STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385272	A. Building B. Wing	03/07/2022

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 26991 Based on interview and record review it was determined the facility failed to allow a resident to go outside for 1 of 3 sampled residents (#29) reviewed for residents right to leave the facility. This placed residents at risk for anxiety. Findings include: Resident 29 was admitted to the facility in 2022 with diagnoses including chronic lung disease. Resident 29's Clinical Admissions form indicated she/he was able to make needs known and had a good long term and short term memory. A 2/4/22 Progress Note indicated Resident 29 reported rapid breathing. The resident was administered medication which was not effective. The physician was notified and new medication orders were received, implemented and were effective. On 2/8/22 Resident 29 stated she/he had chronic breathing issues. On 2/4/22 she/he spent much of the day at physician appointments, was exhausted and anxious. Resident 29 indicated when anxious, she/he needed to go outside for fresh air, otherwise she/he felt like she/he was suffocating. Resident 29 stated on 2/4/22 she/he asked staff to let her/him go outside and the staff denied her/his request. Resident 29 indicated the facility called her/his physician, obtained new medication orders and her/his breathing improved. On 2/10/22 at 11:12 AM Staff 12 (LPN) stated the facility had an outside patio the residents could utilize. At times on night shift, after 8:00 PM, residents were not allowed to go outside by the front entrance because there was not enough staff to watch the residents. The resident's always had access to the back patio. On 2/11/22 at 1:45 PM Staff 17 (CNA) stated on 2/4/22 Resident 29 asked to go outside but there was not enough staff to assist the resident. Staff 17 indicated she took the resident to the nurses station and once the resident's room cooled down the resident seemed better. On 2/8/22 Staff 1 (Chief Operating Officer) stated all residents were allowed to go outside, had a right to leave the building and staff were to assist the residents as needed.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure residents' responsible party or physician were notified of a fall with injury, low oxygen saturation levels, abnormal blood pressures, weight loss, poor oral intake, treatment refusals or omissions of medications and treatments for 6 of 13 sampled residents (#s 1, 10, 12, 14, 15 and 22) reviewed for leg wraps, change in condition, eating assistance, pain and pressure ulcers. This placed residents' families and physicians at risk for lack of information related to residents' health status and worsening health conditions. Findings include: 1. Resident 12 was admitted to the facility in 2021 with diagnoses including dementia. A 6/9/21 Fall report and Progress Note created by Witness 1 (Former RN) indicated Resident 12 was found on the ground at 5:38 AM. The report indicated the resident's representative was not notified of the fall. On 2/10/22 at 9:00 AM and Witness 3 (Spouse) indicated she/he was not notified of the resident's fall. On 2/11/22 at 10:17 AM Witness 2 (Family) indicated he was not notified of Resident 12's fall. On 2/16/22 at 11:45 AM Staff 3 (RNCM) stated the documentation indicated the resident's physician was notified of the fall but there was no family notification. 2. Resident 15 was admitted to the facility in 2021 with diagnoses including COVID-19. Resident 15's January 2021 Vital Signs revealed her/his oxygen saturation levels from 1/20/21 through 1/23/21 remained above 91 percent (normal range-95% or higher if no diagnosis of chronic lung disease). Progress Notes indicated on 1/20/21 Resident 15 informed the facility she/he did not want to be followed by the facility physician. A 1/24/21 at 11:23 PM note by Staff 4 (LPN) indicated the resident's oxygen saturation level was 80% on six liters of oxygen. The resident's oxygen saturation level increased with deep breathing. When the resident did not take deep breaths the oxygen level dropped to the low 80's. A breathing treatment was provided and was not effective to help the resident's oxygen saturation levels. The resident was instructed to continue to deep breathe. A 1/26/21 at 8:28 AM note by Staff 6 (RN) indicated the resident's oxygen saturation level was 85% on seven liters of oxygen. The resident's lungs were clear and the resident denied shortness of breath. The resident's oxygen levels increased if the resident did not move or talk. The note indicated the resident was to be monitored every four hours. There was no documentation to indicate the resident's physician was notified of the resident's low oxygen saturation levels which started on 1/24/21. On 2/11/22 at 13:41 PM Staff 4 stated if a resident's oxygen saturation was below 90% the physician was to be notified. Staff 4 did not recall Resident 15. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/22 at 7:49 AM Staff 6 stated if a resident was administered oxygen or if the oxygen had to be increased, the resident's physician was to be notified. Staff 6 also stated oxygen saturation levels should ideally be above 92%. Staff 6 stated she did not recall Resident 15 but indicated the resident required more oxygen than normal. Staff 6 thought she likely called the physician on both days the oxygen level was low but did not document the notification. A request was made to Staff 6 to provide documentation to verify the resident's physician was notified. No additional information was provided. On 2/25/22 at 8:09 AM Witness 4 (Health Plan Coordinator) stated she worked at Resident 15's physician's office, reviewed Resident 15's record and did not see notes to indicate the facility called the physician on 1/24/21 to report low oxygen saturation levels. Witness 4 stated the resident called the physician's office on 1/26/21 and reported her/his oxygen levels were low. The facility did not report the resident's low oxygen saturation levels were low until 1/27/21. On 2/16/22 at 11:45 PM Staff 23 (RNCM) stated staff should have called the resident's physician when the oxygen saturation levels were in the 80's. 3. Resident 10 was admitted to the facility in 2021 with diagnoses including dementia. The resident's Face Sheet indicated Witness 7 (Complainant) was the resident's Health Care Power of Attorney. A 7/1/21 Progress Note indicated Resident 10 was admitted to the facility and was too lethargic to sign consent forms. Witness 7 provided consent. Resident 10's undated Kardex (CNA guide to resident specific care) revealed Resident 10 required 1 to 1 assist to eat. A Breakfast Intake report for 7/2021 revealed staff documented 10 out of 17 meals. The resident was documented to not eat breakfast on six days, ate 1-25% on three days and 26-50% on one day. A Lunch Intake report for 7/2021 revealed staff documented 10 out of 17 meals. The resident was documented to not eat lunch on five days and ate 1-25 % on five days. A Dinner Intake report for 7/2021 revealed staff documented 9 out of 17 meals. The resident was documented to not eat for three meals and 1-25 % for five meals. Resident 10's 7/2021 Fluids log indicated she/he drank 90-260 cc of fluids each day through 7/11/21. 7/2021 Progress Notes and Daily Skilled Nursing notes did not include notification to the resident's family or physician related to Resident 10's lack of oral intake. A 7/26/21 Intake revealed Witness 7 (Complainant) reported Resident 10 did not eat while in the facility, the facility staff did not notify her of the poor intakes and she was not able to assist with Resident 10's situation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/16/22 at 11:45 AM and 2/28/22 at 3:25 PM Staff 3 (RNCM) acknowledged Resident 10 did not eat or drink well and often the intake was less than 50%, Staff 3 also indicated she would look for documentation the physician and family were notified of the resident's lack of oral intake. No additional information was provided. Refer to F692, example 1. 