STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E075	A. Building B. Wing	03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Rose Care Center	4254 Weathers Street NE Salem, OR 97301

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34702 Based on interview and record review it was determined the facility failed to notify the physician timely for a change of condition and notify family for non-pressure skin issues for 2 of 5 sampled residents (#s 58 and 109) reviewed for hospitalization and non-pressure skin. This placed residents at risk for untimely treatment. Findings include: 1. Resident 58 was admitted to the facility in 2019 with diagnoses including chronic obstructive pulmonary disease (COPD) and anxiety disorder. The 1/18/22 physician order indicated to obtain oxygen saturation level and utilize PRN oxygen to maintain oxygen saturation between 88-92% every four hours. Resident 58's progress notes, MARs and Vital Sign Records indicated the following: -2/2/22 7:08 AM oxygen saturation was 84%. -2/2/22 8:00 AM oxygen saturation was 81%. -2/2/22 8:35 AM oxygen saturation was 86%. -2/2/22 5:59 PM oxygen saturation was 87%. -2/2/22 8:26 PM oxygen saturation was 86%. -2/3/22 12:50 AM oxygen saturation was between 80-86% and increased to 98%. -2/3/22 8:51 AM oxygen saturation was 71% and increased to 81%. -2/3/22 10:52 AM oxygen saturation was 81%. -2/3/22 11:15 AM oxygen saturation was 71% will contact on call provider and leave note in provider's box regarding the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/3/22 12:18 PM the resident began coughing up a scant amount of bright red blood into tissues and her/his oxygen saturation was 69% a message was left for the on-call provider for a 20 minute call back. -2/3/22 1:05 PM (a late entry note) a call back was received from the on-call provider and staff were instructed to send Resident 58 to the hospital. Emergency services were contacted and the resident went to the hospital at approximately 12:55 PM on 2/3/22. There was no indication in the residents clinical record to indicate the physician was notified of Resident 58's oxygen saturations below 88% until 2/3/22 at 11:15 AM. On 3/25/22 at 10:10 AM Witness 6 (Nurse Practitioner) reviewed the findings and stated Resident 58 had an order to maintain oxygen saturations between 88-92% and the expectation was for staff to call the provider if oxygen saturations dropped below 88%. Witness 6 further stated staff did not notify the provider timely of Resident 58's change in condition and the expectation was for staff to have notified the provider the morning of 2/2/22. On 3/25/22 at 11:04 AM Staff 43 (RN) stated she worked day shift on 2/2/22 and 2/3/22. Staff 43 stated she should have notified the physician on the morning of 2/2/22 after Resident 58's oxygen saturations dropped below 88%. On 3/23/22 at 2:14 PM and 3/28/22 at 8:46 AM Staff 2 (DNS) stated Resident 58's physician order indicated to keep oxygen saturations between 88-92 %. Staff 2 stated the expectation was for staff to notify the physician within 30 minutes after a change in condition and the physician should have been notified on 2/2/22 after the resident's oxygen saturations did not increase at 8:35 AM. 2. Resident 109 admitted to the facility in 10/2020 with diagnoses including heart failure. The 12/29/21 progress note indicated an order was received to swab sore on back of head with povidone-iodine until resolved. There were no skin assessments or measurements of the sore on the resident's head in the electronic health record and no indication as to what type of sore or wound Resident 109 had. There was no indication in Resident 109's clinical record to indicate her/his responsible party was notified of the sore/wound. On 3/14/22 at 12:19 PM Witness 1 (Responsible Party) stated she was not notified of the sore on Resident 109's head. On 3/28/22 at 8:49 AM Staff 2 (DNS) acknowledged there were no wound and skin assessments on 12/29/21 or afterward to indicate what type of wound she/he had on the back of her/his head. Staff 2 acknowledged Witness 1 was Resident 109's responsible party and was not notified.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34324 Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect. The facility failed to ensure resident assessments were completed and implemented, care plans were revised and reviewed timely, failed to assess and monitor pressure ulcers, failed to ensure there was coordination of care with hospice, failed to ensure residents received restorative aide therapy to prevent a physical decline, failed to implement therapy orders, failed to notify the physician timely for a change of condition, failed to follow physician orders, address skin conditions and assess change of condition, failed to ensure interventions were implemented and assessed to prevent falls, failed to ensure residents at risk for aspiration were supervised while eating, failed to ensure residents with dementia did not elope from the facility and failed to develop person-centered care plans, failed to adhere to professional standards, and failed implement an antibiotic stewardship. The cumulative effect of these failures in providing care and services contributed to an environment of neglect to 18 of 64 sampled residents (#s 2, 3, 9, 12, 14, 17, 18, 19, 22, 23, 24, 27, 58, 108, 109, 108, 159 and 258) reviewed for care and services. This placed residents at risk for neglect of care. Findings include: According to the Centers for Medicare & Medicaid Services (CMS), S483.5, Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. ASPIRATION Resident 158 Resident 158 admitted on ,d+[DATE] with diagnoses including sepsis, dementia and acute kidney failure. The 2/18/22 hospital discharge diet orders indicated Resident 158 required 1:1 supervision with feeding. The 2/18/22 RN Admission Progress Note indicated the resident was on a regular/pureed thin liquids diet. The note did not indicate Resident 158 was to receive 1:1 supervision with meals. The revised 2/23/22 Admission care plan revealed there was no indication of the resident's diet or whether the resident required supervision with meals. The meal monitoring from 2/27/22 through 3/27/22 revealed the resident had setup help only for all meals and twice the resident had one person physical assist. On 3/14/22 at 11:42 AM observed Resident 158 alone in her/his room. No aspiration signage noted in resident's room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/22 at 3:20 PM Staff 53 (CNA) stated so often residents were not supervised while eating as there were so many Personal Care Assistants (PCAs) and there were not enough staff to monitor residents. Staff 53 stated management had been told over and over and believed this was a form of neglect. Staff 53 further stated the facility needed a system for which residents received thickened liquids. Staff 53 stated new staff were not educated on who required supervision or thickened liquids and Staff 53 had seen residents not supervised during meals or provided thickened liquids. On 3/15/22 at 5:31 PM Staff 13 (PCA) delivered Resident 158's dinner tray to her/his bedside table. Resident 158 was left unattended with the meal and staff closed the door. On 3/15/22 at 5:35 PM Resident 158 was observed eating independently in the room with no staff present. On 3/15/22 at 5:36 PM Staff 13 acknowledged Resident 158 eating in her/his room independently and stated she/he ate independently and was not an aspiration risk. On 3/15/22 at 5:41 PM Staff 7 (LPN) reviewed Resident 158's physician orders which indicated the resident was to be 1:1 supervision for meals. Staff 7 confirmed staff were not providing 1:1 supervision during meals and 1:1 meal supervision is not indicated on the resident's Kardex or care plan. On 3/15/22 a request was made for the meal supervision policy. Staff 2 (DNS) stated the facility did not have a policy for meal supervision. On 3/15/22 at 9:47 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified of the immediate jeopardy (IJ) situation and were provided a copy of the IJ template related to the facility's failure to ensure residents were adequately supervised during meals. Refer to F689 RESIDENT ELOPEMENT Resident 17 Resident 17 admitted to the facility in 12/2021 with diagnoses including dementia with behaviors and delusions and anxiety. Resident 17 admitted from a memory care unit. The 12/10/22 Admission MDS indicated the resident was moderately cognitively impaired. The MDS did not indicate Resident 17 had wandering behaviors. The Care Plan, last updated 12/28/21, did not indicate Resident 17 was an elopement risk. The 12/14/21 Wandering Risk Assessment was not completed in full and categorized Resident 17 as a Low Risk for Wandering. Record review from 1/2022 through 3/2022 indicated Resident had wandering and exiting-seeking behaviors with documentation of behaviors starting on 1/15/22. The records indicated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1/25/22 Resident 17 was opening the facility door to head outside and was stopped by staff. Later that evening staff heard the 300-hall door alarm sound, and it was Resident 17 and staff redirected the resident back into the building. *2/15/22 Call made to Resident 17's daughter to reinforce the resident is not safe in the building due to it not being a locked building. *2/15/22 Resident 17 out in the parking lot attempting to get into a staff's vehicle. The 2/15/22 Incident Investigation indicated on 2/15/22 at 12:20 PM Resident 17 was reported to be outside the facility in the parking lot next to a staff's car with the door open. Resident 17 kept insisting she/he was going to leave. Staff attempted to redirect the resident multiple times and finally after getting Staff 2 (DNS) the resident agreed to return to the facility. The conclusion indicated: Resident 17 had diagnoses of legal blindness, dementia with behavioral disturbance and visual hallucinations. Able to redirect resident's behaviors. Staff will continue to check [Resident 17] and reorient as [she/he] is noted with confusion. There were no witness statements. There was no documented evidence the facility analyzed the hazards and risks related to Resident 7's elopement, updated the care plan, or implemented new interventions to reduce the hazards and risk associated with her/his elopement. On 3/14/22 at 4:37 PM Witness 1 (Family Member) stated she was informed the night prior by Staff 15 (Unit Clerk) that Resident 17 had wandered outside the facility because the exit door down the 100 hall was unlocked. Witness 1 stated Resident 17 was an elopement risk and had attempted to leave the facility multiple times due to her/his diagnoses and previously made it outside the facility and refused to come back in. On 3/14/22 at 5:13 PM Staff 7 (LPN) stated on 3/13/22 the door down the 100 hall was left unlocked, but he was not aware of Resident 17 getting out of the building. On 3/14/22 at 5:17 PM Staff 15 stated she was informed a couple nights prior that Resident 17 got out of the emergency exit down the 100 hall and was informed by morning staff. Staff 15 was unable to recall who specifically informed her of the incident, but believed the incident occurred over the past weekend. Staff 15 was unsure how long the resident was out of the facility, but management was aware of the incident. On 3/14/22 at 5:23 PM Staff 39 (CNA) stated Resident 17 was always exit seeking and had previously gotten out of the back door that residents used to go smoke. Staff 39 stated on Thursday (3/10/22) the resident had gotten outside, but Staff 39 saw the resident right away and redirected the resident back inside. Staff 39 stated a few weeks prior she was coming onto her shift and found Resident 17 outside in the parking lot. Staff 39 stated staff did not have the ability to stop the resident as she/he was so quick and if staff were caring for another resident, Resident 17 would leave. On 3/15/22 at 8:50 AM Resident 19 stated before Resident 44 moved rooms the resident would come into Resident 19's room, and she/he would have to tell Resident 44 to leave. Resident 19 further stated the week prior staff were unable to locate Resident 17, so they went through all the rooms looking for Resident 44 and found the resident in another resident's bathroom. