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	01/11/2023

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 33179 Based on observation and interview it was determined the facility failed to provide a clean, sanitary and homelike environment for 1 of 3 sampled residents (#1) reviewed for clean resident rooms. This placed residents at risk for cross-contamination and an unclean room. Findings include: Resident 1 admitted to the facility in 2020 with diagnoses including paraplegia (paralysis of the legs and lower body). On 12/15/22 at 2:00 PM a CNA was observed to exit Resident 1's room. The surveyor entered the room and observed a dirty towel on the floor. On 12/15/22 at 2:00 PM Resident 1 stated her/his room was not cleaned to her/his satisfaction, pointed to a dirty towel on the floor and stated the CNA put the towel on the floor and left it. On 12/15/22 at 2:25 PM Staff 16 (LPN) was observed to be talking to the resident in her/his room. Staff 16 verified the dirty towel was on the floor.

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on observation, interview and record review the facility failed to ensure residents were free from neglect. The facility failed to ensure a resident had the right to receive skilled care from trained nurses and refuse hospice, failed to ensure resident assessments were completed timely, care plans were reviewed, interventions in place and implemented, failed to assess and monitor pressure ulcers and follow physician orders for skin conditions, failed to recognize and act on a change of condition, and failed to ensure residents did not elope from the facility. The cumulative effect of these failures in providing care and services contributed to an environment of neglect for 8 of 15 sampled residents (#s 2, 3, 4, 5, 9, 11, 13 and 15) reviewed for care and services. This caused Resident 5 to not get physician ordered treatment and coerced to agree to hospice services and placed all 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. CHANGE OF CONDITION Resident 2 Resident 2 admitted to the facility in 4/2022 with diagnoses including intellectual disabilities and neurogenic bladder. The 3/11/22 Risk For Infection related to the use of a urinary catheter care plan included the following interventions: change catheter and Foley (catheter) bag as scheduled or as ordered by the physician, monitor the indwelling catheter and report to the physician signs and symptoms of UTI such as pain, burning, blood tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. The 4/6/22 Return From Hospital care plan interventions included to monitor appetite and document the percentage eaten each meal and to monitor pain and discomfort. A 4/29/22 Progress note revealed Resident 2's urine was cloudy with foul smell, had increased agitation and a UA (urinalysis) was collected. A 5/4/22 Progress note revealed a negative UA result. The 5/4/22 task documentation revealed Resident 2's UOP (urine output) was 1150 cc. Meal intake for breakfast was 26 to 50%, lunch zero to 25% and dinner was refused. Fluid intake was 980 cc. A 5/6/22 Progress note revealed Resident 2 was very irritable and refused the catheter change. Blood Pressure was 71/49 [No evidence of physician notification or assessment or monitoring was completed.] (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 5/6/22 task documentation revealed Resident 2's UOP was 675 cc, fluid intake was 460 cc and meal intake for breakfast and lunch was zero to 25% and dinner 26 to 50%. A 5/7/22 Progress Note revealed Resident 2 was on alert due to having cloudy urine, having increased sediment and foul odor. The 5/8/22 task documentation revealed fluid intake was 540 cc. The 5/9/22 task documentation revealed the resident consumed zero to 25% of all meals and fluid intake was 360 cc. The 5/10/22 task documentation revealed fluid intake was 270 cc. Meal intake for breakfast was 26 to 50%, lunch zero to 25% and refused dinner. The 5/11/22 task documentation revealed 500 cc UOP, 780 cc fluid intake and meal intake varied from zero to 75%. The 5/12/22 task documentation revealed 475 cc UOP, 120 cc fluid intake, meal intake for breakfast and dinner was refused, lunch was zero to 25%. The resident took in additional nutrition in the evening between 75-100%. The 5/13/22 task documentation revealed 950 cc UOP, Fluid intake was 240 cc with one meal intake not documented and meal intake zero to 25% for breakfast and dinner and lunch was not documented. The 5/14/22 task documentation revealed 560 cc UOP, 740 cc fluid intake, breakfast and dinner refused with zero to 25% lunch meal intake. The 5/16/22 task documentation revealed UOP was 25 cc on night shift and 260 cc on day shift. Fluid intake was 20 cc for breakfast and 120 cc for lunch. Meal intake was zero to 25% for breakfast and lunch. The 5/16/22 12:01 PM Progress note revealed a CNA reported Resident 2 was not acting like [her/himself] today. Blood pressure was 94/59, resident stated she/he felt unwell and was unable to describe any specific symptoms. The urine was red/brown tinged and mucus was present. The residents speech was slurred. The provider was called and staff were waiting for a call-back. The 5/16/22 2:00 PM Progress note revealed the provider called back and gave orders to push fluids, administer an antibiotic shot, change the indwelling catheter and to obtain a stat [immediate] UA. The 5/16/22 provider encounter note revealed the resident was seen for a concern of a possible UTI. The urine was reported to have foul odor and was cloudy with a dark color. The catheter was changed and the urine was clear after the indwelling catheter change. The resident complained of stomach and ear pain. The 5/16/22 2:38 PM indicated the resident was transported to the hospital for altered mental status and hypotension (low blood pressure). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 5/17/22 Progress note revealed the hospital notified the facility the resident passed away with a small bowel obstruction, UTI, sepsis (full body infection) and acute renal failure. The 5/17/22 Hospital Records revealed Resident 2 was transferred to the hospital for malaise, fatigue and low blood pressure. The resident was diagnosed with UTI , septic syndrome secondary to UTI, acute kidney injury, anemia, hypoalbuminemia (abnormally low blood level of albumin (type of protein)), gastric outlet obstruction, gastrointestinal bleed and severe anion gap metabolic acidosis (imbalanced electrolytes). On 5/16/22, after discussion of options with the family, the residents POLST was changed to DNR and the resident passed away on 5/17/22. The 5/24/22 Death Certificate revealed Resident 2's immediate cause of death was severe sepsis with septic shock, approximate onset to death, one day, due to pseudomonas UTI, approximate onset to death, five days. Other significant conditions contributing to death gastric outlet obstruction. There was no evidence in the medical record the provider was notified of the residents decreased appetite, fluid intake, urine output, low blood pressure, increased confusion, irritability or malaise. There was no evidence of monitoring of signs and symptoms of UTI. On 12/21/22 at 9:25 AM Resident 16 (roommate) verified she was Resident 2's roommate and stated the week prior to her/his transfer to the hospital Resident 2 had increased irritability and was in pain. On 12/19/22 12:30 PM Staff 6 (Former NA) stated the week prior to Resident 2 transferring to the hospital her/his urine was brown in color and had increased confusion. On 12/19/22 at 2:21 PM Staff 11 (CNA) stated in the two weeks prior to Resident 2's hospital transfer she/he was pretty confused, tired, had a poor appetite, irritable, pretty out of it and the urine bag was not looking like it should. Staff 11 stated she recalled the nurses looking at the resident's urine bag but had no idea what the nurses did. On 12/19/22 at 3:10 PM Staff 13 (LPN) stated staff were monitoring Resident 2's urine for amber color. On 12/20/22 at 2:00 PM Staff 4 (Administrator in Training) recalled talking the Resident 2's sister about her concerns of Resident 2's health related to cognition, loss of appetite, getting up less and concerns of UTI. Staff 4 stated I finally asked [staff] to send her out so they did. On 12/20/22 at 3:30 PM Staff 16 (LPN) verified she wrote the 5/6/22 progress note, confirmed the resident was very irritable, refused the catheter change and had a blood pressure of 71/49. Staff 16 verified she did not further assess the resident or notify the physician of the low blood pressure, irritability or refusal of the catheter change. On 12/20/22 at 3:35 PM Staff 16 (LPN) stated the week prior to Resident 2's hospital transfer she/he was very irritable which was not normal because she/he was usually sweet and pleasant. On 12/21/22 at 9:50 AM Staff 7 (CNA) stated in the two weeks prior to Resident 2's hospital transfer she/he ate less because she didn't feel good enough to eat and needed more encouragement to attempt to eat and drink. Staff 7 further stated she noted a decline in Resident 2's overall abilities. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/21/22 at 9:59 AM Staff 5 (Support RN) verified between 5/2/22 through 5/16/22 there was only one alert note related to monitoring the resident's urine or for signs of UTI. On 12/21/22 at 10:10 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Resident 2's care plans were not followed and the low blood pressure was not reported to the physician or assessed. Staff 1 and Staff 2 acknowledged the resident's decline in condition was not assessed and the physician was not notified until 5/16/22. Staff 1 acknowledged the 5/24/22 Death Certificate revealed Resident 2's immediate cause of death was severe sepsis with septic shock, approximate onset to death, one day, due to pseudomonas UTI, approximate onset to death five days. Other significant conditions contributing to death gastric outlet obstruction. On 12/21/22 at 12:08 PM the facility was notified of the Immediate Jeopardy (IJ) situation and a plan of care was requested. Refer to F690 ELOPEMENT Resident 9 Resident 9 admitted to the facility in 2022 with diagnoses including symptoms involving cognitive functions following other nontraumatic intracranial hemorrhage and cataracts. Prior to admission, the resident was homeless. The Elopement Risk Care Plan, last revised on 12/28/22, revealed Resident 9 was a high elopement risk related to impaired safety awareness; both physical and environmental. The resident had eloped on 11/17/22, 12/12/22 and 12/27/22. The interventions included to remind the resident to notify staff if she/he planned to leave the facility as needed (11/18/22), resident was high fall risk (11/18/22), to not seat the resident in the lobby near the doors without supervision at any time of the day or night. If the resident was up during late night hours to have her/him close to the nurse's station where she/he could be monitored. To walk with the resident if she/he wanted to walk, sit and talk with the resident, attempt to engage the resident to watch television, look at a magazine, offer fluids and snack. If not redirectable, alert the charge nurse, RN, resident care manager or DNS (12/14/22). Remind the resident of the sign posted in her/his room to not leave the facility without assistance for her/his safety and to show her/him the sign above the television (12/15/22). Activities to check in with the resident regularly to see if she/he needed anything from the store and to let nursing know to minimize the desire to exit the facility (12/16/22). Offer Resident 9 a bowl of ice cream (rocky road) every evening sometime after dinner and before bed time. If Resident 9 ambulated toward the front lobby late at night offer the ice cream again (12/28/22). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 9/27/22 Communication Care Plan revealed Resident 9 had a communication problem related to expressive aphasia (a form of aphasia when the person knows what they want to say but are unable to produce the words or sentence. Can be mild to severe), slurring, stroke, weak or absent voice. Interventions included to allow adequate time to respond, face the resident when speaking and make eye contact, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. The resident was able to say yes or no and very short sentences and could shake/nod her/his head. Speak to the resident in a calm, quiet voice because she/he responded better with this approach. Speak on an adult level, speak clearly and slower than normal. The 11/17/22 Incident Note revealed staff noted Resident 9 was not in her/his room, was assisted to bed at 7:00 PM, last seen between 8:15 and 8:30 PM and found on the lawn outside the 200 hall door. The 11/18/22 Wandering Risk Assessment identified Resident 9 as a moderate wander risk. Resident 9 was forgetful, had a short attention span, independent with aid for mobility, early dementia, on antidepressants and had a history of wandering. The 11/18/22 facility investigation revealed the resident was found outside. When interviewed the resident indicated she/he was going to [NAME] for rocky road ice cream. [[NAME] is a store 0.6 miles away from the facility. The resident would have to walk up [NAME] Street, which facility resides on, towards [NAME] Drive which is a highly congested four lane road. The intersection of [NAME] and [NAME] has no intersection and both roads offer minimal lighting.] The 12/6/22 BIMs score was 9 which suggested the resident had moderately impaired cognition. The 12/12/22 Progress Note revealed Resident 9 walked out of the facility around 8:00 PM. The resident wore a sweater, was found down the street walking with her/his walker. The temperature was around 40 degrees and [she/he] was not dressed appropriately. The resident was non-verbal; unable to say why she/he left or where she/he was going. The 12/12/22 Elopement Event identified Resident 9 as an elopement risk, the resident eloped off facility grounds when she/he was left unattended in the front lobby and the resident was disoriented to some-spheres some of the time. The assessment revealed the resident was homeless prior to admission and was not afraid to go out at night. The resident was alert and able to converse most of the time, was slow to answer and very soft spoken which could be misconstrued for non-responsive or cognitive impairment. The 12/13/22 Wandering Risk Assessment identified Resident 9 as a moderate wander risk. Resident 9 was forgetful, had a short attention span, ambulated with one person assistance, early dementia, on antidepressants and had a history of wandering. The 12/13/22 Incident Note revealed Resident 9 was alert and able to converse most of the time but was slow to answer and very soft spoken. Resident 9 stated she/he was going to [NAME]'s for ice cream. Resident 9 stated rocky road was her/his favorite ice cream. The resident stated she/he did not have money for ice cream and stopped responding to the interviewer when repeatedly asked how she/he would have paid for the ice cream. The 12/13/22 BIMs was 14 which indicated the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 12/14/22 Care Conference Notes revealed safety concerns as the resident had exited the facility twice since admission. The resident stated she/he was going to [NAME]'s to get ice cream. It was arranged the resident would be asked weekly if she/he needed anything and ice cream would be available. The 12/28/22 Progress Note revealed Resident 9 walked down the hall around 11:20 PM [on 11/27/22]. The resident walked to the lobby and sat down. Staff asked what she/he needed but the resident did not respond. The CNA sat with the resident for a few minutes but when she went to answer another call light [she/he] left out the front door. The nurse went to check on the resident five minutes later and the resident was gone. Four staff initiated a search, first searching the facility and then outside. Resident 9 was found walking past the park on [NAME] Street. The resident was non-verbal and would not answer any questions. The temperature outside was 50 degrees and raining; the resident wore sweat pants and a T-shirt. The 12/28/22 Progress Note revealed the resident care manager spoke with the resident in the morning and the resident stated she/he was walking to [NAME] for ice cream. When asked if she/he had a bowl of ice cream every night would keep her/him from wanting to go outside, the resident nodded yes. The 12/28/22 Wandering Risk Assessment revealed Resident 9 was a moderate risk for wandering. The resident was forgetful, had a short attention span, did not understand surroundings, independent with mobility, on antidepressants and had a history of wandering. The 12/28/22 facility investigation revealed when Resident 9 eloped staff had not followed the care plan. On 12/28/22 at 5:04 PM Staff 21 (Resident Care Manager) stated Resident 9 exit sought at night between 8:00 PM and 11:00 PM, was homeless prior to admission and did not feel any danger when outside at night. Staff 21 stated Resident 9 always wanted to go to [NAME] to get rocky road ice cream when interviewed. Resident 9 knew she/he did not have any money and would not state how she/he would pay for the ice cream. Staff 21 stated the ice cream was in the activity room but hadn't had any of it. Staff 21 stated although Resident 9 had some cognitive issues she/he had not lost everything and waited until no staff was looking before exiting the building. Staff 21 confirmed Resident 9's care plan instructed not to leave her/him unsupervised in the front lobby which staff did on 12/27/22 when she/he eloped. On 12/28/22 at 5:16 PM Staff 22 (CNA) stated he and another staff member observed Resident 9 walk to the front lobby so he went to check on her/him. Resident 9 was ok and I didn't know [she/he] was going to try to escape. Staff 22 further stated ten or 15 minutes after he checked on the resident a nurse called him and informed him she thought Resident 9 got out so the staff started to look for her/him. Staff 22 stated this was the first time he worked with Resident 9, was not aware to not leave Resident 9 alone in the front lobby and had not read the care plan. On 12/28/22 at 5:33 PM Staff 16 (LPN) verified she worked on 12/27/22 when the resident eloped and stated there was no ice cream available after hours and she could not get into the activity room at night or if she was she was unaware of it. Staff 16 verified Resident 9 was left alone for approximately five minutes in the lobby prior to her/his elopement and stated she was not aware Resident 9's care plan instructed staff she/he was not to be left alone there. Staff 16 stated Resident 9 exit seeked at least once a week at night. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/28/22 at 7:30 PM Staff 20 (Social Service Director) confirmed Resident 9 eloped on 12/27/22 because the care plan was not followed. On 12/29/22 at 8:04 AM Staff 2 (DNS) stated the facility had identified 14 residents who were a moderate to high wander risk. Staff 2 confirmed on 12/27/22 Resident 9 was left alone in the front lobby and the resident's care plan was not followed which resulted in Resident 9's elopement off the facility grounds. On 12/29/22 at 9:16 AM Resident 9 stated when she/he left the facility, it was to go to either [NAME] or Walmart to get ice cream. Resident 9 stated if staff offered her/him ice cream she/he would not leave. On 12/29/22 at 10:06 AM the facility was notified of the Immediate Jeopardy (IJ) situation and a plan of care was requested. Refer to F689 QUALITY OF CARE The 2/12/22 Facility Assessment indicated the facility cared for residents with the following respiratory conditions: chronic obstructive pulmonary disease, pneumonia, asthma, chronic lung disease and respiratory failure. The assessment indicated for decisions related to caring for residents with conditions not listed above, the facility would review documentation and when there was a condition they were not familiar with they would ask questions and do some research to see if the care they would need would be something we could manage. If training was needed prior to admission the facility world request training from the hospital. If a condition developed during a resident's stay they were not familiar with the facility could reach out to the pharmacy or Medical Director for any education which could be offered. Finally, the Facility Assessment revealed six to nine licensed nurses would be scheduled every day to provide direct care to the residents. Additional licensed nursing staff included one DNS, one Assistant DNS and two Resident Care managers. Resident 5 admitted to the facilty on 3/4/22 with diagnoses including heart failure and chronic pleural effusion (an excessive accumulation of fluid in the lungs pleural space). Resident 5 admitted with a PleurX catheter (a small, flexible tube that doctors place within the patient's chest to drain fluid from the pleural space.) [All licensed nurses within the State of Oregon may drain the catheter with proper training.] The facility's staffing records revealed between 3/4/22 through 3/22/22 one and a half to three RN's were on duty daily in addition to multiple LPNs. The 3/4/22 Admission orders directed staff to drain the Pleurx catheter to a maximum 1,000 cc removal at a time, note the amount drained and to notify the physician if the SpO2 (oxygen saturation) was less than 90%. The 3/4/22 Progress Note revealed a nurse to nurse report was received from the hospital and indicated Resident had a chronic right lung pleural effusion with a drain. It was last drained on 3/3/22, was scheduled to be drained every other day and to not remove more than one liter of fluid (1,000 cc). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 3/4/22 Nursing Admission Assessment did not reveal the presence of the PleurX catheter. The skin integrity assessment documented a bandage on chest; did not remove. The March 2022 TARs revealed the following orders: * 3/6/22: Drain the PleurX catheter a maximum of 1,000 cc at a time and to record the amount drained. Note if Resident 5 had a SpO2 under 90%. The 3/6/22 entry was blank. * 3/7/22 through 3/9/22: Drain the PleurX catheter a maximum of 1,000 cc at a time and to record the amount drained. Note if Resident 5 had a SpO2 under 90%. On 3/7/22 documentation revealed 1,000 cc of fluid was drained from the catheter. The 3/9/22 entry was blank. *3/7/22: sterile dressing change weekly and PRN with dry gauze and occlusive dressing to PleurX site. Every Monday day shift. It was documented as completed on 3/7/22 and 3/21/22. On 3/14/22 it was documented as 9 and left blank on 3/28/22. * 3/9/22: Drain PleurX catheter only at clinic or hospital. The 3/9/22 provider encounter note revealed there was a concern with getting Resident 5's PleurX catheter drained and [the provider] was requested to see patient urgently via telemedicine in order to do a face-to-face for home health for assistance with Pleurx [sic] catheter related to recurrent pleural effusions. The provider noted the resident had great self awareness of when this needs to happen. And reporting that [she/he] is having difficulty breathing and needing it. The provider spoke with the DNS and it was determined if the facility had no staff available to drain the catheter then to transfer the resident to the hospital. The provider further noted the effort to leave their domicile to obtain outpatient services would be taxing and overburdensome for this patient. [There was no evidence the facility informed the physician it was within the nurse's scope of practice to drain the catheter.] The 3/9/22 Progress Notes revealed Resident 5 was transferred to the hospital for increased pulse and shortness of breath at 9:37 AM, the hospital drained 2,000 cc from the catheter and the resident returned to the facilty at 3:00 PM. The 3/9/22 updated Physician Order indicated the catheter was to be drained at a clinic or hospital only. Every Monday, Wednesday and Friday. The 3/11/22 provider note indicated Resident 5 experienced shortness of breath although 2,000 cc was drained from the catheter two days prior. The provider spoke with Resident 5's healthcare POA, discussed concerns of ongoing draining of the PleurX catheter and after a long discussion of options for draining at the facility it was decided to update the POLST form for DNR comfort only and refer Resident 5 to hospice. The 3/11/22 Progress Note revealed Hospice was ordered and they would manage and drain the PleurX catheter. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 3/17/22 Progress Note revealed Resident 5 healthcare POA was upset because she was not told why the facility could not drain Resident 5's PleurX catheter and wanted to transition Resident 5 off of hospice but needed home health set up first so the resident would not have to go to the hospital to get the catheter drained. The 3/21/22 Progress Note revealed the facility spoke with Resident 5's daughter about the PleurX catheter and how we were unable to meet [her/his] needs due to the licensing of our nurses and not having an RN to do it. Options were discussed and it was decided the facilty would look for alternative placement but to keep the resident on hospice so they could manage the drain. On 12/28/22 at 8:47 AM Witness 7 (Complainant) stated the facility did not want to provide care and services for the PleurX catheter and placed the resident on hospice against her/his will. Resident 5's family notified Witness 7 that they did not want hospice but felt like their back was against the wall. The resident was admitted to the facility specifically for the facility to manage the catheter however care did not happen and she/he was sent to the hospital for catheter care. Resident 5 and family were given the decision to either send the resident to the hospital for routine catheter care or go onto hospice. Witness 7 stated she reached out to the facility to coordinate nurse education if that was what was needed and offered to have a provider or the catheter company provide a tutorial which the facility declined. The facilty stated this [PleurX catheter] was something they did not do. Witness 7 stated care facilities should be able to manage the catheter and even lay people can be taught to do it. On 12/25/22 at 8:58 AM an interview was conducted with Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS). Staff 1 stated the facility did not know how to care for the catheter, did not have sufficient RN staffing to care for the resident and the facilty was unaware the resident had a PleurX catheter on admission but verified this information was in the resident's admission paperwork which they reviewed prior to the resident's admission. Staff 1 stated she declined training offered by the Resident's Case Manager and verified the resident went on hospice to avoid hospital emergency room visits. On 12/29/22 in the AM Staff 1 and Staff 3 stated they were unaware LPN's were allowed to provide care and services related to the PleurX catheter with proper training. F684 and F726 RESIDENT ASSESSMENTS, CARE PLAN INTERVENTIONS Resident 15 admitted to the facility in 2020 with diagnoses including end stage renal disease and a hip fracture. The 10/14/22 Annual MDS indicated the resident was cognitively intact, required extensive assistance with bed mobility, was non-ambulatory, and had a history of falls. (continued on next page)

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	38E075	A. Building B. Wing	01/11/2023

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 0600 Level of Harm - Actual harm Residents Affected - Few	An 11/24/22 Fall Investigation indicated Resident 15 fell out of bed while reaching down for something and hit her/his head on the floor. The resident stated, I was laying on the edge of the bed and I felt myself sliding down and I tried to grab for something, and I fell . The resident's call light was noted to be initiated. The investigation did not indicate how long the call light had been on. The resident was noted to have been last toileted and repositioned two hours prior to the fall. The resident's air mattress was noted to be a bit high so the air in the mattress was decreased. The resident requested side rails for her/his bed. On 1/3/23 at 9:25 AM Resident 15 stated she/he had pressed her/his call light as she/he was close to the edge of the bed. The resident stated she/he yelled I am going to fall, but by the time staff came to the room the resident was on the floor. Resident 15 stated her/his call light had been initiated for 30 minute and stated the long call light time happened all the time. Resident 15 stated right after the fall she/he had requested bed mobility bars, but she/he never received them. The resident's bed was observed to be without any bed mobility bars or side rails. Resident 15 further stated she/he almost fell out of bed a few days prior, but a staff member was able to prevent the fall and helped reposition the resident in the center of the bed. On 1/3/23 at 11:29 AM and 11:55 AM Staff 3 (LPN, Assistant DNS) acknowledged the investigation did not include how long Resident 15's call light was initiated. Staff 3 further stated the expectation was for the resident to have mobility bars per the resident's request and the resident did not currently have mobility bars on her/his bed. Refer to F689 Resident 11 admitted to the facility on [DATE] with diagnoses including osteoarthritis. The 10/15/22 Admission MDS was completed on 10/25/22; three days late. On 12/30/22 at 12:51 PM Staff 2 (DNS) verified the 10/15/22 Admission MDS was completed late. Refer to F636 Resident 3 admitted to the facility in 2020 with diagnoses including paraplegia (paralysis of the legs and lower body). Resident 3's 9/20/22 Annual MDS was completed on 10/5/22; one day late. On 12/28/22 at 9:12 AM Staff 2 (DNS) verified the 9/20/22 Annual MDS was completed one day late. Refer to F636 Resident 13 admitted to the facility on [DATE] with diagnoses including hypertension. The 7/26/22 Admission MDS was completed on 8/3/22; one day late. On 12/30/22 at 12:52 PM Staff 2 (DNS) verified the 7/26/22 Admission MDS was completed late. Refer to F636 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	ASSESSMENT AND MONITORING OF PRESSURE ULCERS Resident 3 admitted to the facility in 2020 with diagnoses including paraplegia (paralysis of the legs and lower body) and a chronic Stage 4 (full thickness skin and tissue loss) pressure ulcer. The August 2022 and September 2022 TARs revealed wound care was completed for Resident 3's coccyx wound. The Weekly Skin Evaluations revealed the following: *8/5/22: Stage 4 coccyx pressure wound which measured 0.5 cm x 0.5 cm x 0 cm. Treatment was in place and it appeared to be healing. [The assessment was not comprehensive.] *8/12/22: Stage 4 coccyx pressure wound which measured 3 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, no foul odor, no complaints of pain. [The assessment was not comprehensive.] *8/19/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, no foul odor, no complaints of pain. [The assessment was not comprehensive.] *8/26/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, odor present, no complaints of pain. [The assessment was not comprehensive.] *9/2/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, odor present, no complaints of pain. [The assessment was not comprehensive.] Review of Resident 3's medical record revealed no further skin assessments until the 10/20/22 RN Wound Assessment. The RN Wound Assessments revealed the following: *10/20/22: Stage 3 (full thickness skin loss, may extend into the subcutaneous tissue layer) coccyx pressure wound which measured 4 cm x 1.2 cm x 0/7 cm. This was a chronic wound the resident had for years. Tunneling present at 6 o'clock measured 0.7 cm. The wound bed was 50% slough and 50% pale pink tissue. [Not a comprehensive assessment; downstaged wound.] *10/27/22: Stage 3 coccyx pressure wound which measured 3 cm x 1 cm x 0.6 cm. Tunnel at 6 o'clock was deeper and slough at wound base was thicker and covered most of the wound bed. [Not a comprehensive assessment; downstaged wound.] *10/29/22: Stage 3 coccyx pressure wound 90% slough and 10% pink tissue. [Not a comprehensive assessment; downstaged wound.] 11/3/22[TRUNCATED]

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to complete a MDS in the required timeframe for 3 of 8 sampled residents (#s 3, 11 and 13) reviewed for skin conditions, hospice and infection control. This placed residents at risk for unassessed and unmet care needs. Findings include: 1. Resident 11 admitted to the facilty on 10/8/22 with diagnoses including osteoarthritis. The 10/15/22 Admission MDS was completed on 10/25/22; three days late. On 12/30/22 at 12:51 PM Staff 2 (DNS) verified the 10/15/22 Admission MDS was completed late. 2. Resident 3 admitted to the facility in 2020 with diagnoses including paraplegia (paralysis of the legs and lower body). Resident 3's 9/20/22 Annual MDS was completed on 10/5/22; one day late. On 12/28/22 at 9:12 AM Staff 2 (DNS) verified the 9/20/22 Annual MDS was completed one day late. 3. Resident 13 admitted to the facility on [DATE] with diagnoses including hypertension. The 7/26/22 Admission MDS was completed on 8/3/22; one day late. On 12/30/22 at 12:52 PM Staff 2 (DNS) verified the 7/26/22 Admission MDS was completed late.