32543 4. Resident 1 was admitted to the facility in 11/2021 with diagnoses including COVID-19, nutritional deficiency and high blood pressure. a. A review of Resident 1's weight record revealed on 11/10/21 the resident's weight was 139.2 pounds. On 11/17/21 the resident's weight was 128.6. The facility's electronic medical record flagged the 11/17/21 weight as outside the acceptable range for weight change. This was a 7.6% body weight loss over seven days. A review of Resident 1's clinical record revealed no indication Staff 20 (RD) or the resident's physician were notified of the weight loss identified on 11/17/21. A review of Resident 1's food intake record from 11/10/21 through 11/20/21 revealed overall poor food intake including: - Seven out of ten breakfast intakes of 0-25% consumed. - Seven out of ten lunch intakes of 0-25% consumed. - Seven out of ten dinner intakes of 0-50% consumed. An RD assessment dated [DATE] indicated the resident had a severe weight loss and the resident was at increased nutritional risk due to poor intake and weight loss. On 2/25/22 at 12:00 PM Staff 20 (RD) confirmed Resident 1's weights, weight loss and poor intake. Staff 20 stated she would expect the facility to assess the resident and implement appropriate interventions based on the resident's documented poor intake, as well as notify her and the resident's physician. b. A review of Resident 1's 11/2021 vital signs record revealed the following abnormal blood pressure (BP) and O2 sats readings: - On 11/10/21 at 4:50 PM the resident's BP was 167/85 (normal is 120/80) - On 11/11/21 at 3:05 PM the resident's BP was 74/40 - On 11/12/21 at 12:51 AM the resident's BP was 85/53 - On 11/12/21 at 3:36 PM the resident's BP was 105/47 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 11/13/21 at 4:47 PM the resident's BP was 161/73 - On 11/13/21 at 10:55 PM the resident's BP was 121/48 - On 11/15/21 at 11:25 PM the resident's BP was 162/71 - On 11/16/21 at 2:54 PM the resident's BP was 199/92 - On 11/18/21 at 6:42 AM the resident's O2 sats was 87% (normal is 95% to 100%) - On 11/19/21 at 3:15 PM the resident's BP was 184/77 A review of Resident 1's 11/10/21 through 11/19/21 Progress Notes revealed no notifications to the physician or family related to the abnormal vital signs. On 2/16/22 at 10:07 AM Staff 7 (DNS) verified Resident 1's physician and family were not notified. Refer to F-684 example 3 and F-692 example 3 33179 5. Resident 22 admitted to the facility on ,d+[DATE] with diagnoses including dementia, COVID-19 and a chronic pressure ulcer. The 1/6/22 Admission orders included the following orders: -Pressure ulcer wound care to be completed daily and as needed. -Protein gel (nutritional supplement) 20 ml in 120 ml in juice daily. -Loratadine (allergy medication) daily. -Omeprazole (treats reflux) bid before meals. -Senna syrup (stool softener) bid. A January 2022 TARs revealed Resident 22 refused wound treatments on January 7, 19, 11, 12 and 14. The January 2022 MARs indicated the following: - Loratadine: documented as not administered/drug unavailable on January 7, 8, 13, 14, 15, 16, 17. - Omeprazole: administered late on January 8, 15 and 16 and documented as unavailable/not administered on January 18, 19 (both administrations) and 20 (both administrations). -Protein gel: documented as unavailable on January 7, 8, 9, 10 and 11. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Senna syrup: documented as unavailable on January 15 (day), 19 (day and evening), 20 (day) and 21 (day). The medical record revealed the physician was not notified of the missed doses of loratadine, omeprazole, protein gel and Senna syrup. There was no evidence in the medical record the family or physician were notified of the treatment refusals until 1/19/22. On 2/14/22 at 9:09 AM Staff 7 (DNS) verified the wound care, loratadine, omeprazole, protein gel and Senna syrup were not administered as ordered and the physician was not notified of the missed medication refusals and not notified of the treatment refusals until 1/19/22. 6. Resident 14 admitted to the facility in 4/2021 with diagnoses including diabetes and [NAME]-[NAME] syndrome (a genetic disorder which affects many parts of the body and growth). The 4/15/21 Admission Orders included the following orders: -Dilute one part vinegar with two parts water in spray bottle, clean folds with mixture, dry well, apply other creams and powders bid for skin care. -Hibiclens 4% (antiseptic soap) topical once a day on Sunday, Wednesday and Friday for skin impairment. -Proctozone-HC (steroid) cream bid. The April 2021 and May 2021 TARs revealed the following missed administrations: - Vinegar: Not completed from 4/15/21 through discharge on 5/4/21. - Hibiclens: not completed on April 16, 21, 23, 25 and May 2. -Proctozone-HC: Not completed on April 15, 16 (both doses) and 17 (both doses). There was no evidence in the medical record the physician was notified of the missed treatments of the vinegar, Hibiclens or Proctozone-HC. On 2/14/22 at 8:48 AM Staff 7 (DNS) verified the vinegar, Hibiclens and Proctozone was not administered as ordered and the physician was not notified of the missed doses.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41453 Based on interview and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 3 residents (#7) reviewed for abuse. This placed residents at risk for physical and psychosocial harm. Findings include: Resident 7 was admitted to the facility in 9/2021 with chronic obstructive pulmonary disease (lung disease making it difficult to breathe) and acute respiratory disease. Resident 7's 9/1/21 Annual MDS revealed a BIMS score of 15 (no cognitive impairment). Resident 39 was admitted to the facility in 8/2021 with diagnoses including acute respiratory disease and major depressive disorder. Resident 39's 9/3/21 Admission MDS revealed Resident 39 was documented as having memory problems and physical behaviors effecting others. An 8/29/21 progress note indicated staff were aware Resident 39 wandered into resident rooms, was moved to a different room, and continued to wander into resident rooms. The same progress note indicated Resident 39 had been physically aggressive with staff. A 9/2/21 FRI indicated Resident 7 was heard yelling Get her/him out of here at Resident 39. Staff 11 (LPN) entered the room, stopped Resident 39 from yanking Resident 7 out of bed. Resident 39 was escorted out of the room. The 9/1/21 Facility Abuse Investigation indicated Resident 39 was found in Resident 7's room. Resident 39 grabbed Resident 7 by the ankles, yanked repeatedly and attempted to pull Resident 7 out of bed. Resident 7 flailed her/his legs and screamed at Resident 39 and for staff assistance. Staff 11 intervened and removed Resident 39 from the room. Resident 39 was interviewed the next day and stated she/he had no recollection of the event. Resident 7 stated she/he was kicking, screaming, and was very scared when the incident occurred. Resident 7 discharged eight days after the incident occurred. A progress note dated 9/2/21 indicated she/he was assessed for injury. No documentation of further monitoring, or assessment for latent injuries or lingering emotional distress was found. On 2/17/22 at 1:37 PM , Staff 7 (DNS) confirmed the incident between Residents 7 and 39 occurred.

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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. 41453 Based on interview and record review it was determined the facility failed to report an allegation of abuse to the State Agency within the required timeframe for 1 of 3 sampled residents (#7) reviewed for abuse. This placed residents at risk for continued abuse. Findings include: Resident 7 admitted to the facility in 8/2021 with diagnoses including COVID-19. The 9/1/21 BIMs (cognitive assessment) indicated Resident 7 was not cognitively impairment. The 9/1/21 Facility Abuse Investigation indicated Resident 39 was found in Resident 7's room. Resident 39 grabbed Resident 7 by the ankles, yanked repeatedly and attempted to pull Resident 7 out of bed. Resident 7 flailed her/his legs and screamed at Resident 39 and for staff assistance. The 9/1/21 abuse investigation report further indicated the incident occurred at 9:00 PM on 9/1/21. The 9/2/21 FRI was submitted to the State Agency at 9:00 AM on 9/2/21, reported the incident occurred on 9/1/21. On 2/17/22 at 1:37 PM, Staff 7 (DNS) confirmed the incident between Residents 39 and 7 was reported the next day.