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/22 at 4:13 PM Staff 19 (Admissions) stated he was not aware Resident 17 was outside the facility but was informed by Witness 1 on 3/13/22 that the resident attempted to leave the facility that day due to the door down the 100-hall being unlocked. Staff 19 stated he reported the incident to Staff 1 (Administrator). On 3/15/22 at 4:18 PM Staff 1 (Administrator) stated she was aware Resident 17 had left the facility previously but was not aware of Resident 17 recently leaving the facility out the 100-hall door as the door was always locked. On 3/15/22 at 4:44 PM Staff 26 (LPN) had wandering behaviors and liked to wander into other residents' rooms and all hallways. Staff 26 reported there were times staff could not find the resident and had to look throughout the facility for her/him. On 3/15/22 at 8:11 PM Staff 28 (CNA) stated Resident 17 had wandering behaviors, including going into other residents' rooms and had nearly gotten out of the exit door down the 300-hall. Staff 28 stated Resident 17 would often go past the nurses' station, so staff would shut the fire doors to prevent the resident from leaving. There was no investigation for the alleged incident Resident 17 left the facility during the month of 3/2022, until 3/24/22. The care plan did not indicate wandering and elopement behaviors or interventions. There was no updated assessment of Resident 17's wandering and elopement behaviors. On 3/15/22 at 9:47 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified Resident 17's elopement and attempted elopements constituted an immediate jeopardy situation. Refer to F689 RESIDENT ASSESSMENTS, CARE PLAN REVISION AND REVIEW Resident 108 Resident 108 admitted to the facility on [DATE] with diagnoses including depression, anxiety and assistance with personal care. An Admission MDS was initiated on 3/3/22 with an assessment reference dated 3/9/22. The MDS was noted to be still in process, 17 days overdue as of 3/18/22. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed the Admission MDS for Resident 108 was not completed and overdue. F636 Resident 158 Resident 158 was admitted to the facility on [DATE] with diagnoses including dementia and congestive heart failure. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Admission MDS was initiated on 2/25/22 with an assessment reference date of 3/3/22. The MDS was noted to be still in process, 29 days overdue as of 3/18/22. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed the Admission MDS for Resident 158 was not completed and overdue. Refer to F636 Resident 258 Resident 258 admitted to the facility on [DATE] with diagnoses including cerebral palsy and depression. Review of Resident 258's clinical record on 3/17/22 did not indicate an Admission MDS was completed. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed Resident 258's Admission MDS was not completed for the required time frame. Refer to F636 Resident 17 a. Resident 17 admitted to the facility in 12/2021 with diagnoses including dementia with behaviors and delusions, and anxiety. A 2/27/22 Admission note indicated Resident 17 readmitted to the facility on hospice on 2/27/22 following a hospitalization . Review of Resident 17's record indicated a Significant Change MDS was due 3/11/22 related to the resident admitting to hospice and had not been completed. On 3/17/22 at 10:56 AM staff 2 (DNS) acknowledged Resident 17 admitted to hospice on 2/27/22 and a Significant Change MDS had not been completed. b. The 12/3/21 Wandering Risk Assessment was incomplete but indicated Resident 17 was a low risk for wandering. The Resident's Care Plan, last updated 2/22/22, did not include wandering behaviors or any interventions related to prevent wandering or elopement. On 3/14/22 04:37 PM Witness 1 (Family Member) stated she Resident 17 was an elopement risk and had attempted to leave the facility multiple times due to her/his diagnoses. On 3/14/22 at 5:23 PM Staff 39 (CNA) stated Resident 17 was always exit seeking, wandered into other residents' rooms, and had previously gotten out of the back door of the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/22 at 4:44 PM Staff 26 (LPN) had wandering behaviors and liked to wander into other residents' rooms and all hallways. Staff 26 reported there were times staff could not find the resident and had to look throughout the facility for her/him. On 3/18/22 at 10:19 AM Staff 2 (DNS) acknowledged Resident 17's care plan did not include wandering behaviors or interventions to prevent wandering. Staff 2 stated all care plans were in progress and not updated for residents. Refer to F637 and F657 Resident 3 Resident 3 admitted to the facility in 21018 with diagnoses including congestive heart failure and dementia. A progress note dated 3/7/22 indicate Resident 3's identified significant change was on 2/28/22. A Significant Change MDS was initiated with an assessment reference dated of 2/28/22. The MDS was noted to be still in process, 18 days overdue as of 3/18/22. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed the Significant Change MDS for Resident 3 was not completed and overdue. Refer to F637 Resident 27 Resident 27 admitted to the facility in 2018 with diagnoses including aphasia and stroke. An Observation on 3/15/22 at 11:57 AM of Resident 27 was made of staff delivering a lunch tray to the resident. At 12:00 PM Resident 27 was observed feeding himself with no staff present. The resident stated she/he fed her/himself and received no assistance or supervision from staff. Resident 27's care plan dated 9/24/19 indicated she/he needed supervision for meals. Resident 27's Kardex (in room care plan) indicated she/he required supervision with meals. Review of the medical record indicate a Refusal to Follow Prescribed Diet Release form was completed. The form indicated Resident 27 did not want to follow the prescribe diet, including supervision with meals. The form was signed by the resident on 2/7/20. On 3/18/22 at 10:19 AM Staff 2 (DNS) Resident 27's care plan was not updated to reflect the current diet and meal assistance preference. Refer to F657 Resident 14 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 14 admitted to the facility in 11/20218 with diagnoses including a stroke resulting in hemiparesis (paralysis of half the body) and a hip fracture. A 3/1/22 Encounter Note indicated Resident 17 had a right hip fracture in August 2020 and was experiencing increased pain. On 3/14/22 at 1:55 PM Resident 14 stated her/his pain medications were always late and she/he often had pain in her/his hip. Resident 14's care plan was last updated in 2019 and did include the resident sustaining a hip fracture with increased pain or interventions to improve the resident's pain. On 3/17/22 at 2:07 PM and 3/18/22 at 10:19 AM Staff 2 (DNS) acknowledged Resident 14's care plan had not been updated since 2019 to include her/his hip fracture, which resulted in increased pain and required pain interventions. Staff 2 stated all resident care plans were in progress and not updated. Refer to F657 ASSESSMENT AND MONITORING OF PRESSURE ULCERS Resident 18 Resident 18 was admitted to the facility in 1/2021 with diagnoses including Alzheimer's disease and failure to thrive. The 2/4/22 skin assessment indicated there were no new skin issues noted and there were current orders in place for known skin issues, will continue to monitor and hospice will continue to evaluate. The note did not indicate Resident 18's wound type or measurements of wounds. The 12/22/21 physician order indicated to cleanse the wound on the right lateral foot with wound cleanser, pat dry, apply iodosorb and calcium alginate to wound bed, apply skin prep to surrounding skin and cover with foam dressing. Change three times per week and PRN for soilage or accidental removal. Hospice nurse to change on Monday and Thursday, facility nurse to change on Saturday [and PRN]. The 2/22 and 3/22 TARs indicated dressing changes were completed as ordered. On 3/16/22 at 1:47 PM Staff 11 (RN) and Staff 43 (RN) indicated they were the treatment nurses for the entire facility on 3/16/22 and both staff were unaware Resident 18 had a pressure ulcer. The 3/23/21 care plan indicated Resident 18 had a Stage 4 pressure ulcer to the coccyx. The care plan did not include information about Resident 18's pressure ulcer on the foot. On 3/23/22 10:05 AM Witness 11 (Hospice RN) was observed to complete a dressing change for Resident 18. Witness 11 stated Resident 18 had a healed pressure ulcer to the coccyx but was still placing a dressing on the area for preventative care and a pressure ulcer on her/his right foot. The area was observed to be open and red. Witness 11 stated the pressure ulcer to the foot was red and had less slough than the week prior and it was improving. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/22 at 10:34 AM Staff 2 (DNS) acknowledged Resident 18 had an open pressure ulcer to the right foot and there was no indication of the stage of the pressure ulcer, no assessments, no measurements and no facility weekly skin assessments for Resident 18's the pressure ulcer on the right foot. Staff 2 further acknowledged there were no hospice notes indicating the condition of the pressure ulcer. Refer to F686 Resident 14 Resident 14 admitted to the facility in 11/20218 with diagnoses including a stroke resulting in hemiparesis (paralysis of half the body) and a hip fracture. The 11/30/21 Annual MDS indicated the resident was moderately cognitively impaired and was coded as having one Stage II pressure ulcer that was not present upon admission. Physician orders indicated: *1/1/22: Clean bilateral buttock and right posterior thigh with soap and water; pat dry. Apply Aquaphor (topical ointment) every evening shift every three days. *2/28/22: Right gluteal fold: Clean with normal saline. Apply barrier cream and cover. Review of the 3/2022 TAR indicated wound treatments were completed as ordered. Weekly Skin Evaluations were reviewed for 1/2022 through 3/2022 and indicated: *1/30/22: Buttocks wound with no description, measurements, or staging. Summary indicated the wound had improved and current treatment in place. *2/2/22: Right buttock, left buttock, left gluteal fold, and right gluteal fold wounds. No measurements or staging. The only description of all four wounds was redness. The summary indicated orders on TAR to complete weekly skin check to monitor improvement. Barrier cream being applied. *2/20/22: Right gluteal fold wound, no description, measurements or staging. Summary indicated the provider had been notified and orders were entered in the TAR for monitoring of the wound. *3/2/22: Form left blank. A 3/17/22 Shower Skin Sheet indicated the resident had a sore in [her/his] left bottom. There was no other description of the wound or an assessment. On 3/15/22 at 11:52 AM Resident 14 stated she/he had a pressure sore on her/his bottom and was unsure if it was healing. Resident 14 stated staff attempted to reposition her/him, but she/he often refused and had the sore for forever. Resident 14 declined to have the surveyor nurse observe the wound. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/22 at 11:57 AM Staff 2 (DNS) and stated facility treatment nurses were not completing wound assessments and acknowledged the multiple dates Resident 14's skin assessments were not completed or completed in full. On 3/22/22 at 10:14 AM Witness 6 (Nurse Practitioner) stated she was unsure the status of Resident 14's buttocks wound. Refer to F686 HOSPICE COORDINATION Resident 17 Resident 17 admitted to the facility in 12/2021 with diagnoses including dementia with behaviors and delusions and anxiety. The 12/10/22 Admission MDS indicated the resident was moderately cognitively impaired. Resident 17 admitted to hospice on 2/27/22. Resident 17 had PRN orders for: *Haloperidol (antipsychotic medication) tablet 0.5 G every two hours PRN *Lorazepam (antianxiety medication) tablet 0.5 MG every two hours PRN The 3/2022 MAR indicated Haloperidol was administered nine times out of the 13 days reviewed. Progress Notes reviewed from 2/1/2022 through 3/14/22 indicated Resident 17 had multiple behaviors including wandering, calling out, hallucinations, aggression, agitation, and exit seeking. On 3/8/22 the surveyor requested hospice notes for the past 30 days for Resident 17. On 3/21/22 at 12:58 PM Staff 1 (Administrator) stated hospice notes were not available in the record for Resident 17 and she had to request them. On 3/18/22 at 9:11 AM Witness 3 (Hospice LPN) stated she was seeing Resident 17 that day to increase scheduled psychotropic medications and use less PRN ones. Witness 3 stated she had a lot of concerns regarding communication with the facility. Witness 3 stated at times the facility did not notify hospice about Resident 17's behaviors, including elopement. Witness 3 further stated she had issues with medication orders being sent to the facility, but the facility not putting them into the system. Witness 3 stated she was doing a lot of education for PRN medication as staff were underutilizing the medication but now were now overusing them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/22 at 3:33 PM Witness 2 (Hospice RN) stated she had concerns about medication orders and having to keep calling the facility to ensure they received the order. Witness 2 stated orders were at times not implemented until the next day. Witness 2 stated facility staff were not utilizing PRN psychotropic medications for Resident 17 until a crisis point, and by then it was difficult to get the resident back to baseline. On 3/28/22 at 12:40 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the communication concerns with hospice. Refer to F689 and F744 Resident 18 Resident 18 was admitted to the facility in 1/2021 with diagnoses including Alzheimer's disease and failure to thrive. The 2/4/22 skin assessment indicated there were no new skin issues noted and there were current orders in place for known skin issues, will continue to monitor and hospice will continue to evaluate. The note did not indicate Resident 18's wound type or measurements of wounds. The 12/22/21 physician order indicated to cleanse the wound on the right lateral foot with wound cleanser, pat dry, apply iodosorb and calcium alginate to wound bed, apply skin prep to surrounding skin and cover with foam dressing. Change three times per week and PRN for soilage or accidental removal. Hospice nurse to change on Monday and Thursday, facility nurse to change on Saturday [and PRN]. On 3/16/22 at 1:47 PM Staff 11 (RN) and Staff 43 (RN) indicated they were the treatment nurses for the entire facility on 3/16/22 and both staff were unaware Resident 18 had a pressure ulcer. The 3/23/21 care plan indicated Resident 18 had a Stage 4 pressure ulcer to the coccyx. The care plan did not include information about Resident 18's pressure ulcer on the foot. On 3/23/22 10:05 AM Witness 11 (Hospice RN) was observed to complete a dressing change for Resident 18. Witness 11 stated Resident 18 had a healed pressure ulcer to the coccyx but was still placing a dressing on the area for preventative care and a pressure ulcer on her/his right foot. The area was observed to be open and red. Witness 11 stated the pressure ulcer to the foot was red and had less slough than the week prior and it was improving. Witness 11 further stated if changes needed to be made immediately, she communicated with different facility staff depending on who was working. Witness 11 stated she hand delivered hospice notes to the facility on ce a month and there was no process in place to ensure the facility received hospice notes timely after she visited the resident. On 3/24/22 at 10:34 AM Staff 2 (DNS) acknowledged Resident 18 had an open pressure ulcer to the right foot and there was no indication of the stage of the pressure ulcer, no assessments, no measurements, and no facility weekly skin assessments for Resident 18's the pressure ulcer on the right foot. Staff 2 further acknowledged there were no hospice notes indicating the condition of the pressure ulcer. Refer to F686 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESTORATIVE AIDE AND THERAPY Resident 258 Resident 258 admitted to the facility on [DATE] with diagnoses including cerebral palsy and depression. The 2/8/22 Care Plan indicated Resident 258 had contractures of her/his bilateral upper extremities related to cerebral palsy. Staff were instructed to provide a cloth/palm pad as needed to keep clean and prevent skin breakdown. The 3/25/22 Admission MDS indicated Resident 258 was cognitively intact and was totally dependent on staff for transfers, eating, dressing, and bed mobility. The resident received zero days of range of motion (both active and passive) in the look-back period. a. A 2/22/22 Physician Order instructed staff to place appropriately sized piece of foam into Resident 258's left hand one time a day for contracture. Observations of Resident 258 from 3/14/22 through 3/17/22 did not reveal the resident with a piece of foam for her/his left-hand contracture. On 3/16/22 at 1:56 PM Resident 258 was asked about the foam for her/his left hand. Resident 258 stated the foam did not fit, it fell out of her/his hand and was not the right size, so staff did not use the foam. On 3/17/22 at 9:13 AM Staff 35 (Restorative Services/CNA) stated Resident 258 had a foam grip in her/his bedroom drawer. On 3/17/22 at 9:16 AM Staff 35 and surveyor entered Resident 258's room. Staff 35 acknowledged Resident 258 did not have the foam grip or other intervention for the resident's left contracture and the foam grip was on the bedside table. Resident 258 stated the foam grip was too big. Staff 35 stated she would order a smaller one and was unsure how often the foam grip was to be used for the resident. On 3/17/22 at 10:48 AM Staff 2 (DNS) acknowledged Resident 258 was not utilizing the ordered foam intervention as the device was not the correct size. Staff 2 stated resident care managers were expected to complete assessments for residents like 258 to ensure the resident had the correct size foam, but the facility did not currently have any resident care managers. b. On 3/14/22 at 10:24 AM Resident 258 stated she did not receive physical therapy or restorative aid and had requested them. Resident 258 stated staff did not assist the resident with ROM. Resident's bilateral upper extremities were observed to be contracted. On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA in the beginning and now there was no resident care managers to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no resident care managers to oversee the RA program. Refer to F688 Resident 12 Resident 12 admitted to the facility in 8/2018 with diagnoses including ulcerative colitis (inflammatory bowel disease) and diabetes. The 2/25/22 MDS indicated the resident was cognitively intact and was totally dependent on staff for transfers and required extensive assistance for bed mobility. The resident did not receive therapy or a restorative program was not performed during the look-back period. On 3/14/22 at 11:20 AM Resident 12 stated the facility ceased physical therapy in March 2021, and no one had offered to assist the resident with ROM. Resident 12 was observed to have a resistance band on her/his bed and stated that CNAs were unable to do RA with residents, including assisting the resident to use the band. Resident 12 stated management was aware she/he wanted therapy and RA, but stated she/he would have to tell them again. A 3/15/22 Physician Encounter note indicated the resident had a diagnoses of generalized weakness. Per the resident's report someone came to the facility to evaluate the resident for therapy, but the provider was also asked to put in a referral. The summary indicated a Physical/Occupational Therapy home health order for the resident was needed for home health services based on the resident's clinical condition. On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA and now there was no resident care managers to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no resident care managers to oversee the RA program currently. Refer to F688 Resident 14 Resident 14 admitted to the facility in 11/2018 with diagnoses including a stroke resulting in hemi-paresis (paralysis of half the body) and a right hip fracture. The 11/30/21 Annual MDS indicated Resident 14 was moderately cognitively impaired, and was totally dependent on staff for transfers and bed mobility. The resident did not receive therapy or a restorative program during the look-back period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/14/22 at 1:55 PM Resident 14 stated she/he wanted to receive RA, but there was not enough staff to help her/him do exercises. The 3/2022 RNA (Restorative Nursing Aid) Ambulating Task Sheet indicated staff were to document how much time the resident spent practicing ambulating. The sheet was blank for the past 20 days reviewed. A 3/14/22 Physician Encounter indicated Resident 14 had limited ROM and right sided weakness and staff were to perform passive range of motion right lower extremity (RLE) daily. On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA and now there was no RCMs to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no RCMs to oversee the RA program currently. Refer to F688 Resident 19 Resident 19 was admitted to the facility on [DATE] with diagnoses including hypertension. The 12/15/21 admission orders indicated Resident 19 had referrals for physical therapy and occupational therapy. The 2/1/22 physician order indicated physical therapy and occupational therapy were to evaluate and treat Resident 19. The 3/15/22 progress note indicated the resident reported she/he had not yet started therapy. On 3/15/22 at 8:33 AM Resident 19 stated she/he had orders for therapy and was frustrated she/he had not yet received therapy services. On 3/22/22 at 10:08 AM Witness 6 (Nurse Practitioner) stated Resident 19 had orders for therapy in 12/2021 and 2/2022 and she/he had not [NAME] [TRUNCATED]