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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. 33179 Based on interview and record review it was determined the facility failed to ensure a resident received the required care and services related to a drainage catheter and to follow physician orders for 2 of 4 sampled residents (#s 4 and 5) reviewed for catheters and skin conditions. This caused Resident 5 to experience an avoidable hospital transfer, pain, shortness of breath and an increased pulse rate. The facility failures placed residents at risk for delayed treatment and worsening wounds. Findings include: 1. The 2/12/22 Facility Assessment indicated the facility cared for residents with the following respiratory conditions: chronic obstructive pulmonary disease, pneumonia, asthma, chronic lung disease and respiratory failure. The assessment indicated for decisions related to caring for residents with conditions not listed above, the facility would review documentation and when there was a condition they were not familiar with they would ask questions and do some research to see if the care they would need would be something we could manage. If training was needed prior to admission the facility world request training from the hospital. If a condition developed during a resident's stay they were not familiar with the facility could reach out to the pharmacy or Medical Director for any education which could be offered. Finally, the Facility Assessment revealed six to nine licensed nurses would be scheduled every day to provide direct care to the residents. Additional licensed nursing staff included one DNS, one Assistant DNS and two Resident Care managers. Resident 5 admitted to the facilty on 3/4/22 with diagnoses including heart failure and chronic pleural effusion (an excessive accumulation of fluid in the lungs pleural space). Resident 5 admitted with a PleurX catheter (a small, flexible tube that doctors place within the patient's chest to drain fluid from the pleural space.) [All licensed nurses within the State of Oregon may drain the catheter with proper training.] The facility's staffing records revealed between 3/4/22 through 3/22/22 one and a half to three RN's were on duty daily in addition to multiple LPNs. The 3/4/22 Admission orders directed staff to drain the Pleurx catheter to a maximum 1,000 cc removal at a time, note the amount drained and to notify the physician if the SpO2 (oxygen saturation) was less than 90%. The 3/4/22 Progress Note revealed a nurse to nurse report was received from the hospital and indicated Resident had a chronic right lung pleural effusion with a drain. It was last drained on 3/3/22, was scheduled to be drained every other day and to not remove more than one liter of fluid (1,000 cc). The 3/4/22 Nursing Admission Assessment did not reveal the presence of the PleurX catheter. The skin integrity assessment documented a bandage on chest; did not remove. The March 2022 TARs revealed the following orders: * 3/6/22: Drain the PleurX catheter a maximum of 1,000 cc at a time and to record the amount drained. Note if Resident 5 had a SpO2 under 90%. The 3/6/22 entry was blank. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	* 3/7/22 through 3/9/22: Drain the PleurX catheter a maximum of 1,000 cc at a time and to record the amount drained. Note if Resident 5 had a SpO2 under 90%. On 3/7/22 documentation revealed 1,000 cc of fluid was drained from the catheter. The 3/9/22 entry was blank. *3/7/22: sterile dressing change weekly and PRN with dry gauze and occlusive dressing to PleurX site. Every Monday day shift. It was documented as completed on 3/7/22 and 3/21/22. On 3/14/22 it was documented as 9 and left blank on 3/28/22. * 3/9/22: Drain PleurX catheter only at clinic or hospital. The 3/9/22 provider encounter note revealed there was a concern with getting Resident 5's PleurX catheter drained and [the provider] was requested to see patient urgently via telemedicine in order to do a face-to-face for home health for assistance with Pleurx [sic] catheter related to recurrent pleural effusions. The provider noted the resident had great self awareness of when this needs to happen. And reporting that [she/he] is having difficulty breathing and needing it. The provider spoke with the DNS and it was determined if the facility had no staff available to drain the catheter then to transfer the resident to the hospital. The provider further noted the effort to leave their domicile to obtain outpatient services would be taxing and overburdensome for this patient. [There was no evidence the facility informed the physician it was within the nurse's scope of practice to drain the catheter.] The 3/9/22 Progress Notes revealed Resident 5 was transferred to the hospital for increased pulse and shortness of breath at 9:37 AM, the hospital drained 2,000 cc from the catheter and the resident returned to the facilty at 3:00 PM. The 3/9/22 updated Physician Order indicated the catheter was to be drained at a clinic or hospital only. Every Monday, Wednesday and Friday. The 3/11/22 provider note indicated Resident 5 experienced shortness of breath although 2,000 cc was drained from the catheter two days prior. The provider spoke with Resident 5's healthcare POA, discussed concerns of ongoing draining of the PleurX catheter and after a long discussion of options for draining at the facility it was decided to update the POLST form for DNR comfort only and refer Resident 5 to hospice. The 3/11/22 Progress Note revealed Hospice was ordered and they would manage and drain the PleurX catheter. The 3/17/22 Progress Note revealed Resident 5 healthcare POA was upset because she was not told why the facility could not drain Resident 5's PleurX catheter and wanted to transition Resident 5 off of hospice but needed home health set up first so the resident would not have to go to the hospital to get the catheter drained. The 3/21/22 Progress Note revealed the facility spoke with Resident 5's daughter about the PleurX catheter and how we were unable to meet [her/his] needs due to the licensing of our nurses and not having an RN to do it. Options were discussed and it was decided the facilty would look for alternative placement but to keep the resident on hospice so they could manage the drain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/28/22 at 8:47 AM Witness 7 (Complainant) stated the facility did not want to provide care and services for the PleurX catheter and placed the resident on hospice against her/his will. Resident 5's family notified Witness 7 that they did not want hospice but felt like their back was against the wall. The resident was admitted to the facility specifically for the facility to manage the catheter however care did not happen and she/he was sent to the hospital for catheter care. Resident 5 and family were given the decision to either send the resident to the hospital for routine catheter care or go onto hospice. Witness 7 stated she reached out to the facility to coordinate nurse education if that was what was needed and offered to have a provider or the catheter company provide a tutorial which the facility declined. The facilty stated this [PleurX catheter] was something they did not do. Witness 7 stated care facilities should be able to manage the catheter and even lay people can be taught to do it. On 12/25/22 at 8:58 AM an interview was conducted with Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS). Staff 1 stated the facility did not know how to care for the catheter, did not have sufficient RN staffing to care for the resident and the facilty was unaware the resident had a PleurX catheter on admission but verified this information was in the resident's admission paperwork which they reviewed prior to the resident's admission. Staff 1 stated she declined training offered by the Resident's Case Manager and verified the resident went on hospice to avoid hospital emergency room visits. On 12/29/22 in the AM Staff 1 and Staff 3 stated they were unaware LPN's were allowed to provide care and services related to the PleurX catheter with proper training. 2. Resident 4 admitted to the facility in 3/2022 with diagnoses including heart failure and dementia. An 8/12/22 Physician Order instructed staff to clean Resident 4's wounds daily in the first, second and third right webspaces with saline or wound cleanser and then to apply Bacitracin (antibiotic ointment). Place gauze between the webspaces. Clean the wound on the dorsal aspect of the right second toe, apply Bacitracin and cover with gauze. Secure the gauze with Kerlex dressing. The August 2022 TARs revealed the wound treatment was not initiated until 8/14/22. On 12/28/22 at 9:26 PM Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS) confirmed the 8/12/22 Physician Order was not started until 8/14/22.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33179 Based on interview and record review it was determined the facility failed to assess and monitor a pressure ulcer for 1 of 3 sampled residents (#3) reviewed for skin conditions. This placed residents at risk for worsening of wounds. Findings include: CMS instructed pressure ulcers were to be comprehensively assessed and documented with each dressing change or at minimum weekly. The documentation should include the following: *the type of injury; *the stage and location of the wound; *a description of the wound's characteristics: presence, location and extent of any undermining (erosion occurs underneath the outwardly visible wound margins) or tunneling (extends from the skin surface to various underlying tissues), exudate (drainage) if present/type, color, odor and approximate amount; *pain, if present, nature and frequency; *wound bed: color and type of tissue/character including evidence of healing (granulation tissue: new vascular tissue) or necrosis (slough [yellow/white material in the wound bed; usually wet] or eschar [dead tissue]); *description of wound edges and surrounding tissue. Resident 3 admitted to the facility in 2020 with diagnoses including paraplegia (paralysis of the legs and lower body) and a chronic Stage 4 (full thickness skin and tissue loss) pressure ulcer. The August 2022 and September 2022 TARs revealed wound care was completed for Resident 3's coccyx wound. The Weekly Skin Evaluations revealed the following: *8/5/22: Stage 4 coccyx pressure wound which measured 0.5 cm x 0.5 cm x 0 cm. Treatment was in place and it appeared to be healing. [The assessment was not comprehensive.] *8/12/22: Stage 4 coccyx pressure wound which measured 3 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, no foul odor, no complaints of pain. [The assessment was not comprehensive.] *8/19/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, no foul odor, no complaints of pain. [The assessment was not comprehensive.] (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*8/26/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, odor present, no complaints of pain. [The assessment was not comprehensive.] *9/2/22: Stage 4 coccyx pressure wound which measured 33.5 cm x 5 cm x 0.5 cm. Treatment in place. Wound was larger, periwound was macerated, wound bed had slough, odor present, no complaints of pain. [The assessment was not comprehensive.] Review of Resident 3's medical record revealed no further skin assessments until the 10/20/22 RN Wound Assessment. The RN Wound Assessments revealed the following: *10/20/22: Stage 3 (full thickness skin loss, may extend into the subcutaneous tissue layer) coccyx pressure wound which measured 4 cm x 1.2 cm x 0/7 cm. This was a chronic wound the resident had for years. Tunneling present at 6 o'clock measured 0.7 cm. The wound bed was 50% slough and 50% pale pink tissue. [Not a comprehensive assessment; downstaged wound.] *10/27/22: Stage 3 coccyx pressure wound which measured 3 cm x 1 cm x 0.6 cm. Tunnel at 6 o'clock was deeper and slough at wound base was thicker and covered most of the wound bed. [Not a comprehensive assessment; downstaged wound.] *10/29/22: Stage 3 coccyx pressure wound 90% slough and 10% pink tissue. [Not a comprehensive assessment; downstaged wound.] 11/3/22: Stage 3 coccyx pressure wound which measured 3 cm x 1 cm x 0.5 cm. Macerated thick skin, tunnel at 6 o'clock which measured 1.5 cm. Would bed had 75% slough and 25% pale pink tissue. Wound circumference was slightly smaller but tunnel was deeper and slough at the wound base was decreased. Surrounding tissue remained thick and white macerated. [Not a comprehensive assessment; downstaged wound.] *11/10/22 Stage 3 coccyx pressure ulcer which measured 3.5 cm x 0.6 cm x 0.3 cm. Tunnel at 6 o'clock measured 0.3 cm. Wound bed was 75% slough and 25% pale pink tissue; some debridement at wound clinic .surrounding tissue remained thick and white macerated. [Not a comprehensive assessment; downstaged wound.] *11/15/22 Stage 3 coccyx pressure ulcer which measured 3.5 cm x 0.6 cm x 0.3 cm. The area is surrounded with macerated thick skin with a tunnel at 6 o'clock which measured 0.3 cm. Wound bed was 75% slough and 25% pale pink tissue. Some debridement at wound clinic. Tunnel is smaller but no overall change to wound bed. Resident was discharged from wound clinic this week. Referral obtained for [alternative] wound clinic. [Not a comprehensive assessment; downstaged wound.] *11/20/22 Stage 3 coccyx pressure ulcer which measured 3.5 cm x 0.6 cm x 0.3 cm. Area surrounded with macerated thick skin and had a tunnel at 6 o'clock which measured 0.5 cm. Wound bed was 75% slough and 25% pale pink tissue; some debridement at wound clinic. Tunnel was smaller but no overall change to wound bed. Resident goes out to wound clinic weekly, had debridement at last appointment. Surrounding tissue remained thick and white macerated. [Not a comprehensive assessment; downstaged wound.] (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*11/22/22 Stage 3 coccyx pressure ulcer which measured 3.2 cm x 1 cm x 0.5 cm. New assessor with new wound clinic today. Approximately 70% epithelial tissue, 20% granulation tissue and 105 slough, wound debrided. Tunnel changed to undermining form 6 to 7 o'clock and measured 1.6 cm new orders received. [Not a comprehensive assessment; downstaged wound.] On 12/28/22 at 9:12 AM Staff 1 (Administrator) and Staff 2 (DNS) confirmed the 8/5/22, 8/12/22, 8/19/22, 8/26/22 and 9/22 Weekly Skin assessments were not comprehensive. Additionally Staff 2 confirmed the 10/20/22, 10/27/22, 10/29/22, 11/3/22, 11/10/22, 11/15/22, 11/20/22 and 11/22/22 RN Wound assessments were not comprehensive and the wound stage was incorrectly downgraded from a Stage 4 to a Stage 3 pressure ulcer.