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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. 41453 Based on interview and record review it was determined the facility failed to thoroughly investigate an allegation of abuse for 1 of 4 sampled residents (#7) reviewed for abuse. This placed residents at risk for inaccurate abuse determinations. Findings include: An 8/29/21 Progress Note indicated Resident 39 was observed wandering throughout the facility with and without clothing on. The same progress notes further indicated Resident 39 had gone into occupied rooms, and grabbed female staff aggressively. The 9/1/21 Facility Abuse Investigation indicated Resident 39 was found in Resident 7's room. Resident 39 grabbed Resident 7 by the ankles, yanked repeatedly and attempted to pull Resident 7 out of bed. Resident 7 flailed her/his legs and screamed at Resident 39 and for staff assistance. The 9/1/21 Resident to Resident Altercation report included a summary of the incident, alleged perpetrator interview, alleged victim interview, one staff interview, and a conclusion statement. The report did not determine the root cause and did not identify previous behaviors of Resident 39. There were no additional interviews of staff who were familiar with the incident. On 2/17/22 at 2:21 PM Staff 4 (Administrator) confirmed the investigation had limited staff interviews, could not determine a root cause, and did not identify previous behaviors which impacted both residents and staff.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 33179 Based on interview and record review it was determined the facility failed to comprehensively assess a resident's ADL and nutritional status for 1 of 4 sampled residents (#2) reviewed for weight loss. This placed residents at risk for unmet nutritional needs and lack of eating assistance. Findings include: Resident 2 admitted to the facility 10/2021 with diagnoses including diabetes and stroke. A 10/4/21 admission note indicated Resident 2 admitted to the facility with left sided weakness due to stroke. A 10/4/21 Physician Orders revealed a diet order for mechanical soft diet and thickened liquids. A 10/11/21 Admission MDS revealed Resident 2 had unplanned weight loss and required one person supervision with eating. The Nutritional Assessment CAA did not include an analysis of Resident 2's nutritional risk. It did not include Resident 2's recent stroke with left sided impairment, unplanned weight loss or the mechanically altered diet and thickened liquids she/he was ordered. The ADL CAA did not analyze Resident 2's need for eating assistance due to her/his left sided weakness. Both CAAs were not comprehensive. On 2/15/22 at 1:48 PM Staff 7 (DNS) acknowledged the Admission Nutritional CAA and the Admission ADL CAA were not comprehensive assessments of Resident 2's nutritional and ADL status.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 41453 Based on interview and record review it was determined the facility failed to complete a discharge summary for 2 of 8 sampled residents (#s 3 and 7) reviewed for dehydration and discharge. This placed residents at risk for unmet discharge needs. Findings include: 1. Resident 3 admitted to the facility in 1/2021 with diagnoses including COVID-19 and heart failure. The resident discharged as planned on 1/30/21. Resident 3's medical record revealed no evidence a discharge summary was completed. On 2/23/22 at 10:17 AM Staff 4 (Administrator) stated he was unable to locate a discharge summary for the resident. 2. Resident 7 admitted to the facility in 8/2021 with diagnoses including COVID-19. The resident discharged as planned on 9/10/21. Resident 7's medical record revealed no evidence a discharge summary was completed. On 2/23/22 at 10:17 AM Staff 4 (Administrator) stated he was unable to locate a discharge summary for the resident.

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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. 26991 Based on interview and record review it was determined the facility failed to ensure a resident received scheduled showers for 1 of 3 sampled residents (#9) reviewed for grooming. This placed residents at risk for poor hygiene. Findings include: Resident 9 was admitted to the facility 7/19/21 with diagnoses including dementia. An undated Kardex (CNA guide for resident specific care) indicated the resident required the assistance of one person for bathing and showers were scheduled for Tuesday and Friday evening shifts. Resident 9's 7/2021 and 8/2021 bathing record indicated the resident refused one shower on 7/20/21. The resident missed three opportunities for showers (7/23/21, 7/27/21 and 7/30/21) prior to discharge on 8/3/21. On 2/15/22 at 10:12 AM Staff 15 (CNA) stated residents were scheduled to have two showers a week. If a resident was scheduled for a shower, staff were to make multiple attempts to provide a shower. If the resident refused the nurse was informed and the nurse attempted to encourage the resident to shower. If the resident continued to refuse it was documented as a refusal in the resident's record. On 2/16/22 at 11:45 AM Staff 3 (RNCM) indicated residents were to be offered a shower at least twice a week. Staff 3 acknowledged Resident 9 was offered a shower on 7/20/21 but no additional showers were documented as offered. A request was made to Staff 3 to provide documentation to indicate Resident 9 was offered showers after 7/20/21. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to administer medication and complete treatments according to physician's order, failed to monitor a resident's venous access port and failed to monitor for a change of condition for 5 of 10 sampled residents (#1, 12, 14, 20 and 22) reviewed for change in condition, physicians orders, venous access ports and unsafe medication system. This placed residents at risk for reduced medication efficacy, worsening skin conditions, lack of treatment for a change of condition and unidentified complications. Findings include: 1. Resident 22 admitted to the facility in 1/2022 with diagnoses of dementia and COVID-19. Resident 22's 1/6/22 Admission Orders included the following: -Loratadine (allergy medication) daily. -Omeprazole (reflux medication) bid before meals. -Protein gel daily. -Senna syrup (stool softener) bid. The resident's January 2022 MARs indicated the following: - Loratadine: documented as not administered/drug unavailable on January 7, 8, 13, 14, 15, 16, 17. - Omeprazole: administered late on January 8, 15 and 16 and documented as unavailable/not administered on January 18, 19 (both administrations) and 20 (both administrations). -Protein Gel: documented as unavailable on January 7, 8, 9, 10 and 11. -Senna syrup: documented as unavailable on January 15 (day), 19 (day and evening), 20 (day) and 21 (day). The medical record revealed the physician was not notified of the missed doses of loratadine, omeprazole, protein gel and senna syrup. On 2/14/22 at 9:09 AM Staff 7 (DNS) verified loratadine, omeprazole, protein gel and senna syrup were not administered as ordered and the physician was not notified of the missed doses. 2. Resident 14 admitted to the facility in 4/2021 with diagnoses including diabetes and [NAME]-[NAME] syndrome (a genetic disorder which affects many parts of the body and growth). Resident 14's 4/15/21 Admission Orders included the following orders: -Dilute one part vinegar with two parts water in spray bottle, clean folds with mixture, dry well, apply other creams and powders bid for skin care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hibiclens 4% (antiseptic soap) topical once a day on Wednesday, Friday and Sunday for skin impairment. -Proctozone-HC (steroid) cream bid. The resident's April 2021 and May 2021 TARs revealed the following missed administrations: - Vinegar: Not completed from 4/15/21 through discharge on 5/4/21. - Hibiclens: not completed on April 16, 21, 23, 25 and May 2. -Proctozone-HC: Not completed on April 15, 16 (both doses) and 17 (both doses). There was no evidence in the medical record the physician was notified of the missed treatments of the vinegar, Hibiclens or Proctozone-HC. On 2/8/21 at 10:58 AM Witness 8 (Assisted Living Nurse) stated the vinegar skin treatments worked well for Resident 14 because it suppressed the candida (fungal) growth. Witness 8 stated if the vinegar treatment was not completed Resident 14 would begin to have skin problems. On 2/14/22 at 8:48 AM Staff 7 (DNS) verified the vinegar, Hibiclens and Proctozone was not administered as ordered. 32543 3. Resident 1 was admitted to the facility in 11/2021 with diagnoses including depression, insomnia, COVID-19 and COPD (chronic obstructive pulmonary disorder causes inflammation of the lungs which obstructs airflow). a. A review of Resident 1's 11/2021 MAR revealed the resident was ordered tramadol (pain medication) 50 mg, one tablet, four times a day. On 11/13/21 at 9:58 AM and 2:50 PM an unidentified Agency Nurse indicated the tramadol was administered late because the drug was unavailable and a half tab (25 mg) was administered to the resident. A review of Resident 1's 11/2021 Progress Notes revealed no indication the pharmacy was notified regarding the supply of trazadone or a request to the physician to administer a half tablet instead of a full tablet. A review of Resident 1's 11/2021 physician's orders revealed no order for the administration of a half tablet instead of a full tablet of tramadol. On 2/16/22 at 10:07 AM the administration of a half tablet of trazadone to Resident 1 was discussed with Staff 7 (DNS) who verified it was not appropriate to administer a half tablet when the order was for a full tablet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of Resident 1's Progress Note revealed a note on 11/20/21 which indicated the resident's condition declined since admission to the facility and was not willing to keep oxygen [tubing used to deliver oxygen] in place. The note failed to indicate specifically how the resident's condition had declined. The Progress Notes failed to indicate the date and a rationale for when the oxygen therapy was first initiated or that the resident's family and physician were notified. Resident 1's 11/2021 physician's orders revealed no order for oxygen