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34324 Based on interview and record review it was determined the facility failed to timely and comprehensively assess residents' needs for 3 of 8 sampled residents (#s 108, 158 and 258) reviewed for resident assessments and limited range of motion. This placed residents at risk for unassessed needs. Findings include: According to the RAI Manual 3.0 a resident must have an Admission MDS assessment completed within 14 days of admission to the facility. 1. Resident 108 admitted to the facility on [DATE] with diagnoses including depression, anxiety and assistance with personal care. An Admission MDS was initiated on 3/3/22 with an assessment reference dated 3/9/22. The MDS was noted to be still in process, 17 days overdue as of 3/18/22. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed the Admission MDS for Resident 108 was not completed and overdue. 2. Resident 158 was admitted to the facility on [DATE] with diagnoses including dementia and congestive heart failure. An Admission MDS was initiated on 2/25/22 with an assessment reference date of 3/3/22. The MDS was noted to be still in process, 29 days over due as of 3/18/22. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed the Admission MDS for Resident 158 was not completed and overdue. 40767 3. Resident 258 admitted to the facility on [DATE] with diagnoses including cerebral palsy and depression. Review of Resident 258's clinical record on 3/17/22 did not indicate an Admission MDS was completed. On 3/18/22 at 10:19 AM Staff 2 (DNS) confirmed Resident 258's Admission MDS was not completed for the required time frame.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34324 Based on interview and record review it was determined the facility failed to review and revise care planned interventions for 3 of 7 sampled residents (#s 14, 17 and 27) reviewed for accidents, pain, and hospice. This placed residents at risk for unassessed needs. Findings include: 1. Resident 27 admitted to the facility in 2018 with diagnoses including aphasia (inability to comprehend formulate language) and stroke. An observation on 3/15/22 at 11:57 AM was made of staff delivering a lunch tray to Resident 27. At 12:00 PM Resident 27 was observed feeding her/himself with no staff present. The resident stated she/he fed her/himself and received no assistance or supervision from staff. Resident 27's Care Plan dated 9/24/19 indicated she/he needed to be supervised for meals. Resident 27's Kardex (in room care plan) indicated she/he required supervision with meals. Review of the medical record indicated a Refusal to Follow Prescribed Diet Release form was completed by Resident 27. The form indicated Resident 27 did not want to follow the prescribed diet, including supervision with meals. The form was signed by the resident on 2/7/20. On 3/18/22 at 10:19 AM Staff 2 (DNS) stated Resident 27's care plan was not updated to reflect the current diet and meal assistance preference. 40767 2. Resident 17 admitted to the facility in 12/2021 with diagnoses including dementia with behaviors and delusions. The 12/3/21 Wandering Risk Assessment was incomplete, but indicated Resident 17 was a low risk for wandering. The resident's Care Plan, last updated 2/22/22, did not include wandering behaviors or any interventions related to prevent wandering or elopement. On 3/14/22 at 4:37 PM Witness 1 (Family Member) stated Resident 17 was an elopement risk and had attempted to leave the facility multiple times due to her/his diagnoses. On 3/14/22 at 5:23 PM Staff 39 (CNA) stated Resident 17 was always exit seeking, wandered into other residents' rooms, and had previously gotten out of the back door of the facility. On 3/15/22 at 4:44 PM Staff 26 (LPN) had wandering behaviors and liked to wander into other residents' rooms and all hallways. Staff 26 reported there were times staff could not find the resident and had to look throughout the facility for her/him. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/22 at 8:11 PM Staff 28 (CNA) stated Resident 17 had wandering behaviors, including going into other residents' rooms and had nearly gotten out of the exit door down the 300-hall. Staff 28 stated Resident 17 would often go past the nurses station, so staff would shut the fire doors to prevent the resident from leaving. On 3/21/22 at 3:39 PM Staff 33 (LPN) stated the resident had wandering behaviors and one time was found in the back parking lot. Staff 33 stated Resident 17 was always trying to leave, wandered into other residents' rooms and staff had to close the fire doors at night to prevent the resident from wandering out. Staff 33 stated interventions to prevent the resident from wandering included: hot chocolate, sandwiches, and since the resident used to be a nurse Staff 33 let Resident 17 pretend to take her vitals. On 3/18/22 at 10:19 AM Staff 2 (DNS) acknowledged Resident 17's care plan did not include wandering behaviors or interventions to prevent wandering. Staff 2 stated all care plans were in progress and not updated for residents. Refer to F689. 3. Resident 14 admitted to the facility in 11/2018 with diagnoses including a stroke resulting in hemiparesis (paralysis of half the body) and a hip fracture. A 3/1/22 Encounter Note indicated Resident 17 had a right hip fracture in August, 2020 and was experiencing increased pain. On 3/14/22 at 1:55 PM Resident 14 stated her/his pain medications were always late and she/he often had pain in her/his hip. Resident 14's Care Plan was last updated in 2019 and did include the resident sustaining a hip fracture with increased pain or interventions to improve the resident's pain. On 3/17/22 at 2:07 PM and 3/18/22 at 10:19 AM Staff 2 (DNS) acknowledged Resident 14's care plan had not been updated since 2019 to include her/his hip fracture, which resulted in increased pain and required pain interventions. Staff 2 stated all resident care plans were in progress and not updated. Refer to F697.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to address a change of condition, follow physician orders and address skin conditions for 4 of 8 sampled residents (#s 23, 58, 109, and 159) reviewed for medication, non-pressure skin, and hospitalization . This failure resulted in Resident 58 experiencing a noted decline in condition without appropriate intervention prior to the resident's hospitalization . This placed residents at risk for adverse side effects of medications, worsening conditions, and death. Findings include: 1. Resident 58 was admitted to the facility in 2019 with diagnoses including chronic obstructive pulmonary disease (COPD) and anxiety disorder. The 1/18/22 physician orders indicated to obtain oxygen saturation level and utilize PRN oxygen to maintain oxygen saturation between 88-92% every four hours. The 1/25/22 progress note indicated Resident 58 tested positive for COVID that day and was moved to the isolation unit. The 2/2/22 at 7:08 AM progress note indicated Resident 58's oxygen saturation was 84% and the resident was on oxygen 3 liters per minute. The resident's oxygen could be increased to 4 liters per minute and the oxygen was to be rechecked in 30-45 minutes. The 2/2/22 MAR indicated Resident 58's oxygen saturation was 81% at 8:00 AM. The 2/2/22 Vital Sign records indicated at 8:35 AM indicated Resident 58's oxygen saturation was 86%. There was no indication in the residents clinical record to indicate the physician was notified of Resident 58's oxygen saturations below 88%. The 2/2/22 Vital Sign records indicated at 11:43 PM Resident 58's temperature was 97.5 F. This was the last temperature documented in the clinical record. The 2/3/22 at 12:50 AM Progress Note indicated Resident 58 had shortness of breath at the start of the shift with oxygen saturations ranging between 80%-86%. The nurse assisted the resident with breathing techniques to lower rapid breathing and deepen inhalation resulting in resident becoming more relaxed and oxygen increasing to over 90%. Oxygen saturation was 98%. No fever present. Resident has been compliant with cares and isolation status. Sleeping comfortably at this time. Vital signs stable and within normal limits. Will continue to monitor. The 2/3/22 at 8:51 AM Progress Note indicated Resident 58 oxygen saturation dropped to 71% on 4 liters of oxygen per minute via mask. Oxygen was instructed to be increased to 5 liters per minute via mask and the resident was assisted with breathing techniques to help deepen breathing and reduce anxiety. Resident's oxygen saturations went up to 81%. Continue with breathing techniques and to monitor oxygen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 2/3/22 at 11:15 AM Progress Note indicated Resident 58's oxygen saturation was at 71% on 5 liters per minute via mask. Assist resident with deep breathing exercises. Will contact on-call provider and leave a note in provider's box regarding resident. The 2/3/22 at 12:18 PM Progress Note indicated Resident 58 began coughing up a scant amount of bright red blood into tissues and her/his oxygen saturations were 69%. A message was left for on-call provider for a 20-minute call back. The 2/3/22 at 1:05 PM [late entry] Progress Note indicated the facility received a call back from the on-call provider was instructed to send Resident 58 to the hospital. Emergency services were contacted. They arrived and collected resident and left for Salem Hospital at approximately 12:55 PM on 2/3/22. The 2/3/22 hospital records indicated the following: -Resident 58 came from the care facility to the emergency department for worsening shortness of breath and recently tested positive for COVID one week ago and had been having difficulty breathing. Staff at the care facility were having a difficult time maintaining her/his oxygen saturations today and called paramedics. While at the facility, she/he had saturations of 67% while on oxygen. She/he was placed on non-rebreather by paramedics, which brought her/his oxygen saturations up to 79%. Patient arrived on CPAP with oxygen saturations at 88%. Paramedics reported a fever with temperature of 103 F. The 2/4/22 progress note indicated Resident 58 was admitted to the hospital with admitting diagnoses of COPD exacerbadtion, pneumonia due to COVID and respiratory failure. The 2/7/22 at 1:11 PM progress note indicated the hospital called to confirm that Resident 58 passed away at 8:04 AM on 2/5/22. On 3/25/22 at 10:10 AM Witness 6 (Nurse Practitioner) reviewed the findings and stated Resident 58 had an order to maintain oxygen saturations between 88-92% and the expectation was for staff to call the provider if oxygen saturations dropped below 88%. Witness 6 further stated staff did not notify the provider timely of Resident 58's change in condition and the expectation was for staff to have notified the provider the morning of 2/2/22. On 3/25/22 at 11:04 AM Staff 43 (RN) stated she worked day shift on 2/2/22 and 2/3/22. Staff 43 stated she should have notified the physician in my professional opinion on the morning of 2/2/22 after Resident 58's oxygen saturations dropped below 88%. On 3/23/22 at 2:14 PM and 3/28/22 at 8:46 AM Staff 2 (DNS) stated Resident 58's physician order indicated to keep oxygen saturations between 88-92 %. Staff 2 stated the expectation was for staff to notify the physician within 30 minutes after a change in condition and the physician should have been notified on 2/2/22 after the resident's oxygen saturations did not increase at 8:35 AM. 2. Resident 109 admitted to the facility in 10/2020 with diagnoses including heart failure. The 12/29/21 Progress Note indicated an order was received to swab sore on back of head with povidone-iodine until resolved. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 1/2022 TAR indicated the resident did not receive wound treatment on 1/1/22. The 1/3/22 Progress Note indicated wound care was provided to the sore on the back of the head the sore was drying out and resident reported less pain. The 1/5/22 Progress Note indicated head wound had no drainage, no open area and was slightly raised. The area was swabbed with povidine-iodine per order. There were no skin assessments or measurements of the sore on the resident's head in the electronic health record and no indication as to what type of sore or wound it was. On 3/28/22 at 8:49 AM Staff 2 (DNS) acknowledged there was no initial skin and wound assessment on 12/29/21 and no ongoing skin assessments indicating the type, measurements and characteristics of the head wound. Staff 2 further acknowledged the treatment for povidone-iodine was not completed on 1/1/22. 3. Resident 159 was admitted to the facility on [DATE] with diagnoses including heart failure. a. The 2/23/22 skin evaluation indicated the resident had a rash to the groin and left gluteal fold. There were no measurements of the identified areas. A review of the clinical record indicated there was no follow up skin evaluations or skin assessments completed after 2/23/22. The resident discharged on [DATE]. No skin assessments were completed prior to her/his discharge. On 3/18/22 at 2:00 PM Staff 2 (DNS) acknowledged Resident 159 had no measurements of the rash to the groin and left gluteal fold. She further acknowledged there were no additional skin assessments prior to her/his discharge. b. The 2/7/17 Intake and Output (I and O) Policy for documentation and monitoring of I and O indicated residents who may be at risk for an imbalance in fluids or electrolytes and a comparison total for I and O may be used as part of the comprehensive assessment in residents at risk for these imbalances. The 2/23/22 physician order indicated Resident 159 was to receive torsemide (a diuretic medication used to treat heart failure) daily. A review of the clinical record indicated no documentation of intake and output. On 3/22/22 at 6:36 AM Staff 7 (LPN) stated CNA staff should have documented I and O for Resident 159 especially since the resident had a Foley catheter. On 3/22/22 at 8:28 AM Staff 11 (RN) stated she recalled Resident 159 but staff did not monitor I's and O's for her/him. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Rose Care Center	4254 Weathers Street NE Salem, OR 97301

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/23/22 at 8:28 AM Staff 2 (DNS) stated Resident 159 was receiving diuretic medication and the expectation was for staff to monitor I's and O's on any resident received a diuretic. Staff 2 acknowledged the facility did not monitor I's and O's for Resident 159. 4. Resident 23 admitted to the facility in 2019 with diagnoses including heart failure and hypertension. The 12/22/19 Physician Order indicated staff were to check blood pressure and pulse every morning related to hypertension. The 3/22 MARs indicated staff did not check blood pressure or pulse on the following dates: -3/7/22 -3/8/22 -3/9/22 -3/10/22 On 3/23/22 at 8:25 AM Staff 2 (DNS) stated an agency staff was working 3/7/22 through 3/10/22 and acknowledged Resident 23 did not received blood pressure or pulse checks as ordered by the physician.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on observation, interview and record review it was determined the facility failed to ensure residents received restorative services and appropriate orthotic devices for 4 of 4 sampled residents (#s 12, 14, 36, and 258) reviewed for ROM and mobility. This placed residents at risk for decreased mobility and independence. Findings include: 1. Resident 258 admitted to the facility on [DATE] with diagnoses including cerebral palsy and depression. The 2/8/22 Care Plan indicated Resident 258 had contractures of her/his bilateral upper extremities related to cerebral palsy. Staff were instructed to provide a cloth/palm pad as needed to keep clean and prevent skin breakdown. The 3/25/22 Admission MDS indicated Resident 258 was cognitively intact and was totally dependent on staff for transfers, eating, dressing, and bed mobility. The resident received zero days of ROM (both active and passive) in the look-back period. a. A 2/22/22 Physician Order instructed staff to place an appropriate sized piece of foam into Resident 258's left hand one time a day for contracture. Observations of Resident 258 from 3/14/22 through 3/17/22 did not reveal the resident with a piece of foam for her/his left hand contracture. On 3/16/22 at 1:56 PM Resident 258 was asked about the foam for her/his left hand. Resident 258 stated the foam did not fit, it fell out of her/his hand and was not the right size, so staff did not use the foam. On 3/17/22 at 9:13 AM Staff 35 (Restorative Services/CNA) stated Resident 258 had a foam grip in her/his bedroom drawer. On 3/17/22 at 9:16 AM Staff 35 and surveyor entered Resident 258's room. Staff 35 acknowledged Resident 258 did not have the foam grip or other intervention for the resident's left hand and the foam grip was on the bedside table. Resident 258 stated the foam grip was too big. Staff 35 stated she would order a smaller one and was unsure how often the foam grip was to be used for the resident. On 3/17/22 at 10:48 AM Staff 2 (DNS) acknowledged Resident 258 was not utilizing the ordered foam intervention as the device was not the correct size. Staff 2 stated resident care managers (RCMs) were expected to complete assessments for residents ensure the resident had the correct size foam, but the facility did not currently have any RCMs. b. On 3/14/22 at 10:24 AM Resident 258 stated she did not receive physical therapy or restorative aid and had requested them. Resident 258 stated staff did not assist the resident with ROM. Resident's bilateral upper extremities were observed to be contracted. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA and now there was no resident care managers (RCMs) to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no RCMs to oversee the RA program. 2. Resident 12 admitted to the facility in 8/2018 with diagnoses including ulcerative colitis (inflammatory bowel disease) and diabetes. The 2/25/22 MDS indicated the resident was cognitively intact and was totally dependent on staff for transfers and required extensive assistance for bed mobility. The resident did not receive therapy or a restorative program was not performed during the look-back period. On 3/14/22 at 11:20 AM Resident 12 stated the facility ceased physical therapy in March 2021, and no one had offered to assist the resident with ROM. Resident 12 was observed to have a resistance band on her/his bed and stated that CNAs were unable to do RA with residents, including assisting the resident to use the band. Resident 12 stated management was aware she/he wanted therapy and RA, but stated she/he would have to tell them again. A 3/15/22 Physician Encounter note indicated the resident had a diagnoses of generalized weakness. Per the resident's report someone came to the facility to evaluate the resident for therapy, but the provider was also asked to put in a referral. The summary indicated a Physical/Occupational Therapy home health order for the resident was needed for home health services based on the resident's clinical condition. On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA and now there was no resident care managers to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no resident care managers to oversee the RA program currently. 3. Resident 14 admitted to the facility in 11/2018 with diagnoses including a stroke resulting in hemi-paresis (paralysis of half the body) and a right hip fracture. The 11/30/21 Annual MDS indicated Resident 14 was moderately cognitively impaired, and was totally dependent on staff for transfers and bed mobility. The resident did not receive therapy or a restorative program during the look-back period. On 3/14/22 at 1:55 PM Resident 14 stated she/he wanted to receive RA, but there was not enough staff to help her/him do exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/2022 RNA (Restorative Nursing Aid) Ambulating Task Sheet indicated staff were to document how much time the resident spent practicing ambulating. The sheet was blank for the past 20 days reviewed. A 3/14/22 Physician Encounter indicated Resident 14 had limited ROM and right sided weakness and staff were to perform passive range of motion right lower extremity (RLE) daily. On 3/17/22 at 9:13 AM and 9:16 AM Staff 35 (Restorative Services/CNA) stated no residents in the facility received RA for a year, as she was getting pulled to be a CNA and now there was no RCMs to oversee the program. Staff 35 stated residents want me back. Staff 35 further stated the facility did not have any in-house physical or occupational therapists. On 3/17/22 at 10:48 AM Staff 2 (DNS) confirmed there was no RA program for the facility and no residents had received RA since 5/2021. Staff 2 confirmed Staff 35 was working the floor as a CNA and stated there were no RCMs to oversee the RA program currently. 4. Resident 36 was admitted to the facility on [DATE] with diagnoses including stroke, high blood pressure and dementia. Resident 36's Admission MDS date indicated she/he was cognitively impaired. Resident 36's care plan revised on 4/8/2021, indicated she/he was to receive restorative aid (RA) for right hand /wrist range of motion three times a week and bilateral leg extensions while seated in wheelchair as needed for leg contractures. On 3/25/22 at 3:07 PM and on 3/28/22 Staff 2 (DNS) confirmed Resident 36 did not receive RA as ordered because the facility did not have an RA program since April 2021 due to staffing shortages.