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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** 33179 1. Based on interview and record review it was determined the facility failed to ensure Resident 9 did not elope from the facility for 1 of 1 sampled residents (#9) reviewed for elopement. This failure was determined to be an immediate jeopardy situation because the facility failed to follow the residents care plan and provide supervision which resulted in Resident 9's elopement from the facility. Findings include: Resident 9 admitted to the facility in 2022 with diagnoses including symptoms involving cognitive functions following other nontraumatic intracranial hemorrhage and cataracts. Prior to admission, the resident was homeless. The 9/27/22 Communication Care Plan revealed Resident 9 had a communication problem related to expressive aphasia (a form of aphasia when the person knows what they want to say but are unable to produce the words or sentence. Can be mild to severe), slurring, stroke, weak or absent voice. Interventions included to allow adequate time to respond, face the resident when speaking and make eye contact, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. The resident was able to say yes or no and very short sentences and could shake/nod her/his head. Speak to the resident in a calm, quiet voice because she/he responded better with this approach. Speak on an adult level, speak clearly and slower than normal. The 9/27/22 Fall Care Plan revealed Resident 9 was a high risk for falls related to gait and balance problems. The 11/18/22 Vision Care Plan revealed Resident 9 was at risk for poor vision related to cataracts. The Elopement Risk Care Plan, last revised on 12/28/22, revealed Resident 9 was a high elopement risk related to impaired safety awareness; both physical and environmental. The resident had eloped on 11/17/22, 12/12/22 and 12/27/22. The interventions included to remind the resident to notify staff if she/he planned to leave the facility as needed (11/18/22), resident was high fall risk (11/18/22), to not seat the resident in the lobby near the doors without supervision at any time of the day or night. If the resident was up during late night hours to have her/him close to the nurse's station where she/he could be monitored. To walk with the resident if she/he wanted to walk, sit and talk with the resident, attempt to engage the resident to watch television, look at a magazine, offer fluids and snack. If not redirectable, alert the charge nurse, RN, resident care manager or DNS (12/14/22). Remind the resident of the sign posted in her/his room to not leave the facility without assistance for her/his safety and to show her/him the sign above the television (12/15/22). Activities to check in with the resident regularly to see if she/he needed anything from the store and to let nursing know to minimize the desire to exit the facility (12/16/22). Offer Resident 9 a bowl of ice cream (rocky road) every evening sometime after dinner and before bed time. If Resident 9 ambulated toward the front lobby late at night offer the ice cream again (12/28/22). (continued on next page)

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	38E075	A. Building B. Wing	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 11/17/22 at 9:34 PM Incident Note revealed staff noted Resident 9 was not in her/his room, was assisted to bed at 7:00 PM, last seen between 8:15 PM and 8:30 PM and found on the lawn outside the 200 hall door. The 11/18/22 Wandering Risk Assessment identified Resident 9 as a moderate wander risk. Resident 9 was forgetful, had a short attention span, independent with aid for mobility, early dementia, on antidepressants and had a history of wandering. The 11/18/22 facility investigation revealed the resident was found outside. When interviewed the resident indicated she/he was going to [NAME] for rocky road ice cream. [[NAME] is a store 0.6 miles away from the facility. The resident would have to walk up [NAME] Street, which facility resides on, towards [NAME] Drive which is a highly congested four lane road. The intersection of [NAME] and [NAME] has no intersection and both roads offer minimal lighting.] The 12/6/22 BIMs score was 9 which suggested the resident had moderately impaired cognition. The 12/12/22 Progress Note revealed Resident 9 walked out of the facility around 8:00 PM. The resident wore a sweater, was found down the street walking with her/his walker. The temperature was around 40 degrees and [she/he] was not dressed appropriately. The resident was non-verbal; unable to say why she/he left or where she/he was going. The 12/12/22 Elopement Event identified Resident 9 as an elopement risk, the resident eloped off facility grounds when she/he was left unattended in the front lobby and the resident was disoriented to some-spheres some of the time. The assessment revealed the resident was homeless prior to admission and was not afraid to go out at night. The resident was alert and able to converse most of the time, was slow to answer and very soft spoken which could be misconstrued for non-responsive or cognitive impairment. The 12/13/22 Wandering Risk Assessment identified Resident 9 as a moderate wander risk. Resident 9 was forgetful, had a short attention span, ambulated with one person assistance, early dementia, on antidepressants and had a history of wandering. The 12/13/22 Incident Note revealed Resident 9 was alert and able to converse most of the time but was slow to answer and very soft spoken. Resident 9 stated she/he was going to [NAME]'s for ice cream. Resident 9 stated rocky road was her/his favorite ice cream. The resident stated she/he did not have money for ice cream and stopped responding to the interviewer when repeatedly asked how she/he would have paid for the ice cream. The 12/13/22 BIMs was 14 which indicated the resident was cognitively intact. The 12/14/22 Care Conference Notes revealed safety concerns as the resident had exited the facility twice since admission. The resident stated she/he was going to [NAME]'s to get ice cream. It was arranged the resident would be asked weekly if she/he needed anything and ice cream would be available. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 12/28/22 Progress Note revealed Resident 9 walked down the hall around 11:20 PM [on 11/27/22]. The resident walked to the lobby and sat down. Staff asked what she/he needed but the resident did not respond. The CNA sat with the resident for a few minutes but when she went to answer another call light [she/he] left out the front door. The nurse went to check on the resident five minutes later and the resident was gone. Four staff initiated a search, first searching the facility and then outside. Resident 9 was found walking past the park on [NAME] Street. The resident was non-verbal and would not answer any questions. The temperature outside was 50 degrees and raining; the resident wore sweat pants and a T-shirt. The 12/28/22 Progress Note revealed the resident care manager spoke with the resident in the morning and the resident stated she/he was walking to [NAME] for ice cream. When asked if she/he had a bowl of ice cream every night would keep her/him from wanting to go outside, the resident nodded yes. The 12/28/22 Wandering Risk Assessment revealed Resident 9 was a moderate risk for wandering. The resident was forgetful, had a short attention span, did not understand surroundings, independent with mobility, on antidepressants and had a history of wandering. The 12/28/22 facility investigation revealed when Resident 9 eloped staff had not followed the care plan. On 12/28/22 at 5:04 PM Staff 21 (Resident Care Manager) stated Resident 9 exit sought at night between 8:00 PM and 11:00 PM, was homeless prior to admission and did not feel any danger when outside at night. Staff 21 stated Resident 9 always wanted to go to [NAME] to get rocky road ice cream when interviewed. Resident 9 knew she/he did not have any money and would not state how she/he would pay for the ice cream. Staff 21 stated the ice cream had been in the activity room but hadn't had any of it. Staff 21 stated although Resident 9 had some cognitive issues she/he had not lost everything and waited until no staff was looking before exiting the building. Staff 21 confirmed Resident 9's care plan instructed not to leave her/him unsupervised in the front lobby which staff did on 12/27/22 when she/he eloped. On 12/28/22 at 5:16 PM Staff 22 (CNA) stated he and another staff member observed Resident 9 walk to the front lobby so he went to check on her/him. Resident 9 was ok and I didn't know [she/he] was going to try to escape. Staff 22 further stated ten or 15 minutes after he checked on the resident a nurse called him and informed him she thought Resident 9 got out so the staff started to look for her/him. Staff 22 stated this was the first time he worked with Resident 9, was not aware to not leave Resident 9 alone in the front lobby and had not read the care plan. On 12/28/22 at 5:33 PM Staff 16 (LPN) verified she worked on 12/27/22 when the resident eloped and stated there was no ice cream available after hours and she could not get into the activity room at night or if she was she was unaware of it. Staff 16 verified Resident 9 was left alone for approximately five minutes in the lobby prior to her/his elopement and stated she was not aware Resident 9's care plan instructed staff she/he was not to be left alone there. Staff 16 stated Resident 9 exit seeked at least once a week at night. On 12/28/22 at 7:30 PM Staff 20 (Social Service Director) confirmed Resident 9 eloped on 12/27/22 because the care plan was not followed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/29/22 at 8:04 AM Staff 2 (DNS) stated the facility had identified 14 residents who were a moderate to high wander risk. Staff 2 confirmed on 12/27/22 Resident 9 was left alone in the front lobby and the resident's care plan was to followed which resulted in Resident 9's elopement off the facility grounds. On 12/29/22 at 9:16 AM Resident 9 stated when she/he left the facility, it was to go to either [NAME] or Walmart to get ice cream. Resident 9 stated if staff offered her/him ice cream she/he would not leave. On 12/29/22 at 10:06 AM the facility was notified of the Immediate Jeopardy (IJ) situation and a plan of care was requested. On 12/29/22 at 12:40 PM the facility submitted an acceptable immediacy removal plan which would abate the IJ situation. The immediacy removal plan included the following: *Resident 9 would be visually monitored by staff at all times from dinner until 2:00 AM. Ice [NAME] would be offered every evening before bed. The visual monitoring would remain in place until the wander guard that was ordered arrived and was put into place. *The elopement care plans for the 13 residents who were moderate to high risk for wandering would be printed and required to be reviewed by the nursing staff prior to them working with the residents. *The facility had identified on 12/20/22 some staff had not read care plan changes and a new system of notifying staff was implemented. *All residents had a potential to be affected. *All staff would be informed of what residents were at risk for wandering/elopement. All nursing staff would receive education on the new system for notifying staff of care plan changes and the expectation to read the care plan prior to providing care to the resident. Education would begin on 12/29/22 and would by completed by 12/30/22 at 3:00 PM or upon return if on a leave of absence prior to working with residents. *Random weekly audits of care plans would be completed to ensure staff were notified of changes per the new system for 30 days. Results of the audits would be reviewed by the QAPI (Quality Assurance and Performance Improvement) team to determine if further auditing was necessary On 12/30/22 staff interviews verified re-education per the immediacy removal plan was competed. A review of facility documentation revealed all aspects of the immediacy removal plan was implemented. On 12/30/22 at 2:50 PM it was determined the IJ immediacy was removed. 