therapy. On 2/16/22 at 10:07 AM the administration of oxygen therapy with no physician's order for Resident 1 was discussed with Staff 7 (DNS). Staff 7 stated the facility had standing orders for the use of oxygen therapy to residents. Staff 7 stated the expectation was for a nurse to assess the resident and document the assessment and rationale for initiating oxygen therapy. The standing order was then placed on the resident's orders in the electronic medical record. Staff 7 reviewed Resident 1's clinical record but could not find a date or rationale for when oxygen therapy was initiated. c. A review of Resident 1's 11/2021 vital signs record revealed the following abnormal blood pressure (BP) and O2 sats readings: - On 11/10/21 at 4:50 PM the resident's BP was 167/85 (normal is 120/80) - On 11/11/21 at 3:05 PM the resident's BP was 74/40 - On 11/12/21 at 12:51 AM the resident's BP was 85/53 - On 11/12/21 at 3:36 PM the resident's BP was 105/47 - On 11/13/21 at 4:47 PM the resident's BP was 161/73 - On 11/13/21 at 10:55 PM the resident's BP was 121/48 - On 11/15/21 at 11:25 PM the resident's BP was 162/71 - On 11/16/21 at 2:54 PM the resident's BP was 199/92 - On 11/18/21 at 6:42 AM the resident's O2 sats was 87% (normal is 95% to 100%) - On 11/19/21 at 3:15 PM the resident's BP was 184/77 A review of Resident 1's 11/10/21 through 11/19/21 Progress Notes revealed no nursing assessments, re-checks to verify the readings, notifications to the physician or family related to the abnormal vital signs. On 2/16/22 at 10:07 AM Staff 7 (DNS) stated abnormal vital signs should be rechecked and the resident should be assessed. Staff 7 verified Resident 1's vital signs were not rechecked and there were no assessments. Staff 7 verified Resident 1's physician and family were not notified. 4. Resident 20 was admitted to the facility in 2020 with diagnoses including fracture. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20's 1/22/20 hospital History & Physical revealed the resident had a left upper chest implanted port. No anticoagulant injections were ordered or provided to maintain the port. No discharge orders were given to the facility by the hospital for monitoring or maintenance of the port. A Progress Note dated 3/12/20 indicated an un-named Resident Care Manager, Nurse Practitioner and Charge Nurse looked at Resident 20's left chest port. The resident asked if the port would be flushed or not. The note failed to indicate what prompted staff to look at the port and did not document an assessment of the port. The note failed to indicate a response to the resident's question regarding flushing the port. A Physician Progress Note dated 3/18/20 revealed Resident 20 had a left upper chest port covered by skin with scar tissue and, [the port] does not look accessible anymore, and therefore heparin (blood thinner) flushes would not be helpful, [the resident] is requesting heparin flushes as [the resident] had before when [the resident] was in the hospital. Patient does not remember under whose direction the port was put in We will continue to monitor for now. A review of Resident 20's 3/2020 and 4/2020 Physician's Orders, Progress Notes and TARs revealed no indication the resident's port was monitored. On 2/11/22 at 10:26 AM Staff 7 (DNS) stated the facility was not aware of the physician's instructions to monitor the resident's port because physician's notes were sent directly to medical records and were not reviewed by nursing. 26991 5. Resident 12 was admitted to the facility in 2021 with diagnoses including dementia. A 6/9/21 Progress Note at 5:54 AM indicated the resident had an unwitnessed fall and sustained a laceration to the right eyebrow. The note indicated neurological assessments (monitors a resident for adverse effects related to an actual or potential head injury) were started. The 6/9/21 at 11:31 AM note did not indicate the resident was assessed for latent injuries from the fall. There was no documentation related to the resident's condition after she/he fell until 6/10/21 at 8:56 AM which indicated the resident was sent to the hospital emergency department due to a change in cognition. The resident's clinical record did not include neurological assessments. On 2/16/22 at 11:45 AM Staff 3 (RNCM) indicated staff were to perform scheduled neurological checks after a resident fell . The completed document was to be submitted to the RNCM and then the document was to be scanned into the resident's record. Staff 3 indicated at times the neurological assessment sheets were initiated but not completed. A request was made to Staff 3 to provide documentation Resident 12 was monitored for a change in condition from 6/9/21 at 5:54 AM through 6/10/21 when Resident 12 was discharged to the hospital for evaluation. No additional information was provided. Resident 12's 6/10/21 hospital Emergency Department dictation indicated the resident arrived to the emergency room and was overall nontoxic-appearing and her/his vital signs were stable. The resident was weak and oriented to self. The resident's head scan did not reveal new trauma or bleeding. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to ensure a resident received the necessary treatment and services to prevent infection and the worsening of a Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone) for 1 of 3 sampled residents (#22) reviewed for pressure ulcers. This failure, which was determined to be immediate jeopardy, resulted in worsening of Resident 22's pressure ulcer and subsequent transfer to the hospital where the resident died from complications related to the worsening of the pressure ulcer. Findings include: Resident 22 admitted to the facility on [DATE] with diagnoses including dementia, COVID-19 and a chronic Stage 4 pressure ulcer. Resident 22's [DATE] Skin and Wound Evaluation from the resident's previous facility assessed the Stage 4 pressure ulcer to measure 1.9 cm x 2.0 cm (no depth was documented) with 90% epithelial tissue (tissue that forms the outer covering of skin) and no evidence of infection. No exudate (drainage) or odor was present, the wound edges were attached and the surrounding tissue was normal with no indurating (abnormal hardening of the tissue) or edema (swelling). The peri-wound (skin around the ulcer) was normal and the resident denied pain. The wound was determined to be stable but slow to heal. Resident 22's [DATE] Admission Transfer assessment revealed the resident had a Stage 4 pressure ulcer to the coccyx. [A comprehensive wound assessment was not completed.] A [DATE] Care Plan indicated Resident 22 was at risk for skin breakdown related to an existing pressure injury and changes in mobility and ADLs which were further complicated by the COVID-19 viral infection. Interventions included repositioning the resident every two hours. There was no documentation in the medical record repositioning every two hours occurred. The resident's [DATE] Admission orders included the following orders: -Stage 4 pressure ulcer wound care: cleanse with normal saline (NS), apply skin prep to the peri-wound, apply collagen to the wound base (mix NS with collagen powder to create paste) and then gently fill the remaining ulcer with calcium alginate and cover with a foam bordered dressing. Change daily and as needed. -Protein gel: 20 ml in 120 ml in juice daily (nutritional supplement). The [DATE] TARs revealed Resident 22 refused wound treatments on [DATE], 10, 11, 12 and 14. (A [DATE] Progress Note revealed the wound treatment was completed.) There was no evidence in the medical record the facility staff provided encouragement or education to the resident or family related to the treatment refusals. There was no evidence in the medical record the family or physician were notified of the refusals until [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A [DATE] MARs revealed Resident 22 did not receive the prescribed protein gel on [DATE], 9, 10 and 11. There was no evidence in the medical record the physician was notified the protein gel was not administered. A [DATE] Wound Management assessment indicated the resident's wound measured 3.2 cm x 3 cm x 2.7 cm with light serosanguineous (light pink/red, thin and water-like) exudate and no odor. Undermining (wounds that extend under the skin) was 9.7 cm with no tunneling (channels formed beneath the skin). Granulation tissue (new tissue) was present, wound edges were rolled under and thickened and the surrounding skin was dry, thin and scaling. The wound was determined to be stable. [The assessment failed to identify the wound had worsened since admission.] A [DATE] Progress Note revealed the resident's wound did not have odor and did not have signs of infection. The wound was painful to touch. A [DATE] Nutritional Assessment revealed Resident 22 should continue her/his current diet, add NEM (nutritionally enhanced meals), add 120 ml of 2 cal (nutritional health shake) five times a day, provide a multivitamin with minerals to the evening mediation pass and notify the RD PRN. [The assessment did not include the resident only consumed mandarin oranges, bananas and drank milk for two meals daily.] There was no evidence in the medical records the RD recommendations were initiated and followed. The [DATE] Wound Management assessment indicated the wound measured 4 cm x 3.4 cm x 2.8 cm with light seropurulent (mixture of serum and pus) drainage. A strong, foul odor was present. There was 2 cm of undermining of the entire wound and 4 cm of tunneling from one to five o'clock present. The wound was assessed to have declined. The [DATE] Wound Management assessment indicated the wound measured 4 cm x 3.4 cm x 2.8 cm with moderate seropurulent drainage. Odor was present, undermining was 4.5 cm and tunneling was 5 cm. The wound was assessed to have declined. Additionally a second wound was identified as an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (moist, devitalized tissue) and/or eschar (dead tissue) adjacent to the Stage 4 pressure ulcer. There was no evidence in the medical record her/his physician physically assessed the Stage 4 pressure ulcer. The [DATE] Progress note revealed Resident 22 transferred back to her/his prior long-term care facility. On [DATE] the receiving facility completed a Skin and Wound evaluation which assessed the Stage 4 pressure ulcer to measure 9.6 cm x 8.7 cm (no depth identified). The wound bed had eschar and there was evidence of infection which included increased pain, redness/inflammation and a strong odor. The surrounding tissue had black/blue discoloration and erythema (redness), the peri-wound skin temperature was warm and the resident complained of intermittent pain. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident's [DATE] Hospital records revealed Resident 22 was found to be unresponsive the morning of [DATE] and was transferred to the hospital. The resident was identified to be in multi-organ failure due to chronic infection and admitted to the intensive care unit. On [DATE] Resident 22 died . The principal cause of death was septic shock present for days due to the sacral decubitus (pressure) ulcer and UTI. On [DATE] at 9:09 AM Staff 7 (DNS) verified the Stage 4 pressure ulcer was identified but not assessed on admission, verified both the wound care and protein gel were not completed per physician orders and the facility did not notify the physician or the family of the treatment refusals until [DATE]. Staff 7 further stated the facility did not accommodate Resident 22's specific food preference, did not follow the RD recommendations, did not document care plan turning interventions and verified the physician did not visually assess the wounds during Resident 22's stay at the facility. On [DATE] at 9:27 AM Staff 20 (RD) acknowledged she was unaware of Resident 22's food preferences, likes and dislikes and was unaware Resident 22 only ate mandarin oranges, bananas and milk twice a day. Staff 20 stated she would have recommended other dietary interventions had she known of Resident 22's food preferences. Staff 20 acknowledged the [DATE] Nutritional Assessment was not a comprehensive assessment. On [DATE] at 10:05 AM Staff 3 (RNCM) acknowledged the Stage 4 pressure ulcer worsened at the time of the [DATE] assessment. Staff 3 stated she knew little of the wound prior to [DATE] when a nurse approached her regarding the frequent refusals of care. She then observed and thoroughly cleaned the wound. Staff 3 stated the nurses were complacent with the resident treatment refusals and did not provide strong encouragement or education. Additionally, Staff 3 stated the wound treatments were not completed as prescribed. Staff 3 stated on [DATE] she pulled out a dressing from the wound that was not the prescribed treatment and found the wound had deteriorated. Staff 3 further stated the second wound documented on [DATE] was a continuation of the Stage 4 pressure ulcer and not a separate wound. On [DATE] at 1:26 PM Staff 2 (Administrator) and Staff 3 (RNCM) were notified of the immediate jeopardy (IJ) and provided a copy of the IJ template related to the facility's failure to ensure a resident received the necessary treatment and services to prevent infection and the worsening of a Stage 4 pressure ulcer. An immediate plan of correction (POC) was requested. On [DATE] at 4:10 PM the submitted POC was approved. The IJ Immediacy Removal Plan included: -Immediately 1. Identification of all pressure ulcers -Ongoing 2. Verify assessments of all pressure ulcers are up to date (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Verify current assessments are up to date with accurate measurements 4. All identified pressure ulcer care plans reviewed and updated to ensure they cover nutrition, treatment and positioning. 5. RNCM will review RD recommendations of all current residents. 6. RNCM will follow up on all RD recommendations to ensure recommendations are being implemented as recommended. 7. Residents who are refusing care and services will be provided risk versus benefit education upon refusal. The nurse will try to negotiate a reasonable alternative. If the resident continues to refuse after the risk benefit, a reapproach will be attempted prior to the end of the shift. In the event the nurse is unsuccessful and the resident continues to refuse service the facility will notify the family and physician that day. 8. Care plans will be updated as appropriate. -Systematic Changes 1. RNCM will conduct admission audits following day after admit to ensure skin issues are appropriately documented and interventions are in place. 2. Residents who are refusing care and services will be provided risk and benefit education upon refusal. The nurse will listen to why the resident is refusing to help seek/negotiate a reasonable alternative. If the resident continues to refuse after risk and benefit, a reapproach will be attempted prior to end of shift. In the event the nurse is unsuccessful and the resident continues to refuse service the facility will notify the family and physician the same day. 3. Educate the nurses starting [DATE] with nurses on staff and educate them prior to the start of the nurses next shift. a. RD recommendations b. Wound assessments and documentation c. Notification of family d. Notification of physician e. RN assessment anytime a wound is declining. f. Location of supplies g. Following physician orders (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	h. Importance of documentation, if it is not documented it is not done. -Monitoring 4. RNCM to do wound rounds once a week to verify wound status, documentation and interventions are in place. 5. DNS or designee will audit pressure/injuries every week and report to monthly QAPI (Quality Assurance and Performance Improvement) to ensure ongoing compliance. 6. DNS or designee will audit RD recommendations every week and report to monthly QAPI to ensure ongoing compliance. 7. DNS or designee will audit MAR/TAR for refusal/not available every week and report to monthly QAPI to ensure ongoing compliance. 8. DNS or designee will audit for refusal of care every week and report to monthly QAPI to ensure ongoing compliance. 9. Audits will continue for at least three months and be re-evaluated at QAPI if auditing can be titrated to twice a month intervals, monthly intervals or no longer needed. On [DATE] at 4:26 PM Staff 2 (Administrator) and Staff 24 (Corporate RN) were notified the immediacy was removed based on observations, staff interviews and record review that the IJ removal plan was fully implemented.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure fall prevention interventions were identified and implemented for a resident assessed to be at high risk for falls for 1 of 3 sampled residents (#12) reviewed for falls. This placed residents at risk for injury. Findings include: Resident 12 was admitted to the facility 6/8/21 with diagnoses including dementia. A 6/8/21 hospital Care Management Care Facility Admission Orders indicated Resident 12 was at risk for falls, used a front wheeled walker and required one person moderate assist to walk. A facility Admission Fall Risk Assessment completed on 6/8/21 at 3:57 PM indicated the resident was at high risk for falls due to factors including the resident was disoriented and had one or two falls in the last three months. There were no interventions listed in the plan of care section of the form. A 6/9/21 Fall report indicated Resident 12 had an unwitnessed fall on 6/9/21 at 5:38 AM. The resident was found sitting on the left side of the bed trying to get back up. The resident was last seen resting in bed at 4:00 AM, one and one half hours after prior to the fall. The resident was assessed to have an abrasion and laceration. The contributing factor for the fall was identified to be related to the resident's cognitive impairment. Interventions put in place to prevent future falls were frequent checks, fall mat and the bed was to be lowered to the ground. A 6/9/21 at 5:54 AM Progress Note indicated the resident was found on the ground, denied pain and had blood on the right brow with a small laceration. The bed was lowered and the day shift staff were to find fall mats for the resident's room. The undated Kardex (CNA guide for resident specific care) indicated Resident 12 was at risk for falls. Interventions included mats and bed in lowest position. These interventions were identified on the 6/9/21 Fall report to be added after the fall. There were no additional interventions on the Kardex related to falls. An undated Resident Census (list of rooms Resident 12 resided) indicated the resident was in room [ROOM NUMBER] (end of hall further from nurse's station) on 6/8/21 and on 6/9/21 was moved to room [ROOM NUMBER] (near nurses' station). On 2/14/22 at 10:15 AM Staff 13 (CNA) indicated she did not recall Resident 12. If a resident was at risk for falls the nurse would notify staff of the risk. Interventions to prevent falls were located on the Kardex. Interventions could include mats on the floor by the bed, frequent checks and to keep the bed in low position. The staff had access to mats and could be placed upon a resident's admission to the facility. Staff 13 stated room [ROOM NUMBER] was at the end of the hall and room [ROOM NUMBER] was near the nurses' station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/22 at 10:29 AM Staff 14 (CNA) stated he did not recall Resident 12. If a resident was identified as a fall risk, the nurses notified staff and interventions were placed on the Kardex. Some interventions could be mats at the bedside, bed in low position and to keep the call light be the resident. On 2/16/22 at 11:45 AM Staff 3 (RNCM) indicated if a resident was assessed to be at risk for falls, interventions were to be implemented. Staff 3 indicated at times it was difficult to implement interventions on the first day a resident was in the facility. Staff 3 acknowledged Resident 12 was assessed to be at risk for falls when she/he was admitted to the facility and interventions were implemented after the fall. On 2/17/22 at 9:25 AM Staff 7 (DNS) indicated the resident was assessed on admission to be a high risk for falls and no interventions were implemented after the assessment was completed. A 6/10/21 hospital Emergency Department dictation indicated Resident 12 fell at the facility had a very slight laceration about the right eyebrow which was treated at the facility with Steri-Strips (thin adhesive bandages) and a Band-Aid. The laceration did not have active bleeding, swelling or purulence.