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42271 1. Based on observation, interview, and record review it was determined the facility failed to ensure residents with dementia did not elope from the facility and the facility failed to ensure residents who were at risk for aspiration were supervised while eating for 4 of 14 sampled residents (#s 2, 17, 18 and 158) reviewed for elopement and aspiration precautions. These failures resulted in immediate jeopardy situations and placed other residents at risk for accidents. Findings include: A. Resident 158 admitted on ,d+[DATE] with diagnoses including sepsis, dementia and acute kidney failure. The 2/18/22 hospital discharge diet orders indicated Resident 158 required 1:1 supervision with feeding. The 2/18/22 RN Admission Progress Note indicated the resident was on a regular/pureed thin liquids diet. The note did not indicate Resident 158 was to receive 1:1 supervision with meals. The revised 2/23/22 Admission care plan revealed there was no indication of the resident's diet or whether the resident required supervision with meals. The 2/25/22 Admission MDS indicated the resident had severely impaired cognition. A 2/25/22 narrative note entered by Witness 13 (hospice RN) on the Hospice Client Coordination Note Report, stated Resident 158 was 'up to WC (wheelchair) with the assist of one, ambulated in hall with assist of one, fed self after set up.' The meal monitoring sheets from 2/27/22 through 3/27/22 revealed the resident had setup help only for all meals and twice the resident had one person physical assist. On 3/14/22 at 11:42 AM Resident 158 was observed alone in her/his room. No aspiration signage noted in resident's room. On 3/15/22 at 3:20 PM Staff 53 (CNA) stated so often residents were not supervised while eating as there were so many Personal Care Assistants (PCAs) and there were not enough staff to monitor residents. Staff 53 stated management had been told over and over and believed this was a form of neglect. Staff 53 further stated the facility needed a system for which residents received thickened liquids. Staff 53 stated new staff were not educated on who required supervision or thickened liquids and Staff 53 had seen residents not supervised during meals or provided thickened liquids. On 3/15/22 at 5:31 PM Staff 13 (Personal Care Assistant) delivered Resident 158's dinner tray to her/his bedside table. Resident 158 was left unattended with the meal and staff closed the door. On 3/15/22 at 5:35 PM Resident 158 was observed eating independently in the room with no staff present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/15/22 at 5:36 PM Staff 13 acknowledged Resident 158 was eating in her/his room independently and stated she/he ate independently and was not an aspiration risk. On 3/15/22 at 5:41 PM Staff 7 (LPN) reviewed Resident 158's physician orders which indicated the resident was to be 1:1 supervision for meals. Staff 7 confirmed staff were not providing 1:1 supervision during meals and 1:1 meal supervision was not indicated on the resident's Kardex or care plan. On 3/15/22 a request was made for the meal supervision policy. Staff 2 (DNS) stated the facility did not have a policy for meal supervision. On 3/15/22 at 7:33 PM hospice physician's orders indicated to discontinue 1:1 feeding and the resident was able to self feed after set-up. There was no indication Resident 158 was assessed prior to the order change. On 3/15/22 at 9:47 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified of the immediate jeopardy (IJ) situation and were provided a copy of the IJ template related to the facility's failure to ensure residents were adequately supervised during meals. On 3/16/22 at 3:00 PM Witness 12 (Hospice RN) performed a swallow evaluation recommending a dysphagia level three (mechanical soft/minced/moist) diet with thin liquids and the resident no longer needed 1:1 assist with meals, set-up only. On 3/16/22 at 4:12 PM hospice physician orders: 'DC previous diet order. New diet order: dysphagia level three, mechanical soft, thin liquids, set up assistance only.' A plan to abate the immediate jeopardy situation was submitted by the facility and accepted on 3/16/22 at 12:59 AM. An immediate plan of correction (POC) was requested. The IJ Removal Plan included: -The facility will follow the order for 1:1 supervision starting at breakfast on 3/16/22 by encouraging Resident 158 to go to the dining room and if unwilling facility will have the resident eat in the hall so the resident can be visualized by staff for meals. -Resident 158 will be assessed by hospice for need of this supervision and orders will be obtained depending on the outcome of the assessment. -Resident 158's care plan will be updated according to the assessment by 3/18/22. -Orders for all residents will be reviewed to assure they are accurate and that all precautions are in place and assessed for appropriate meal supervision by 3/17/22. -The facility will develop a policy and procedure for meal supervision by 3/18/22. -Licensed nurses will be in-serviced on the process of entering admission orders and identifying precautions that need to be included in the orders. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All nursing staff will be trained on what is required when a resident needs meal supervision from the policy that we develop 3/18/22. -There will be a binder for agency staff to read our expectations regarding meal supervision and the staff who orient agency and new employees to the floor will include this policy and procedure. -Random monthly audits of all new admit orders will be done by the DNS or designee to assure that precautions are in place for three months and then quarterly thereafter. 2. Resident 18 admitted to the facility in 2021 with diagnoses including dysphagia (difficulty swallowing) and Alzheimer's disease. The 1/6/21 and 3/22/21 Care Plans indicated the following: -Resident 18 had a swallowing problem; -Resident 18 was to eat only with 1:1 supervision; -Instruct the resident to eat in an upright position as close to 90 degrees as possible, body in midline position, upright 15 minutes after eating or drinking; -Eat small bites slowly and to chew each bite thoroughly; -Monitor, document and report PRN any signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, and appear concerned during meals. a. On 3/17/22 at 8:26 AM and 8:29 AM Resident 18 was observed to be in bed with her/his bedside table in reach with a bowl of blueberries and strawberries. The resident was observed to be laying on her/his right side facing the bedside table with the head of bed slightly elevated. No staff were present in the room. Resident 18 took a bite of a strawberry and the Surveyor immediately exited the room to alert nursing staff. On 3/17/22 at 8:31 AM Staff 11 (RN) entered Resident 18's room and acknowledged Resident 18 had blueberries and strawberries within reach. Staff 11 was informed of the observation of the resident eating independently and Staff 11 removed the food items. On 3/17/22 at 8:40 AM Staff 54 (CNA) stated she was Resident 18's primary CNA today [3/17/22] and assisted the resident at breakfast earlier that morning. Staff 54 stated she left the strawberries and blueberries in a bowl on her/his bedside table that was pushed away from [her/him] and left the room. Staff 54 stated the resident was not to be left alone with food in the room and the resident must have grabbed the table and pulled it toward her/him. Staff 54 stated the resident was more alert and hungrier this morning than usual and grabbed the French toast off the fork at breakfast when she was assisting the resident which she/he usually did not do. On 3/17/22 at approximately 9:00 AM Staff 1 (Administrator) was informed of the observation of Resident 18 having strawberries and blueberries in her/his room and was observed eating without staff present and was care planned to be 1:1 supervision with meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 3/18/22 at 8:59 AM Resident 18 was observed in bed laying on her/his side facing the bedside table. There was a cup of grapes on the table and it was within the resident's reach. On 3/18/22 at 9:01 AM Staff 55 (CMA) entered the room to pass medication to Resident 18's roommate. Staff 55 was asked by the Surveyor to observe Resident 18. Staff 55 acknowledged Resident 18 had a cup of grapes on her/his bedside table within reach. Staff 55 stated the resident was not to be left unattended with food in her/his room and removed the grapes from the room. On 3/18/22 at 9:08 AM Staff 1 (Administrator) was informed of the observation of Resident 18 being unattended with grapes on her/his bedside table and she/he was care planned to be 1:1 supervision with meals. 3. Resident 2 admitted to the facility in 2021 with diagnoses including stroke. The 2/9/21 physician order indicated Resident 2 was to receive a dysphagia mechanical soft diet with nectar thick consistency. The 2/9/21 Care Plan indicated Resident 2 had swallowing problems related to a history of a stroke and required nectar thick liquids. On 3/25/22 at 6:26 PM Resident 2 was observed in her/his room with the head of bed slightly elevated and had a water cup on the bedside table with a straw in it. The water was regular consistency and was not thickened. Resident 2 stated she/he had a swallow study completed and it was determined stuff was going into my lungs. Resident 2 stated she/he preferred to have thickened liquids to be safe but had drank some thin water that was on her/his bedside table on 3/25/21. On 3/25/22 at 6:33 PM Staff 33 (LPN) acknowledged Resident 2 had regular water in her/his cup on the bedside table within reach and acknowledged the resident was care planned to have thickened liquids. Staff 33 removed the water from the room. On 3/25/22 at 6:47 PM Staff 1 (Administrator) and Staff 2 (DNS) were informed of the observation of Resident 2 having thin liquids at the bedside within reach and acknowledged she/he was care planned for thickened liquids. On 3/28/22 at 12:59 PM Staff 1 and Staff 2 that immediacy has been removed for the aspiration portion of F689 regulation. 40767 B. Resident 17 admitted to the facility in 12/2021 with diagnoses including dementia with behaviors and delusions. Resident 17 admitted from a memory care unit. The 12/10/22 Admission MDS indicated the resident was moderately cognitively impaired. The MDS did not indicate Resident 17 had wandering behaviors. The Care Plan, last updated 12/28/21, did not indicate Resident 17 was an elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 12/14/21 Wandering Risk Assessment was not completed in full with the Behavior/Mood section, the Mobility section, and History of Wandering section left blank. The assessment categorized Resident 17 as a Low Risk for Wandering. Record review from 1/2022 through 3/2022 indicated Resident 17 had wandering and exiting-seeking behaviors with documentation of behaviors starting on 1/15/22. The records indicated: *1/15/22 at 12:57 AM Resident wandering in hallways per wheelchair locomotion, accepting of staff redirection when attempts to go behind nurses desk or into wrong room. *1/16/22 at 9:32 AM Resident was wheeling her/himself down the hall and yelling in other residents' rooms that she/he was going to put them on the law suit. Resident if difficult to re-direct and she/he was resistive to cares. *A 1/21/22 Physician Encounter Note completed by Witness 6 (Nurse Practitioner) indicated staff discussed Resident 17 going into other residents' rooms. *1/24/22 at 12:25 AM Resident continued to have delusions and behaviors, such as going into other residents' rooms. *1/25/22 6:35 PM Resident 17 was opening the facility door to head outside and was stopped by staff informing the resident it was cold outside. Later that evening staff heard the 300-hall door alarm sound and it was Resident 17 and staff redirected the resident back into the building. *1/27/22 at 9:20 PM Resident had been increasingly exit seeking. The resident had some 1:1 time for redirection. It worked temporarily and redirection was needed again. Will continue to keep a close eye on resident. *1/29/22 at 2:29 AM Resident currently now wandering throughout the facility via wheelchair. *1/31/22 at 6:45 AM It was reported the resident was wandering and the staff could not find the resident for