40767 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Based on observation, interview and record review it was determined the facility failed to ensure interventions were in place to prevent accidents for 1 of 3 sampled residents (#15) reviewed for falls. This placed residents at risk for injury. Findings include: Resident 15 admitted to the facility in 2020 with diagnoses including end stage renal disease and a hip fracture. The 10/14/22 Annual MDS indicated the resident was cognitively intact, required extensive assistance with bed mobility, was non-ambulatory, and had a history of falls. An 11/24/22 Fall Investigation indicated Resident 15 fell out of bed while reaching down for something and hit her/his head on the floor. The resident stated, I was laying on the edge of the bed and I felt myself sliding down and I tried to grab for something, and I fell . The resident's call light was noted to be initiated. The investigation did not indicate how long the call light had been on. The resident was noted to have been last toileted and repositioned two hours prior to the fall. The resident's air mattress was noted to be a bit high so the air in the mattress was decreased. The resident requested side rails for her/his bed. On 1/3/23 at 9:25 AM Resident 15 stated she/he had pressed her/his call light as she/he was close to the edge of the bed. The resident stated she/he yelled I am going to fall, but by the time staff came to the room the resident was on the floor. Resident 15 stated her/his call light had been initiated for 30 minute and stated the long call light time happened all the time. Resident 15 stated right after the fall she/he had requested bed mobility bars, but she/he never received them. The resident's bed was observed to be without any bed mobility bars or side rails. Resident 15 further stated she/he almost fell out of bed a few days prior, but a staff member was able to prevent the fall and helped reposition the resident in the center of the bed. On 1/3/23 at 11:29 AM ad 11:55 AM Staff 3 (LPN, Assistant DNS) acknowledged the investigation did not include how long Resident 15's call light was initiated. Staff 3 further stated the expectation was for the resident to have mobility bars per the resident's request and the resident did not currently have mobility bars on her/his bed.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 33179 Based on interview and record review it was determined the the facility failed to monitor and assess Resident 2 for signs of UTI (urinary tract infection) such as decreased food and fluid intake and decreased urine output and failed to notify the provider of condition changes for 1 of 3 sampled residents (#2) reviewed for change of condition. This failure was determined to be an immediate jeopardy situation because the facility failed to recognize and treat a UTI which resulted in severe sepsis and death. Findings include: Resident 2 admitted to the facility in 4/2022 with diagnoses including intellectual disabilities and neurogenic bladder. The 3/11/22 Risk For Infection related to the use of a urinary catheter care plan included the following interventions: change catheter and Foley (catheter) bag as scheduled or as ordered by the physician, monitor the indwelling catheter and report to the physician signs and symptoms of UTI such as pain, burning, blood tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. The 4/6/22 Return From Hospital care plan interventions included to monitor appetite and document the percentage eaten each meal and to monitor pain and discomfort. A 4/29/22 Progress note revealed Resident 2's urine was cloudy with foul smell, had increased agitation and a UA (urinalysis) was collected. A 5/4/22 Progress note revealed a negative UA result. The 5/4/22 task documentation revealed Resident 2's UOP (urine output) was 1150 cc. Meal intake for breakfast was 26 to 50%, lunch zero to 25% and dinner was refused. Fluid intake was 980 cc. A 5/6/22 Progress note revealed Resident 2 was very irritable and refused the catheter change. Blood Pressure was 71/49 [No evidence of physician notification, assessment or monitoring was completed or offered additional food and fluids.] The 5/6/22 task documentation revealed Resident 2's UOP was 675 cc, fluid intake was 460 cc and meal intake for breakfast and lunch was zero to 25% and dinner 26 to 50%. A 5/7/22 Progress Note revealed Resident 2 was on alert due to having cloudy urine, having increased sediment and foul odor. The 5/8/22 task documentation revealed fluid intake was 540 cc. The 5/9/22 task documentation revealed the resident consumed zero to 25% of all meals and fluid intake was 360 cc. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 5/10/22 task documentation revealed fluid intake was 270 cc. Meal intake for breakfast was 26 to 50%, lunch zero to 25% and refused dinner. The 5/11/22 task documentation revealed 500 cc UOP, 780 cc fluid intake and meal intake varied from zero to 75%. The 5/12/22 task documentation revealed 475 cc UOP, 120 cc fluid intake, meal intake for breakfast and dinner was refused, lunch was zero to 25%. The resident took in additional nutrition in the evening between 75-100%. The 5/13/22 task documentation revealed 950 cc UOP, Fluid intake was 240 cc with one meal intake not documented and meal intake zero to 25% for breakfast and dinner and lunch was not documented. The 5/14/22 task documentation revealed 560 cc UOP, 740 cc fluid intake, breakfast and dinner refused with zero to 25% lunch meal intake. The 5/16/22 task documentation revealed UOP was 25 cc on night shift and 260 cc on day shift. Fluid intake was 20 cc for breakfast and 120 cc for lunch. Meal intake was zero to 25% for breakfast and lunch. The 5/16/22 12:01 PM Progress note revealed a CNA reported Resident 2 was not acting like [her/himself] today. Blood pressure was 94/59, resident stated she/he felt unwell and was unable to describe any specific symptoms. The urine was red/brown tinged and mucus was present. The residents speech was slurred. The provider was called and staff were waiting for a call-back. The 5/16/22 2:00 PM Progress note revealed the provider called back and gave orders to push fluids, administer an antibiotic shot, change the indwelling catheter and to obtain a stat [immediate] UA. The 5/16/22 provider encounter note revealed the resident was seen for a concern of a possible UTI. The urine was reported to have foul odor and was cloudy with a dark color. The catheter was changed and the urine was clear after the indwelling catheter change. The resident complained of stomach and ear pain. The 5/16/22 2:38 PM indicated the resident was transported to the hospital for altered mental status and hypotension (low blood pressure). The 5/17/22 Progress note revealed the hospital notified the facility the resident passed away with a small bowel obstruction, UTI, sepsis (full body infection) and acute renal failure. The 5/17/22 Hospital Records revealed Resident 2 was transferred to the hospital for malaise, fatigue and low blood pressure. The resident was diagnosed with UTI , septic syndrome secondary to UTI, acute kidney injury, anemia, hypoalbuminemia (abnormally low blood level of albumin (type of protein)), gastric outlet obstruction, gastrointestinal bleed and severe anion gap metabolic acidosis (imbalanced electrolytes). On 5/16/22, after discussion of options with the family, the residents POLST was changed to DNR and the resident passed away on 5/17/22. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 5/24/22 Death Certificate revealed Resident 2's immediate cause of death was severe sepsis with septic shock, approximate onset to death, one day, due to pseudomonas UTI, approximate onset to death, five days. Other significant conditions contributing to death gastric outlet obstruction. There was no evidence in the medical record the provider was notified of the residents decreased appetite, fluid intake, urine output, low blood pressure, increased confusion, irritability or malaise. There was no evidence of monitoring of signs and symptoms of UTI. On 12/21/22 at 9:25 AM Resident 16 (roommate) verified she was Resident 2's roommate and stated the week prior to her/his transfer to the hospital Resident 2 had increased irritability and was in pain. On 12/19/22 12:30 PM Staff 6 (Former NA) stated the week prior to Resident 2 transferring to the hospital her/his urine was brown in color and had increased confusion. On 12/19/22 at 2:21 PM Staff 11 (CNA) stated in the two weeks prior to Resident 2's hospital transfer she/he was pretty confused, tired, had a poor appetite, irritable, pretty out of it and the urine bag was not looking like it should. Staff 11 stated she recalled the nurses looking at the resident's urine bag but had no idea what the nurses did. On 12/19/22 at 3:10 PM Staff 13 (LPN) stated staff were monitoring Resident 2's urine for amber color. On 12/20/22 at 2:00 PM Staff 4 (Administrator in Training) recalled talking the Resident 2's sister about her concerns of Resident 2's health related to cognition, loss of appetite, getting up less and concerns of UTI. Staff 4 stated I finally asked [staff] to send her out so they did. On 12/20/22 at 3:30 PM Staff 16 (LPN) verified she wrote the 5/6/22 progress note, confirmed the resident was very irritable, refused the catheter change and had a blood pressure of 71/49. Staff 16 verified she did not further assess the resident or notify the physician of the low blood pressure, irritability or refusal of the catheter change. On 12/20/22 at 3:35 PM Staff 35 (LPN) stated the week prior to Resident 2's hospital transfer she/he was very irritable which was not normal because she/he was usually sweet and pleasant. On 12/21/22 at 9:50 AM Staff 7 (CNA) stated in the two weeks prior to Resident 2's hospital transfer she/he ate less because she didn't feel good enough to eat and needed more encouragement to attempt to eat and drink. Staff 7 further stated she noted a decline in Resident 2's overall abilities. On 12/21/22 at 9:59 AM Staff 5 (Support RN) verified between 5/2/22 through 5/16/22 there was only one alert note related to monitoring the resident's urine or for signs of UTI. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/21/22 at 10:10 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Resident 2's care plans were not followed and the low blood pressure was not reported to the physician or assessed. Staff 1 and Staff 2 acknowledged the resident's decline in condition was not assessed and the physician was not notified until 5/16/22. Staff 1 acknowledged the 5/24/22 Death Certificate revealed Resident 2's immediate cause of death was severe sepsis with septic shock, approximate onset to death, one day, due to pseudomonas UTI, approximate onset to death five days. Other significant conditions contributing to death gastric outlet obstruction. On 12/21/22 at 12:08 PM the facility was notified of the Immediate Jeopardy (IJ) situation and an immediacy removal plan was requested. On 12/21/22 at 2:44 PM the facility submitted an acceptable immediacy removal plan which would abate the IJ situation. The immediacy removal plan included the following: *All residents with signs and symptoms of UTI will be monitored and provider would be notified via SBAR to assure residents were being treated timely and appropriately. RCM's (Resident Care Managers) would monitor residents who ate less than 50% for two or more meals. The RCMs would assess if the resident needed to stay on alert or if it was an indication of a problem that needed to be further assessed by the provider. *All residents had the potential to be affected. *All licensed nurses would be re-educated on the signs and symptoms of UTI including decreased urine output, pain, burning, blood-tinged urine, cloudiness, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating pattern. The nurses would be re-educated on the new alert process, when to notify the provider and how it relates to addressing a resident with any of the above symptoms. Education would begin on 12/21/22 and be completed by 12/22/22 at 12:00 PM. *Random weekly audits of resident progress notes would be done for 30 days by the DNS or designee to ensure any reports of signs and symptoms of UTI were addressed appropriately. *Results of these audits would be reviewed by the QAPI (Quality Assurance Process and Improvement) team to determine if further auditing was necessary. On 12/21/22 3:06 PM through 12/22/22 7:58 PM staff interviews were completed and verified re-education per the POC was completed. A review of facility documentation revealed all aspects of the POC was implemented. On 12/22/22 at 7:58 AM it was determined the immediacy was removed.