38 AM Staff 5 stated the facility did not follow up on the recommendations from Witness 6 and she could not find any notes in Resident 1's medical record for follow up on the therapy authorization.On 10/17/25 at 8:44 AM Staff 1 (Administrator) was unaware of the recommendations and orders for therapy services for Resident 1. No further information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to notify hospice services of the resident's death in a timely manner for 1 of 1 sampled resident (#16) reviewed for hospice. This placed residents at risk for a lack of coordination of care upon death. Findings include: A review of the facility [DATE] Hospice Services Policy and Procedure revealed the following:- Blue Mountain Care Center (BMCC) will coordinate with the State Recognized Hospice Program to provide support to terminally ill residents (and their families) that resides in the facility.- Hospice and BMCC will communicate with each other when any changes are indicated to the Plan of Care.- The Plan of Care will be consistent with the Hospice philosophy of care.-BMCC will comply with the hospice policies and procedures.On [DATE] a public complaint was received by the State Agency which alleged the facility failed to notify hospice services of Resident 16's death in a timely manner. Resident 16 was admitted to the facility on [DATE] with diagnoses including vascular dementia and adult failure to thrive.Resident 16's [DATE] admission MDS revealed she/he received hospice services while she/he was a resident in the facility.The [DATE] care plan revealed BMCC would collaborate with hospice and Resident 16's family to meet Resident 16's needs.A review of Resident 16's progress notes revealed no notes related to Resident 16's date and time of death or a notification to the hospice provider. A review of the death record and receipt between the facility and the funeral home that was in Resident 16's medical record revealed Resident 16's date and time of death was on [DATE] at 7:30 PM.A review of the [DATE] Discharge Death documentation from hospice revealed Resident 16's time of death was on [DATE] at 7:30 PM, Staff 20 (LPN) notified the hospice provider at 9:45 PM, and the hospice provider notified Resident 16's family at 9:50 PM.On [DATE] at 12:28 PM and on [DATE] at 9:21 AM attempts to contact Staff 20 were unsuccessful.On [DATE] at 12:11 PM Witness 4 (Hospice RN) stated on [DATE] at approximately 9:30 PM Staff 20 contacted hospice and spoke to Witness 4 to notify of Resident 16's death in the facility. Witness 4 stated Staff 20 indicated Resident 16's time of death was on [DATE] at 7:30 PM. Witness 4 stated she was unsure why Staff 20 did not notify hospice of Resident 16's death until about two hours after the resident died. Witness 4 stated staff were expected to notify hospice upon death so hospice could follow their protocol by calling the family timely.On [DATE] at 8:16 AM Staff 1 (Administrator) stated she expected facility staff to communicate timely with the hospice provider upon the resident's death.