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Tigard Rehabilitation and Care	14145 SW 105th Avenue Tigard, OR 97224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to provide supra-pubic (SP, tube which drains from the bladder) catheter care for 1 of 3 sampled residents (#22) reviewed for catheters. This resulted in Resident 22 developing a UTI with sepsis. Findings include: Resident 22 admitted to the facility on [DATE] with diagnoses including dementia, neurogenic bladder (bladder does not function normally due to nerve damage) and a history of UTIs. Resident 22 discharged on [DATE] to a long-term care facility. The [DATE] Admission Orders included the following SP catheter care orders: -Irrigate the SP catheter with 30 ml of normal saline every shift. From [DATE] through [DATE] this was documented as refused seven times. -Apply dimethicone (barrier cream) and split sponge every shift. From [DATE] through [DATE] this was documented as refused six times. There was no evidence in the medical record the resident was provided risk versus benefit education related to the treatment refusals. There was no evidence in the medical record Resident 22's family or physician was notified about the refusals. Hospital records dated [DATE] revealed Resident 22 was transferred to the hospital the day after she/he discharged from the facility and diagnosed with septic shock (full body infection) due to UTI and decubitus ulcer. Resident 22 died in the hospital on [DATE]. On [DATE] at 9:04 AM Staff 16 (CNA) stated Resident 22 frequently refused care and services especially personal hygiene. On [DATE] at 9:09 AM Staff 7 (DNS) verified Resident 22 refused the irrigation of the SP catheter and barrier cream and change, and the facility did not educate the resident of the risks and benefits of the refusals or contact the family and physician of the refusals.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to promptly verify weights, identify and assess when residents' nutritional and hydration intake was less than the residents required needs and/or had an unintended severe weight loss for 6 of 12 sampled residents (#s 1, 2, 9, 10, 22 and 35) reviewed for change in condition, dehydration, weight loss, eating assistance and change in condition. This failure resulted in an unintended severe weight loss for Resident #s 1 and 35, worsening wounds contributing to her/his death for Resident 22 and dehydration for Resident 10. Findings include: 1. Resident 10 was admitted to the facility in 2021 with diagnoses including dementia and COVID-19. A 7/1/21 Progress Note indicated Resident 10 was admitted to the facility and was too lethargic to sign consent forms. Resident 10's undated Kardex (CNA guide to resident specific care) revealed Resident 10 required 1 to 1 assist to eat. A Breakfast Intake report for 7/2021 revealed staff documented 10 out of 17 meals. The resident was documented to not eat breakfast on six days, ate 1-25% on three days and 26-50% on one day. A Lunch Intake report for 7/2021 revealed staff documented 10 out of 17 meals. The resident was documented to not eat lunch on five days and ate 1-25 % on five days. A Dinner Intake report for 7/2021 revealed staff documented 9 out of 17 meals. The resident was documented to not eat for three meals and 1-25 % for five meals. Resident 10's 7/2021 Fluids log indicated she/he drank 90-260 cc of fluids each day through 7/11/21. A 7/2021 Supplements Intake form indicated the resident did not receive any supplements even when the resident ate less than 25%. A 7/2021 AM Snack form revealed the resident was not offered snacks. A 7/2021 Bedtime Intake form revealed the resident was not offered snacks. A 7/11/21 Nutritional Assessment indicated the resident's current intake met 25% or less of her/his estimated needs, required 2250 cc of fluids each day and consumed less than 1000 cc per day. Staff were to offer fluids with medication pass and add a fruit based nutritional supplement BID. A 7/2021 Progress Notes and Daily Skilled Nursing notes did not have an assessment of the resident's lack of oral intake, notification to the resident's family and physician or what interventions the facility would implement to help the resident improve her/his intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Resident 10's 7/2021 Fluids log revealed the amount of fluids consumed increased after the RD recommendation was made for staff to offer the resident additional fluids, but continued to be less than the resident's 2250 cc daily need. The resident's 7/2021 TAR revealed the resident was offered and took up to 120 cc of fluid with each medication pass after the RD recommendations. Resident 10's record did not have documentation to indicate the fruit supplement was started. On 2/15/21 at 5:20 PM Staff 16 (CNA) stated if a resident did not eat her/his meal, the resident could be offered an alternative meal, a snack and or a nutritional supplement. If the resident refused the nurse was notified. The nurse was to check with the resident. On 2/22/22 at 10:21 AM Staff 6 (RN) reviewed Resident 10's record and acknowledged the resident did not eat or drink well. Staff should let the physician know if a resident was not eating or drinking after two to three days of not eating and/or drinking. If needed staff could administer intravenous fluids (fluids administered via a vein) or clysis (fluids administered under the skin). A 7/14/21 Office Visit form indicated Resident 10 was assessed in the facility by the facility physician. The physician assessment revealed the resident was admitted with COVID-19 infection, had fair skin turgor (elasticity of the skin which could be an indication of hydration status) and did not have increased symptoms related to COVID-19. There was no assessment specific to the resident's lack of oral intake of food and fluids. Resident 10's weight on 7/8/21 was 199 pounds and was 197 pounds on 7/15/21. On 2/16/22 at 11:45 AM Staff 3 (RNCM) acknowledged Resident 10 did not eat or drink well and often the intake was less than 50% and the resident was not offered supplements when her/his intake was less than 50%. Staff 3 indicated if a snack or supplement was provided the staff documented the amount consumed in the resident's record. Staff 3 acknowledged the resident was not documented to have snacks. Staff 3 also indicated she would look for documentation the physician was notified of the resident's lack of oral intake. No additional information was provided. On 2/24/22 at 10:00 AM Staff 7 (DNS) stated during COVID-19 the RD assessed residents via virtual visits and record review. The RD wrote a report and then sent it to the facility the next day. The RD recommendations were to be implemented the same day the facility received the recommendation. Staff 7 stated the Staff 19 (Dietary Manager) and RNCM were to work together to get the recommendations in place. Staff were to offer a supplement or snacks if a resident ate less than or equal to 50 percent the meal and they were to document when snacks and supplements were offered. The nurses should assess the resident and monitor the resident if the resident consistently did not eat. Staff 7 acknowledged the resident had decreased food and fluid intake and there was no documentation of snacks or supplements provided. A request was made to Staff 7 to provide documentation the facility assessed the resident and offered additional food and/or fluids to the resident. No additional information was provided. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Resident 10's 7/19/21 hospital History and Physical indicated the resident was admitted to the hospital and was nearly obtunded (slowed responses to stimulation and drowsy between sleep states). The resident had worsening oral intake resulting in dehydration. Resident 10 was assessed to have a free water deficit of approximately 2.4 liters. Resident 10 was administered one liter of intravenous fluids in the emergency department. On 2/25/22 at 12:35 PM Staff 20 (RD) reviewed the resident's record and acknowledged the resident had multiple days of poor fluid and oral intake. Staff did not add the fruit based supplement per recommendation. Staff 20 stated the resident's poor fluid intake, prior to her RD assessment, contributed to the resident's diagnoses of dehydration. Staff 20 stated the resident was likely deficient in fluids from multiple days of poor fluid intake. 