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 1. Based on interview and record review it was determined the facility failed to ensure the licensed nursing staff had the appropriate competencies and skill sets to provide nursing care for a resident with a PleurX Catheter (a small, flexible tube that doctors place within the patient's chest to drain fluid from the pleural space) for 1 of 3 sampled residents (#5) reviewed for hospice. This caused Resident 5 to have increased pain, shortness of breath, psychosocial harm and experienced sustained a distressing and diminished quality of life prior to death. Finding include: Resident 5 admitted to the facility on [DATE] with diagnoses including heart failure and chronic pleural effusion (an excessive accumulation of fluid in the lungs pleural space). The resident had a PleurX catheter in place and died on [DATE]. The facility's staffing records revealed between [DATE] through [DATE] one to three RN's were on duty daily in addition to LPN's. The [DATE] Admission Orders directed staff to drain the PleurX catheter to a maximum 1,000 cc removal at a time, note the amount drained and to notify the physician if the SpO2 (oxygen saturation) was less than 90%. [All licensed nurses within the State of Oregon may care for and drain the catheter with proper training.] The [DATE] Physician Order indicated the catheter was to be drained at a clinic or hospital only every Monday, Wednesday and Friday. [There was no documentation the facility informed the physician it was within the nurses scope of practice to drain the catheter onsite.] A [DATE] provider encounter note revealed there was a concern with getting Resident 5's PleurX catheter drained. The provider noted the resident had great self awareness of when this needs to happen. And reporting that [she/he] is having difficulty breathing and needing it. The provider spoke with the DNS and it was determined if the facility had no staff available to drain the catheter then to transfer the resident to the hospital. The [DATE] Progress Note's revealed Resident 5 was transferred to the hospital for increased pulse and shortness of breath. The hospital drained 2,000 cc from the catheter. A [DATE] provider note indicated she spoke with Resident 5's healthcare POA, discussed concerns of ongoing draining of the PleurX catheter and after a long discussion of options for draining (the catheter) at the facility it was decided to update the resident's POLST form to DNR comfort measures only and refer to hospice. A [DATE] Hospice note revealed Resident 5 was admitted to hospice services. A [DATE] Hospice note revealed the hospice nurse drained 1,000 cc of fluid from the PleurX catheter. (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 0726 Level of Harm - Actual harm Residents Affected - Few	A [DATE] Progress note revealed the resident made comments about harming her/himself, asked for a hammer because she/he hurt so bad and asked the CNA if she could help her/him kill her/himself. A [DATE] Progress note revealed Resident 5's healthcare POA was upset because she was not told why the facility could not drain Resident 5's PleurX catheter. The note further stated the goal was to transition the resident off of hospice so they could obtain aggressive treatment with a specialist but they needed home health set up first so the resident would not have to go to the hospital to get the PleurX catheter drained. The healthcare POA stated she understood the resident may not live much longer but still did not want hospice at this time. A [DATE] Progress note revealed home health would not come to the facility. A [DATE] Progress note revealed they spoke with Resident 5's daughter about the PleurX catheter and how we were unable to meet [her/his] needs due to the licensing of our nurses and not having an RN to do it. Options were discussed and it was decided the facility would look for alternative placement but to keep the resident on hospice so they could manage the drain. The [DATE] Discharge Summary note indicated the funeral home picked the resident up. [There were no notes related to the residents passing in the medical record.] Hospice Notes revealed the PleurX catheter was drained on [DATE], 14, 16 and 20. On [DATE] at 8:47 AM Witness 7 (Complainant) stated the facility did not want to provide care and services for the Pleurx catheter and placed the resident on hospice against her/his will. Resident 5's family notified Witness 7 that they did not want hospice but felt like their back was against the wall. The resident was admitted to the facility specifically for the facility to manage the catheter however care did not happen and she/he was sent to the hospital for catheter care. Resident 5 and family were given the decision to either send the resident to the hospital for routine catheter care or go onto hospice. Witness 7 stated she reached out the the facility to coordinate nurse education if that was what was needed and offered to have a provider or the catheter company provide a tutorial which the facility declined. The facility stated this [PleurX catheter] was something they did not do. Witness 7 stated care facilities should be able to manage the catheter and even lay people can be taught to do it. On [DATE] at 8:58 AM an interview was conducted with Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS). Staff 1 stated the facility did not know how to care for the catheter and did not have sufficient RN staffing to care for the resident as the majority of the RN's were agency personnel. Staff 1 stated the facility was unaware the resident had a PleurX catheter on admission but verified this information was in the resident's admission paperwork. Staff 1 verified the resident went on hospice to avoid hospital emergency room visits. On [DATE] an email was received from the Oregon State Board of Nursing which revealed LPN's could drain and care for PleurX catheters if they had the appropriate training. On [DATE] in the AM Staff 1 and Staff 3 stated they believed LPN's were not able to perform PleurX catheter care and services. The LPN scope of practice information listed PleurX catheter care as something LPN's were unable to complete and did not realize this LPN task list was from Alabama. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	41453 2. Based on interview and record review, it was determined the facility failed to ensure nursing staff received and demonstrated the appropriate competencies and skills to provide nursing services to assure resident safety and maintain highest practicable physical, mental, and psychosocial well-being of each resident for 4 of 4 staff (#s 9, 17, 18 and 19) reviewed for training. This placed residents at risk for lack of care by competent staff. Findings include: On [DATE] at 9:43 AM Staff 24 (Assistant administrator/HR) was asked to provide completed documentation of a competency checklist for Staff 9, Staff 17, Staff 18, and Staff 24. Employee paperwork provided for these employee's did not include a competency checklist of any kind. On [DATE] at 12:39 PM Staff 3 (Assistant DNS) stated no checklist for skills had been completed.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 33179 41453 Based on interview and record review the facility failed to ensure facility staff had the appropriate competencies to work with residents with mental and psychosocial disorders for 4 of 4 sampled residents (#s 9, 17, 18, 19) reviewed for training. This placed residents at risk for diminished physical, mental, and psychosocial well-being. Findings include: On 1/10/23 at 11:10 AM Staff 37 (Unit coordinator) stated the only orientation staff received was in the blue packet and the employee handbook. Staff 37 stated behavioral health training did not occur at orientation, it was performed at monthly all staff meetings. A review of all In-services between 4/2022 and 1/2023 revealed no behavioral health training was completed. On 1/10/23 Staff 1 (Administrator) confirmed there were no other in-services completed between 4/2022 and 1/2023.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on observation and interview it was determined the facility failed to provide sufficient support personnel to effectively carry out the functions of the food and nutrition service for 2 of 3 meals observed for dining. This placed residents at risk of being served luke warm food on disposable tableware. Findings include: 1. On 12/22/22 at 7:55 AM Staff 41 (CNA) was observed to take a food tray with a styrofoam clamshell container on it to the resident in room [ROOM NUMBER]b. On 12/22/22 at 8:43 AM Staff 41 was observed to take food on a paper plate to a resident in the 200 hall. On 12/22/22 at 7:55 AM Staff 41 verified the food was in a disposable styrofoam container and not a normal plate and stated she did not know why as the resident had no medical reason for disposable items. On 12/22/22 at 7:57 AM Staff 8 (LPN) stated someone from the kitchen called and told him some meals would be delivered on disposable items instead of normal plates but did not state why. On 12/22/22 at 7:59 AM and 10:45 AM Staff 3 (LPN, Assistant DNS) stated previously using disposable dishware was a constant problem but now only happened randomly. Staff 3 stated there was a huge turnover in the kitchen, confirmed the kitchen staff utilized the disposable items because they had no dishwasher (staff) and were short staffed. On 12/22/22 at 9:05 AM Staff 42 (Assistant Dietary Manager) stated that morning she had no cook or dishwasher and had trouble with call-in's which was why she used styrofoam and paper plates for the breakfast meal. On 12/28/22 at 10:15 AM Resident 3 stated her/his food was cold and often served on paper plates. 2. On 12/29/22 at 8:45 AM and 9:00 AM all residents in the common dining room were observed to have their food on disposable, styrofoam clamshells. On 12/29/22 Staff 43 (Dietary Manager) stated she did not make the decision to serve the meals on the disposable styrofoam clamshells, the 5:00 AM dishwasher called in and it was a panic decision from the morning staff. Staff 43 verified breakfast should have been served on regular dishware.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33179 Based on interview and record review it was determined the facility to accurately document in the resident medical records for 3 of 6 sampled residents (#s 3, 4 and 5) reviewed for skin conditions and hospice. This placed residents at risk for inaccurate wound assessments and being uniformed of CNA staffing. Findings include: 1. Resident 3 admitted to the facility in 2020 with diagnoses including a chronic Stage 4 pressure ulcer. Resident 3's Weekly Skin evaluations revealed the following wound measurements: *8/5/22: 0.5 cm x 0.5 cm x 0 *8/12/22: 3 cm x 5 cm x 0.5 cm *8/19/22: 33.5 cm x 5 cm x 0.5 cm *8/26/22: 33.5 cm x 5 cm x 0.5 cm *9/2/22: 33.5 cm x 5 cm x 0.5 cm On 12/28/22 at 9:12 AM Staff 1 (Administrator) and Staff 2 (DNS) verified the 8/19/22, 8/26/22 and 9/2/22 wound measurements were inaccurate. 2. Resident 4 admitted to the facility in 3/2022 with diagnoses including heart failure and dementia. The 9/30/22 Weekly Skin Evaluation revealed the following skin issues: *Right antecubital bruising *Left antecubital bruising *Right thigh front skin tear *Right thigh rear skin tear *Right lower leg front skin tear *Left knee front bruising, scab *Left lower leg front skin tear The 10/6/22 Weekly Skin Evaluation revealed the following skin issues: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Right antecubital blister [bruising previous assessment] *Left antecubital blister [bruising previous assessment] *Right thigh front blister [skin tear previous assessment] *Right thigh rear blister [skin tear previous assessment] *Right lower leg front blister [skin tear previous assessment] *Left lower leg front blister [skin tear previous assessment] *All skin issues above documented as unstageable - On 12/28/22 at 9:26 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS) acknowledged the 10/6/22 Skin Evaluations were not accurate and should have not been marked unstageable. 3. Resident 5 admitted to the facility in 2022 with diagnoses including heart failure. The 3/21/22 Discharge Summary note indicated the funeral home picked the resident up. There was no evidence in Resident 5's medical record she/he had passed away including her/his condition prior to her/his death. On 1/4/23 at 11:53 AM Staff 2 (DNS) verified Resident 5's medical record was incomplete.