a while. The resident was in another resident's room. Resident needs constant reorientation and reassurance and was unaware of her/his situation *1/31/22 at 2:47 PM Resident continued to have delusions and was wandering and going into other residents' rooms. *2/1/22 at 4:48 PM Social Services spoke with Resident 17's daughter regarding Resident 17's behaviors today of agitation, exit seeking, hallucinations, and unable to re-direct behaviors. Daughter stated she was looking into Memory Care for the resident. *2/2/22 at 10:34 PM Resident was caught wandering into other residents rooms, mostly male rooms. The resident was found at the back door by kitchen trying to get out of the facility. *2/4/22 at 2:23 PM Resident experiencing a lot of hallucinations and confusion on this shift. Resident was unable to be redirected and was barging into multiple other resident rooms. While attempting to remove resident from a resident's room Resident 17 yelled profanity at the nurse and hit the nurse twice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*2/4/22 at 11:51 AM Resident went into room [ROOM NUMBER] and was asked to leave room after being reminded that it was against facility rules to enter rooms without permission. Resident was asked to leave, but refused. Resident was asked again to leave, but refused to do so. Resident was removed from room by staff. *A 2/4/22 Physician Encounter Note completed by Witness 6 (Nurse Practitioner) indicated this week the resident had been exit-seeking and that day the resident was difficult to redirect and tried going to multiple residents' rooms. *2/12/22 at 2:48 AM Exit seeking behavior noted, redirected with good effect. *2/14/22 at 12:34 PM Resident was wrapping catheter around door handle last night and she/he was wandering throughout the facility. *2/15/22 2:46 AM Call made to Resident 17's daughter to reinforce the resident is not safe in the building due to it not being a locked building. *2/15/22 12:34 PM Resident 17 out in the parking lot attempting to get into a staff's vehicle and required multiple redirection to come back into the facility after explaining the resident would be warmer as it was cold outside. *2/15/22 Provider Note completed by Witness 6 (Nurse Practitioner) indicated that day the resident had been exit seeking and hyper focused and going to other residents' rooms. That afternoon the resident got out into the parking lot and it took the resident's daughter coming in and redirecting the resident back inside. *2/16/22 at 12:08 PM Resident asking where her/his mother was this AM. Staff able to redirect the resident when she/he was exit seeking. *3/12/22 at 5:29 AM Resident having hallucinations, heightened restlessness, agitation and having difficulty staying asleep. The Resident had been wandering into other residents rooms. The 2/15/22 Incident Investigation indicated on 2/15/22 at 12:20 PM Resident 17 was reported to be outside the facility in the parking lot next to a staff member's car with the door open. Resident 17 kept insisting she/he was going to leave. Staff attempted to redirect the resident multiple times and finally after getting Staff 2 (DNS) the resident agreed to return to the facility. The conclusion indicated: Resident 17 had diagnoses of legal blindness, dementia with behavioral disturbance and visual hallucinations. Able to redirect resident's behaviors. Staff will continue to check [Resident 17] and reorient as [she/he] is noted with confusion. There were no witness statements. There was no documented evidence the facility analyzed the hazards and risks related to Resident 7's elopement, updated the care plan, or implemented new interventions to reduce the hazards and risk associated with her/his elopement. (continued on next page)

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	38E075	A. Building B. Wing	03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Rose Care Center	4254 Weathers Street NE Salem, OR 97301

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/22 at 4:37 PM Witness 1 (Family Member) stated she was Resident 17's responsible party and was informed the night prior by Staff 15 (Unit Clerk) that Resident 17 had wandered outside the facility because the exit door down the 100-hall was unlocked. Witness 1 stated Resident 17 was an elopement risk and had attempted to leave the facility multiple times due to her/his diagnoses, but Witness 1 was only informed once when the resident would not come back inside the facility. On 3/14/22 at 5:13 PM Staff 7 (LPN) stated on 3/13/22 the door down the 100-hall was left unlocked as the morgue had a collected a resident previously that day, but he was not aware of Resident 17 leaving the building. On 3/14/22 at 5:17 PM Staff 15 (Unit Clerk) stated Resident 17 was an escape artist and she was informed a couple nights prior that Resident 17 got out of the emergency exit down the 100-hall and was informed by morning staff. Staff 15 was unable to recall who specifically informed her of the incident, but believed the incident occurred over the past weekend (3/12/22 through 3/13/22). Staff 15 was unsure how long the resident was out of the facility, but management was aware of the incident. On 3/14/22 at 5:23 PM Staff 39 (CNA) stated Resident 17 was always exit seeking and had previously gotten out of the back door that residents used to go smoke. Staff 39 stated on Thursday (3/10/22) the resident had gotten outside, but Staff 39 saw the resident right away and redirected the resident back inside. Staff 39 stated a few weeks prior she was coming onto her shift and found Resident 17 outside in the parking lot. Staff 39 stated staff did not have the ability to stop the resident as she/he was so quick and if staff were caring for another resident Resident 17 would leave. On 3/15/22 at 8:50 AM Resident 19 stated before Resident 17 moved rooms the resident would come into Resident 19's room and she/he would have to tell Resident 17 to leave. Resident 19 further stated the week prior staff were unable to locate Resident 17, so they went through all the rooms looking for Resident 17 and found the resident in another resident's bathroom. On 3/15/22 at 4:13 PM Staff 19 (Admissions) stated he was not aware Resident 17 was outside the facility but was informed by Witness 1 on 3/13/22 that the resident attempted to leave the facility that day due to the door down the 100-hall being unlocked. Staff 19 stated he reported the incident to Staff 1 (Administrator). On 3/15/22 at 4:18 PM Staff 1 (Administrator) stated she was aware Resident 17 had left the facility previously, but was not aware of Resident 17 recently leaving the facility out the 100-hall door as the door was always locked. On 3/15/22 at 4:44 PM Staff 26 (LPN) stated Resident 17 had wandering behaviors and liked to wander into other residents' rooms and all hallways. Staff 26 reported there were times staff could not find the resident and had to look throughout the facility for her/him. On 3/15/22 at 8:11 PM Staff 28 (CNA) stated Resident 17 had wandering behaviors, including going into other residents' rooms and had nearly gotten out of the exit door down the 300-hall. Staff 28 stated Resident 17 would often go past the nurses' station, so staff would shut the fire doors to prevent the resident from leaving. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no investigation for the alleged incident Resident 17 left the facility during the month of 3/2022, until 3/24/22. The care plan did not indicate wandering and elopement behaviors or interventions. There was no updated assessment of Resident 17's wandering and elopement behaviors. There was no policy in place for wandering or elopement prior to 3/16/22. On 3/15/22 at 9:47 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified Resident 17's elopement and attempted elopements constituted an immediate jeopardy situation. A plan to abate the immediate jeopardy situation was submitted by the facility and accepted on 3/16/22 at 12:59 AM. The plan included: *Resident 17 would be assessed for wandering/elopement March 16, 2022. The care plan would be updated to reflect the resident's risk of elopement and interventions by March 16, 2022. *No other residents wander, therefore would not be at risk of elopement. However, if staff observe elopement/exit seeking/wandering behavior, an assessment would be completed. *Visual observations of Resident 17's location would be done every 30 minutes for two weeks to establish a potential pattern. Observations would be adjusted accordingly if a pattern was identified. *Visual observations would be documented on a spreadsheet, that identified the time, location, and staff member. *Licensed nurses would be in-serviced on how to assess for wandering and elopement and an assessment would be implemented for all new admission residents by March 18, 2022. All staff would receive dementia training related to wandering and elopement by March 18, 2022. *Random monthly audits of new admission orders would be completed by Staff 2 (DNS) or designee to assure residents who were assessed to be at risk of elopement were care planned for three months and then quarterly thereafter. On 3/24/22 at 3:12 PM Staff 1 and Staff 2 were notified the immediacy was removed based on observations, staff interviews, and record review that the IJ immediacy removal plan was fully implemented. 2. Based on observation, interview, and record review it was determined the facility failed to ensure interventions were implemented and interventions were assessed and updated to prevent falls for 2 of 4 residents (#s 22 and 40) reviewed for falls. This placed residents at risk for repeated falls and injury. Findings include: A. Resident 40 admitted to the facility on [DATE] with diagnoses including dementia and anxiety. The 10/21/21 Quarterly MDS indicated Resident 40 was significantly cognitively impaired and indicated the resident had two or more falls since admission with no injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Fall Care Plan was last revised 2/23/22. There were no interventions updated to prevent falls post the 9/20/21 fall until 1/10/22 when the care plan indicated Resident 40 was to wear non-skid socks and staff were to remind the resident to use the call light with each meet and greet. The care plan had already included the interventions for non-skid socks and to remind the resident to use the call light on 7/15/21 and 7/18/21. The care plan did not indicate signs were to be placed in the resident's room to remind the resident to ask for assistance before transferring. The 9/20/21 Post Fall Assessment indicated Resident 40 was found in her/his room on the floor after self-ambulating barefoot. The investigation indicated the resident hit her/his head on the dresser and was bleeding at the base of her/his skull. The resident was sent out to the hospital. Preventive measure included: Signs placed in room and bathroom to remind the resident she/he needs assistance with transfers. Recommendations to prevent further falls indicated: frequent checks, lower bed, and constant reminding to use the call light because of her/his dementia and her/his tendency to overestimate her/his abilities. There were no witness statements documented or neurological assessments post fall. The Post Fall Assessment was completed on 9/30/21. Resident 40 sustained multiple falls since the 9/20/21 incident. On 