2. Resident 9 was admitted to the facility 7/19/21 with diagnoses including dementia and respiratory illness. Resident 9's 7/29/21 Nutritional Assessment by the RD indicated the resident's weight on 7/20/21 was 81 pounds and was 83 pounds on 7/26/21. The resident had variable acceptance of meals with an average intake of 50%. The assessment also indicated the resident fluid intake required to meet needs was at least 1100 cc and the resident usually drank less than 1000 cc a day. The recommendation included NEMs (nutritionally enhanced meals-adding high fat foods such as butter and sauces to foods) and staff were to encourage fluids during medication pass. The resident's Active Orders report did not include NEMs and/or an order for staff to provide extra fluids during medication pass. On 2/16/22 at 11:45 AM and on 2/22/21 at 3:36 PM Staff 3 (RNCM) indicated she and the dietary manager were to work together to ensure the Staff 20 (RD) recommendations were implemented. Staff 3 indicated she reviewed Resident 9's Nutritional Assessment and acknowledged the RD recommendation was to add NEMs and to encourage fluids during medication pass. NEMs would be documented as a dietary order. Staff 3 stated when the RD recommended fluids be added with medication pass the recommendation was to be put on the MAR for at least BID fluid administration and to document the amount of fluids consumed. A request was made to Staff 3 to provide documentation NEMs and additional fluids were implemented for the resident after the 7/29/21 RD assessment. No additional information was provided. Resident 9 was discharged on [DATE], five days after the RD assessment, and no additional weights were in there resident's record after 7/26/21. The 8/16/21 hospital Discharge summary did not include the diagnosis of dehydration. 32543 3. Resident 1 was admitted to the facility in 11/2021 with diagnoses including COVID-19 and nutritional deficiency. A review of Resident 1's weight record revealed on 11/10/21 the resident's weight was 139.2 pounds. On 11/17/21 the resident's weight was 128.6. The facility's electronic medical record flagged the 11/17/21 weight as outside the acceptable range for weight change. No re-weigh to verify the resident's weight was found. This was a 7.6% body weight loss over seven days. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1's clinical record revealed no indication Staff 20 (RD), the resident's family or the resident's physician were notified of the weight loss identified on 11/17/21. Resident 1's Nutritional Status care plan created on 11/11/21 indicated the resident was at risk for nutritional impairment related to COVID-19 illness. The goal was for the resident to maintain her/his admission weight within five pounds. The only intervention was to monitor the resident's meal intake. A review of Resident 1's food intake record from 11/10/21 through 11/20/21 revealed overall poor food intake including: - Seven out of ten breakfast intakes of 0-25% consumed. - Seven out of ten lunch intakes of 0-25% consumed. - Seven out of ten dinner intakes of 0-50% consumed. An RD assessment dated [DATE] indicated the resident had a severe weight loss and the resident was at increased nutritional risk due to poor intake and weight loss. The assessment indicated Interventions are in place to increase calories and protein provided and remain appropriate., however no interventions, other than meal monitoring, prior to 11/19/21 were found. On 2/25/22 at 12:00 PM Staff 20 confirmed Resident 1's weights, weight loss and poor intake. Staff 20 stated her assessment on 11/19/21 was a normal new admission assessment and was not specifically requested by the facility related to the resident's poor intake or weight loss. Staff 20 stated she would expect the facility to assess the resident and implement appropriate interventions based on the resident's documented poor intake, as well as notify her and the resident's physician. 33179 4. Resident 35 was admitted to the facility in 1/2022 with diagnoses including heart failure. A 1/31/22 BIMS indicated Resident 35 was cognitively intact. A 2/2/22 RD Nutritional Assessment revealed Resident 35 had a variable acceptance of meals. Resident 35's weights revealed a 13.7% severe weight loss. The RD recommendations included to provide a house diabetic nutritional shake if less than 50% of the meal was eaten and to notify the RD as needed. A 2/11/22 Progress Note revealed Resident 35's admission weight on 1/21/22 was 197.4 pounds and Resident 35's 2/11/22 weight was 158 pounds which was a 39.4 pound loss. (This was a 19.96% severe weight loss.) Resident 35's Weight Report revealed the following weights: -1/21/22: 197.4 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	-1/22/22: 192 -1/28/22: 170 -2/4/22: 167 -2/11/22 158 A review of the medical record revealed no documentation the RD recommended diabetic health shakes were offered or given to Resident 35 or the RD was contacted about the ongoing weight loss. On 2/14/22 at 8:25 AM Resident 35 acknowledged she had an almost 40 pound weight loss in the past three weeks and stated the facility staff did nothing to prevent or stop the weight loss. Resident 35 stated she/he was not asked about her/his dietary preferences and was not offered nutritional shakes. Resident 35 further stated she/he sometimes needed assistance with meals due to problems in both hands but staff rarely offered assistance. Resident 35 stated when she/he needed assistance and assistance was not offered she/he just would not eat. On 2/14/22 at 8:56 AM Staff 19 (Dietary Manager) stated he did not interview residents to obtain their food preferences or specific dietary needs. On 2/23/21 at 9:12 AM Staff 20 (RD) stated before she completed a nutritional assessment resident specific information such as food preferences or special dietary needs should be brought to her by the dietary manager. Staff 20 stated she relied highly on staff to communicate with her but the facility did not contact her about Resident 35's ongoing weight loss. On 2/23/22 at 3:26 PM Staff 7 (DNS) and Staff 3 (RNCM) acknowledged Resident 35's 39.4 pound weight loss and verified Resident 35's medical record had no documentation the nutritional shakes were offered. 5. Resident 22 was admitted to the facility in 1/2022 with diagnoses including muscle wasting, heart failure, dementia and a Stage 4 pressure ulcer (full thickness skin and tissue loss including tendons, ligaments and bone). On 2/22/22 at 10:24 AM Witness 10 (Complainant) stated upon admission to the facility the facility staff were aware Resident 22 only ate mandarin oranges, bananas and drank milk for lunch and dinner. Resident 22 did not eat or drink anything else. Witness 10 stated the facility did not provide the mandarin oranges, as requested prior to Resident 22's admission, and did not notify the family Resident 22 did not get them. Witness 10 further stated Resident 22 went without the mandarin oranges for three to four days until she discovered this so she brought them in for the resident. A review of Resident 22's 1/2022 admission paperwork revealed mandarin oranges handwritten in the top right corner of the admission paperwork. A 1/7/22 Nutrition Care Plan revealed Resident 22 was at risk for nutritional impairment related to diminished appetite and poor meal acceptance related to COVID-19. The goal was to maintain weight within five pounds of her/his admission weight. The interventions included to assess and evaluate dietary likes and dislikes and weekly weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A 1/18/22 Nutritional Assessment indicated to continue the prescribed diet, add NEM (nutritional enhanced meals), add 120 ml of 2 cal (nutritional supplement), provide a multivitamin with minerals to the evening medication pass and to notify the RD PRN. The specific diet of mandarin oranges, bananas and milk was not assessed. The Weight Record revealed on 1/7/22 Resident 22 weighed 113.2 pounds. No other weights were obtained during Resident 22's stay at the facility. Review of the medical record revealed no documentation the RD recommendations were initiated. On 2/14/22 at 8:56 AM Staff 19 (Dietary Manager) stated he did not interview residents for their food preferences or specific dietary needs. Staff 19 further stated he was not aware Resident 22 only ate mandarin oranges, bananas and drank milk for lunch and dinner. Staff 19 could not recall if the facility provided the mandarin oranges to Resident 22. On 2/14/22 at 9:04 AM Staff 16 (CNA) stated Resident 22 refused multiple meals and loved the bananas and milk. Staff 16 further stated the facility did not provide Resident 22 with mandarin oranges so the family brought in cans of them later on. On 2/14/22 at 9:09 AM Staff 7 (DNS) acknowledged the facility did not honor Resident 22's food preference for mandarin oranges. Staff 7 further stated there was no documentation the RD recommendations were followed. On 2/23/22 at 9:27 AM Staff 20 (RD) stated she was not aware of Resident 22's specific dietary preferences and was unaware Resident 22 only consumed mandarin oranges, bananas and milk. Staff 20 stated she would have recommended other dietary interventions had she known of Resident 22's food preferences. Staff 20 acknowledged the 1/18/22 Nutritional Assessment was not a comprehensive assessment. 