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 33179 Based on interview and record review it was determined the facility failed to implement and maintain an effective, comprehensive, data-driven QAPI program for 1 of 1 QAPI committees reviewed for QA. This placed residents at risk for elopement, unmet care needs, decreased quality of life and lack of resident choice. Findings include: The 10/21/22 State Operations Manual, Appendix PP, directs the facility to make a good faith attempt to correct an identified quality deficiency. The facility must do more than subjectively assert it made a good faith attempt but rather, the facility's actions, taken as a whole, must evidence a good faith attempt to identify and correct quality deficiencies. The 3/28/22 Annual Survey identified a resident elopement as an immediate jeopardy situation. The 4/21/22 QAPI meeting notes revealed the QAPI team discussed the 3/28/22 Survey results. No other discussion or plan was documented related to elopement. The 7/21/22 QAPI meeting notes revealed a review of weekly elopement audits were completed to ensure the elopements were reported as necessary and monthly audits of residents who were at risk for elopement to ensure interventions were in place to prevent elopement. The 10/20/22 QAPI meeting notes revealed a review of the monthly audits of residents who were at risk for elopement to ensure interventions were in place to prevent elopement. Audits revealed not all resident care plans were up to date. The Administrator's report revealed audits of elopements were completed to ensure they were reported as necessary. Two elopements (Resident 20 and Resident 21) occurred and were reported. The recommendation was to discontinue further auditing the following month. A review of the facilities QAPI meeting notes revealed no formal action plan for resident elopement. Resident 9 eloped from the facility on 11/17/22, 12/12/22 and 12/27/22. On 12/12/22 and 12/27/22 which was identified as an immediate jeopardy situation. There was no evidence the QAPI team met after Resident 9's elopement. Review of facility records revealed the facility failed to collect relevant data and monitor their system for resident elopement. There was no evidence the facility made a food faith effort to correct the identified deficiency related to elopement from the 3/28/22 Annual Survey. On 1/9/23 at 1:30 PM Staff 39 (anonymous QAPI member) stated the follow-up to identified concerns was a mess as they were mentioned in title but the team did not analyze the collected data. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/10/23 at 8:27 AM Staff 40 (anonymous QAPI member) stated much of the QAPI meeting conversations went over her/his head and she/he did not understand much of the conversation. Staff 40 was unable to explain the QAPI process for reviewing identified concerns, stated the QAPI team could do better at monitoring and analyzing the data brought to the team and stated communication was a problem. On 11/10/23 at 11:30 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS) were interviewed for QAPI. Staff 1 stated she considered the POC (plan of correction) for the 3/28/22 Annual Survey to be the Action Plan. Staff 1 acknowledged while resident elopement had been reviewed in QAPI since the 3/28/22 survey, resident elopement had not been corrected and further stated she did not know if the facility would ever stop people from eloping. Staff 1, Staff 2 and Staff 3 confirmed a formal QAPI meeting was not held after any of Resident 9's facility elopements. Staff 1 confirmed the goals from the facility audits changed each quarter and acknowledged no long-term goals related to the prevention of elopement were in place. Staff 1 stated, Our good faith effort is we tried to keep [her/him] from eloping but it was not successful. Refer to F867

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on interview and record review it was determined the facility failed to correct and monitor a quality deficiency identified on the previous survey related to resident elopement and to respond to adverse events timely. This failure was determined to be an immediate jeopardy situation because the facility failed to prevent Resident 9's elopement from the facility three times since the 10/20/22 QAPI committee meeting. Findings Include: The 10/21/22 State Operations Manual, Appendix PP instructs facilities to create a formal action plan for identified deficiencies which included determining contribution causes of the problem; measurable goals, step by step interventions to correct the problem and achieve stable goals, and a description of how the QAPI committee would monitor the concern to ensure changes yield the expected results. The 3/28/22 Annual Survey identified a resident elopement as an immediate jeopardy situation. The 4/21/22 QAPI meeting notes revealed the QAPI team discussed the 3/28/22 Survey results. No other discussion or plan was documented related to elopement. The 7/21/22 QAPI meeting notes revealed a review of weekly elopement audits were completed to ensure the elopements were reported as necessary and monthly audits of residents who were at risk for elopement to ensure interventions were in place to prevent elopement. The 10/20/22 QAPI meeting notes revealed a review of the monthly audits of residents who were at risk for elopement to ensure interventions were in place to prevent elopement. Audits revealed not all resident care plans were up to date. The Administrator's report revealed audits of elopements were completed to ensure they were reported as necessary. Two elopements (Resident 20 and Resident 21) occurred and were reported. The recommendation was to discontinue further auditing the following month. A review of the facilities QAPI meeting notes revealed no formal action plan for resident elopement. Resident 9 eloped from the facility on 11/17/22, 12/12/22 and 12/27/22. On 12/12/22 and 12/27/22 Resident 9 was found on [NAME] street heading toward [NAME] Road which is a highly congested four lane road. There is no crosswalk at the intersection of [NAME] and [NAME] and both roads offer minimal lighting. The resident was walking outside, inappropriately dressed, in the winter weather late at night. The resident's goal was to walk the 0.6 miles to [NAME] to obtain rocky road ice cream although she/he was aware she/he did not have any money. Resident 9's elopement from the facility on 11/17/22, 12/12/22 and 12/27/22 was identified as an immediate jeopardy situation. There was no evidence the QAPI team met after Resident 9's elopement. There was no evidence the facility made a good faith effort to correct the identified deficiency related to elopement from the 3/28/22 Annual Survey. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility records revealed the facility failed to collect relevant data and monitor their system for resident elopement. This resulted in a lack of adequate action to correct the systemic high risk issue which created a situation where residents were likely to experience serious injury, harm or death. On 1/9/23 at 1:30 PM Staff 39 (anonymous QAPI member) stated the follow-up to identified concerns was a mess as they were mentioned in title but the QAPI team did not analyze the data which was collected. On 1/10/23 at 8:27 AM Staff 40 (anonymous QAPI member) stated much of the QAPI meeting conversations went over her/his head and she/he did not understand much of the conversation. Staff 40 was unable to explain the QAPI process for reviewing identified concerns, stated the QAPI team could do better at monitoring and analyzing the data brought to the team and stated communication was a problem. On 11/10/23 at 11:30 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (LPN, Assistant DNS) were interviewed for QAPI. Staff 1 stated she considered the POC (plan of correction) for the 3/28/22 Annual Survey to be the Action Plan. Staff 1 acknowledged while resident elopement had been reviewed in QAPI since the 3/28/22 survey, resident elopement had not been corrected and further stated she did not know if the facility would ever stop people from eloping. Staff 1 stated the facility was trying to ensure there was no bad outcome, the focus was to prevent harm and the prevention of resident elopement might not be ever 100%. Staff 1 acknowledged the QAPI committee may meet quarterly, monthly or as needed. Staff 1 and Staff 3 did not answer what would trigger an as need QAPI meeting. Staff 1, Staff 2 and Staff 3 confirmed a formal QAPI meeting was not held after any of Resident 9's facility elopements. Staff 1 confirmed the goals from the facilty audits changed each quarter and included both reporting elopements, adding moderate elopement risk residents to the Code [NAME] book and ensuring care plan interventions were in place to prevent elopements. Staff 1 acknowledged no long-term goals related to the prevention of elopement were in place. On 1/10/23 at 1:55 PM the facility was notified of the Immediate Jeopardy (IJ) situation and an immediacy removal plan was requested. On 1/10/23 at 3:37 PM the facility submitted an acceptable immediacy removal plan which would abate the IJ situation. The immediacy removal plan included the following: *A formal action plan would be developed and implemented by the QAPI team to include: contributing causes of the problem, measurable goals, step by step interventions to correct the problem, achieve stable goals and description of how the QAPI committee would monitor to ensure changes yield the expected results. *All residents who are at risk for elopement have a potential to be affected by this. *QAPI team would received education on the formal action plan. *Education would begin on 1/1/23 and would be completed by 1/11/23 at 3:00 PM or upon return if on leave of absence prior to working with residents. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Random weekly audits of the action plan would be done to ensure that relevant data was collected and the elopement system was being followed for 30 days. The audits would continue monthly until next QAPI meeting. Results of the audits would be reviewed by the QAPI team at the time to determine if further auditing was necessary. On 1/11/23 from 12:15 PM through 1/11/23 at 1:06 PM staff interviews were completed which verified re-education per the immediacy removal plan was completed. A review of facility documentation revealed all aspects of the immediacy removal plan was implemented. On 1/11/23 PM at 1:08 it was determined the IJ situation was abated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179 Based on observation and interview it was determined the facility failed to follow standard infection control guidelines for 3 of 3 random observations of infection control. This placed residents at risk for cross-contamination and respiratory illness. Findings include: 1. a. On 12/13/22 at 12:30 PM the surveyor entered the building and observed Staff 8 (LPN) to sit at the nursing station with his face mask below his chin. Staff 8 verified he did not wear the face mask correctly. b. On 12/13/22 at 12:33 AM Staff 11 (CNA) was observed to wear her face mask over her mouth but under her nose. Staff 11 verified the face mask was did not cover her nose and corrected the placement of the mask. 2. On 12/19/22 at 2:35 PM Staff 44 (Housekeeper) was observed to bring the entire housekeeping cart into resident room [ROOM NUMBER]. On 12/19/22 at 2:37 PM Staff 44 stated she took the housekeeping cart into room [ROOM NUMBER] to clean it and proceeded to enter resident room [ROOM NUMBER] and take the cart inside that room. [Cart was not cleaned between rooms.]

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	01/11/2023

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 33179 41453 Based on interview and record review the facility failed to ensure staff had the appropriate compliance and ethics training prior to working independently for 4 of 4 sampled staff (#s 9, 17, 18, 19) reviewed for training. This placed residents at risk for non-compliant and unethical treatment. Findings include: On 1/9/23 a review of the facility's new employee packet and employee handbook did not indicate there was any compliance and ethics training at orientation. On 1/10/23 at 11:10 AM Staff 37 (Unit Coordinator) stated the only orientation staff received was in the blue packet and the employee handbook. Staff 37 stated any training that did not occur at orientation was performed at monthly all-staff meetings. On 1/10/23 at 11:28 AM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Assistant DNS) confirmed compliance and ethics training had been added to the in-service schedule but had not been completed.