3/24/22 at 2:06 PM Resident 55's (Resident 40's roommate) call light was initiated. Resident 55 told Staff 49 (CNA) that Resident 40 had self-transferred to the restroom. Staff 49 was observed to enter the restroom with Resident 40. There were no signs in the resident's room or door of the restroom to remind Resident 40 to call for assistance prior to transferring. On 3/24/22 at 2:09 PM Resident 55 stated she/he pressed her/his call light 10 minutes prior to alert staff that Resident 40 had self-transferred to the restroom. Resident 55 stated the facility was so short handed and stated Resident 40 had four falls since Resident 55 had been the resident's roommate. On 3/24/22 at 2:16 PM Staff 50 (CNA) stated Resident 40 experienced multiple falls and interventions included: a gait belt, non-skid socks and the resident used to have signs in the room to remind her/him to use the call light. Staff 50 confirmed there were no signs in Resident 40's room or restroom door to remind the resident to call for assistance. On 3/24/22 at 2:23 PM Staff 2 (DNS) acknowledged the fall investigation was not thorough for the 9/20/22 incident, the investigation was completed 10 days after the incident, and confirmed there were no signs in the resident's room or bathroom per care planned interventions. B. Resident 22 was admitted to the facility on ,d+[DATE] with diagnoses including cerebral vascular accident (CVA/Stroke) and morbid obesity. The 12/2020 initial care plan indicated the resident required extensive assistance by two staff to turn and reposition in bed and required a mechanical lift with two staff assistance for transfers. The 12/2021 MDS indicated the resident had a BIMS score of 11, moderately impaired cognition. The revised 3/23/21 care plan identified the resident as a high risk for falls. Interventions included: Be sure bed is in lowest position when not providing care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 3/1/22 Post Fall Assessment stated Resident 22 had a witnessed fall in the room while being changed by a single staff member and was sent to the hospital to rule out a knee fracture. The 3/11/22 Physician Orders: Bed rails, both sides for mobility and fall mats on both sides of bed. On 3/14/22 at 10:42 AM observations of Resident 22's room revealed bed at regular height, no fall mats, and no side rails. Resident 22 stated she/he had a recent fall on 3/1/22 and had been in misery ever since. Resident 22 stated she/he was leery about being dropped. On 3/17/22 at 1:22 PM observed Staff 30 (Personal Care Assistance/PCA) in room with resident. Staff 30 acknowledged Resident 22's bed was not in the low position, there were no fall mats on either side of the bed and no side rails on the bed. On 3/17/22 at 1:29 PM Staff 10 (LPN) confirmed Resident 22 did not have the bed in low position, no bed rails and no fall mats. On 3/17/22 at 1:44 PM Staff 2 (DNS) observed Resident 22's room and confirmed the bed was not in low position, no bed rails on the bed and no fall mats. Staff 2 stated she expected orders to be implemented as soon as possible and she did not do it because she did not have time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43692 Based on interview and record review the facility failed to ensure residents were free from unnecessary medications for 1 of 6 sampled residents (#159) reviewed for unnecessary medications. This placed residents at risk for significant drug to drug, drug to disease interactions and adverse drug events. Findings include: Resident 159 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF) (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues) and atrial fibrillation (irregular heartbeat). Resident 159's Hospital discharge orders dated 2/23/22 revealed: -Demadex 5 mg once daily (used to treat fluid build- up in heart failure). -DDVAP 0.2 mg at bedtime (used to decrease urine production and prevent bleeding). -Eliquis 5 mg twice daily (a blood thinner used to lower the chance of stroke due to blood clots in residents with irregular heart- beats). Resident 159's Hospital 2/23/22 Discharge Summary and Electronic Health Record did not include any labs assessing Creatinine Clearance or Glomerular Filtration Rate (GFR) (kidney function). The Nursing Admission assessment dated [DATE] e-signed by Witness 9 (Former Resident Care Manager) indicated Medication regimen appears to be appropriate at this time with no known adverse effects. A Progress Note dated 2/24/22 and signed by Witness 6 (Nurse Practitioner) indicated Resident 159 was to continue on Demadex 5 mg, DDVAP 0.2 mg and Eliquis 5 mg as previously ordered by the hospital physician. Resident 159's 2/24/2022 through 3/12/2022 MARs revealed Resident 159 received all three drugs each day. Resident 159's care plan dated 2/23/22 did not indicate any monitoring of fluid input and output, edema (accumulation of extra fluid in the body) or signs and symptoms of blood clots. The Lexicomp Adult Drug information Handbook 30th Edition, 2021-2022 indicated the following: -DDVAP was contraindicated in residents with heart failure. -DDVAP was contraindicated in residents using loop diuretics (Demadex). -DDVAP should have been used cautiously in residents with decreased renal (kidney) function. -DDVAP should have been used cautiously in residents on anticoagulant therapy (Eliquis). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-For all indications fluid intake, urine volume, and signs and symptoms of hyponatremia (low sodium in the blood) should be monitored, especially in those residents with heart failure. On 3/24/22 at 9:54 AM via telephone Witness 9 (Former Resident Care Manager) refused to speak with this surveyor about the resident's medication regimen investigation. On 3/25/22 at 10:22 AM Witness 6 (Nurse Practitioner) stated she was familiar with Resident 159 and had seen her/him twice in the facility since admission from the hospital. She further stated when Resident 159 was admitted she only had the hospital discharge orders to go on because she did not have comprehensive access to the resident's clinical record which usually contained renal function labs. Witness 6 remembered questioning the incoming medication regimen but did not document it and continued the orders. Witness 6 stated she would take the hit and the heat for the medication error and further confirmed DDVAP was contraindicated in residents with heart failure, loop diuretic use and was to be used cautiously in residents on anticoagulants. On 3/28/22 at 9:44 AM Staff 2 (DNS) confirmed when Resident 159 was admitted to the facility, Witness 9 evaluated the medication regimen and did not indicate based on other medication use and disease states including CHF or Atrial fibrillation DDVAP was contraindicated or was to be used with caution. She further confirmed Resident 159's Care Plan did not indicate monitoring of fluid input and output, edema or signs and symptoms of blood clots.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34324 Based on observation, interview and record review it was determined the facility failed to provide palatable and appealing food for 5 of 5 sampled residents (#s 12, 19, 48, 55, and 109) reviewed for food. This placed at residents at risk for weight loss. Findings include: Interviews with residents revealed the following regarding the food provided: - On 3/14/22 at 11:10 AM Resident 12 stated she/he did not like the food and was given items she/he did not like. -On 3/14/22 at 11:35 AM Resident 55 stated she/he did not care for the food and often was given items she/he did not want. - On 3/14/22 at 1:48 PM Resident 48 stated the facility's food was not good and had no variety. - On 3/15/22 at 8:37 AM Resident 19 stated the food was so bad and was often served undistinguishable meat. - On 1/11/22 it was reported by Resident 109 the food provided was cold. Review of the 2/24/22 Resident Council notes indicated several concerns regarding the food including: - The chicken noodles and beef vegtables were no longer good. - The breading on the chicken was soggy. - The eggs were ice cold and when new eggs were requested, they were also cold. - The soup was always cold. On 3/18/22 at 12:15 a lunch test tray was sampled. The meal consisted of roasted potatoes that were dry and cold, mushy shrimp, lukewarm vegetables and a salad containing stale and soggy croutons. On 3/18/22 at 12:20 PM Staff 1 (Administrator) was asked to sampled the test tray. Staff 1 confirmed the potato's were dry and cold, the crouton was stale and soggy and the shrimp was the warmest item on the plate. Staff 1 acknowledged improvements could be done to the food quality.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40767 Based on observations, interview, and record review it was determined the facility's quality assessment and assurance committee (QAA) failed to systematically identify and correct deficiencies in the areas of comprehensive assessments, treatments and services to prevent pressure ulcers, accidents, antibiotic stewardship, care planning timing and revision, hospice coordination of care, pharmacy reviews, physician orders, restorative aid, and therapy orders. This placed residents at risk for multiple unmet care needs. Findings include: 1. The facility failed to ensure those who were at risk for aspiration were supervised while eating and failed to ensure residents with dementia did not elope from the facility for 3 of 14 residents reviewed, which resulted in an immediate jeopardy situation. 2. The facility failed to assess and monitor pressure ulcers for 2 of 2 residents reviewed. 3. The facility failed to ensure coordination of care with hospice for 2 of 3 residents reviewed. 4. The facility failed to develop and implement an antibiotic stewardship program. 5. The facility failed to ensure residents received restorative aide therapy to prevent a physical decline and implement therapy orders for 5 of 6 residents reviewed. 6. The facility failed to notify the physician timely for a change of condition and notify family for non-pressure skin for 2 of 5 residents reviewed. 7. The facility failed to follow physician orders, address skin conditions, and assess change of condition for 6 of 8 residents reviewed. 8. The facility failed to ensure interventions were implemented and residents were assessed to prevent falls for 3 of 4 residents reviewed. 9. The facility failed complete comprehensive assessments and implement, review, and revise resident care plans timely for 10 out of 25 residents reviewed. On 3/28/22 at 12:40 PM Staff 1 (Administrator) and Staff 2 (DNS) stated the last QAA meeting was held on 1/20/22 on Zoom (video meeting). Staff 1 and Staff 2 stated the Nurse Practitioner did not come to the facility as often as previously. Staff 1 and Staff 2 stated the facility did not have resident care managers to complete weekly skin assessments. Staff 1 and Staff 2 stated due to staffing shortages restorative aide was not being completed. Staff 1 and Staff 2 stated they were not aware of any issues with hospice until it was brought up in survey. Staff 1 and Staff 2 further stated they were not aware of any issues with aspiration concerns and the elopement incident only occurred once to their knowledge. Staff 1 and Staff 2 stated the biggest reason the identified issues had not been addressed was due to the facility not having resident care managers.