6. Resident 2 was admitted to the facility in 10/2021 with diagnoses including diabetes, stroke and GERD (gastroesophageal reflux disease). A 10/15/21 RD Nutritional Assessment revealed Resident 2 had a variable acceptance of meals and current weight is less than weight at admit to facility and indicates a 7.7% (weight loss) considered severe, recommend verify weight. The assessment further indicated Resident 2 was at an increased nutritional risk due to mechanically altered texture diet, decrease acceptance of meals and weight loss. The RD recommendations included to add NEM (nutritionally enhanced meals), provide a house supplement (nutritional shake) twice a day between meals and to document the ml's consumed on the MAR and to verify Resident 2's weight due to a 14 pound weight loss in one week. A CBG record revealed between 10/4/21 through 10/14/21 Resident 2's CBGs ranged from 76 to 503 (normal CBG range is 70 to 99). The resident's medical record revealed no documentation the NEM was initiated, the MARs did not document the twice daily house supplements and Resident 2's weight was not verified for accuracy. On 2/15/21 at 1:48 PM Staff 7 (DNS) acknowledged the RD recommendations were not followed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 2/24/22 at 8:33 AM Staff 20 (RD) acknowledged the RD assessment did not include Resident 2's diabetes and varied CBG levels.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 32543 Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (#1) reviewed for change in condition. This placed residents at risk for adverse medication consequences. Findings include: Resident 1 was admitted to the facility in 11/2021 with diagnoses including COVID-19 and high blood pressure. A review of Resident 1's 11/2021 MAR revealed the resident was ordered carvedilol (treats high blood pressure and heart failure) 3.125 mg at bedtime with parameters to not administer the medication if the resident's systolic blood pressure (upper number in a blood pressure reading) was less than 100. On 11/11/21 Resident 1's blood pressure was documented on the MAR as 74/40 and Staff 21 (LPN) administered the carvedilol. No comments on the MAR were found to indicate the rationale for administration of the carvedilol outside the ordered parameters. On 2/23/22 at 4:41 PM and 5:19 PM Staff 21 did not recall administering carvedilol to Resident 1 on 11/11/21. Staff 21 stated in a case like this she would not administer the medication, assess the resident and notify the physician. Staff 21 was asked to review the resident's record for any additional information. After Staff 21 reviewed the resident's record she stated she must have misread the blood pressure reading. On 2/16/22 at 10:07 AM Staff 7 (DNS) stated the carvedilol should not have been administered to Resident 1.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to ensure dietary preferences were accommodated for 1 of 3 sampled residents (#22) reviewed for food preferences. This placed residents at risk for unmet food preferences and increased nutritional risk. Findings include: Resident 22 was admitted to the facility on [DATE] with diagnoses including muscle wasting, heart failure and dementia. On 2/22/22 at 10:24 AM Witness 10 (Complainant) stated upon admission to the facility the facility staff were aware Resident 22 only ate mandarin oranges, bananas and drank milk for lunch and dinner. Resident 22 did not eat or drink anything else. Witness 10 stated the facility did not provide the mandarin oranges as requested prior to Resident 22's admission and did not notify the family Resident 22 did not get them. Witness 10 further stated Resident 22 went without the mandarin oranges for three to four days until she discovered this so she brought them in for the resident. A review of Resident 22's 1/2022 admission paperwork revealed mandarin oranges handwritten in the top right corner of the admission paperwork. A 1/7/22 Nutrition Care Plan revealed Resident 22 was at risk for nutritional impairment related to diminished appetite and poor meal acceptance related to COVID-19. The interventions included to assess and evaluate dietary likes and dislikes. The resident's medical record revealed no assessment of Resident 22's dietary likes and dislikes. On 2/14/22 at 8:56 AM Staff 19 (Dietary Manager) stated he did not interview residents for their food preferences or specific dietary needs. Staff 19 further stated he was not aware Resident 22 only ate mandarin oranges, bananas and drank milk for lunch and dinner. Staff 19 could not recall if the facility provided the mandarin oranges to Resident 22. On 2/14/22 at 9:04 AM Staff 16 (CNA) stated Resident 22 refused multiple meals and loved the bananas and milk. Staff 16 further stated the facility did not provide Resident 22 with mandarin oranges so the family brought in cans of them later on. On 2/14/22 at 9:09 AM Staff 7 (DNS) acknowledged the facility did not honor Resident 22's food preference for mandarin oranges.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41453 Based on interview and record review it was determined the facility failed to update their Facility Assessment for 1 of 1 assessments reviewed. The failure to update resulted in an assessment that did not accurately reflect the acuity level needed or the training required to provide care and services to the residents and placed residents at risk for unassessed needs. Findings include: A Facility Assessment last reviewed on 3/3/22 revealed the resident acuity level indicated the facility had a high long-term care population. The Facility Assessment further revealed the facility would provide monthly trainings, core courses taught, and re-education done as needed and that specific Licensed Nurse and CNA meetings would be coordinated for more specific training and education. On 4/2020 the facility was converted from a long term care facility into a COVID-19 recovery facility. On 3/4/22 at 9:52 AM Staff 2 (Administrator) confirmed that the acuity of the facility as well as the training regimen documented was not accurate to reflect the current acuity and training needs of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385272	A. Building B. Wing	03/07/2022

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

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. 26991 Based on interview and record review it was determined the facility failed to ensure breakfast was documented for 1 of 3 sampled residents (#9) reviewed for weight loss. This placed residents at risk for incomplete records. Findings include: Resident 9 was admitted to the facility 7/2021 with diagnoses including dementia. An Active Order list indicated staff were to document the resident's breakfast intake. Resident 9's Meal intake for 7/20/21 through 8/2021 revealed 3 out of 13 breakfasts were documented. On 2/24/22 at 10:00 AM Staff 7 (DNS) acknowledged only three breakfasts were documented for Resident 9 and staff would not be able to track meal intake and possible concerns if there was no documentation.