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	07/26/2019

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34324 Based on interview and record it was determined the facility failed to assess a resident's ability to safely self administer medications for 1 of 5 sampled residents (#45) reviewed for medications. This placed residents at risk for unsafe medication administration. Findings include: Resident 45 was admitted to the facility in 2017 with diagnoses including depression, anxiety and insomnia. Review of Resident 45's 5/2019, 6/2019 and 7/2019 MARs revealed on various occasions, several medications were marked with a 3 indicating the resident was absent from home [facility] with medications. The medications included: -Ambien (sedative/hypnotic) -duloxetine (antidepressant) -lovastatin (cholesterol-lowering medication) -Keppra (anticonvulsant) -Lyrica (pain medication) -tizanidine (muscle relaxer) On 7/23/19 at 10:22 AM Staff 25 (LPN) stated Resident 45 left the facility daily and was gone all day. She stated the resident was taking medication out of the facility for the past couple of months. Staff 25 confirmed the medications marked with a 3 on the MAR indicated the medications were sent out of the facility with the resident. Review of Resident 45's medical record revealed no evidence an assessment was completed for the self administration of medication. On 7/23/19 at 10:36 AM Staff 6 (RNCM) confirmed there was no assessment for the self administration of medication for Resident 45.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41454 Based on observation, interview and record review, the facility failed to provide an accessible lockbox for secure storage of personal possessions for 1 of 1 sampled resident (#14) reviewed for accommodation of needs. This placed residents at risk for unsecured personal items. Findings include: Resident 14 was readmitted to the facility in 2019 with diagnoses including cerebral infarction (damage to tissues in the brain) with left sided hemiplegia (weakness on one side of the body). Resident 14 was cognitively intact. Review of Resident 14's 1/18/19 CAA summary indicated Resident 14 required extensive assistance with bed mobility, was totally dependent for transfers and required extensive assistance for locomotion. On 7/18/19 at 10:18 AM Resident 14 was observed in bed on her/his back on the bed. There was a wheelchair at the bedside. Resident 14 had limited movement of the right side and no ability to move the left side. On 7/18/19 at 1:45 PM Resident 14 was observed in a wheelchair in her/his room. The wheelchair was wide and specifically designed to lean the head back to maintain Resident 14's alignment. Resident 14 was unable to propel the wheelchair. Resident 14 was observed to be completely dependent on staff for transfer and personal care. There was a white metal lock box with a key, on the floor of Resident 14's closet which was located between the wall and the bed. The area between the bed and the wall was approximately two and a half feet wide. On 7/18/19 at 2:00 PM Resident 14 stated there was a lock box in her/his closet but she/he was unable to reach it. Resident 14 also stated due to her/his mobility and dexterity limitations she/he was unable to access the side of the bed the closet was on and the lock box was in the bottom of the closet where she/he could not reach. On 7/18/19 at 2:00 PM Witness 3 (Family) stated Resident 14 had missing items, and was unable to lock up valuables and felt unprotected. She/he further stated Resident 14 was unable to physically access the lock box located in the bottom of her/his closet. On 7/22/19 at 2:17 PM Staff 13 (Social Services) stated the facility provided Resident 14 a lock box for valuables. Staff 13 acknowledged there were no interventions in place for Resident 14 to access the lock box.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40767 1. Based on observation, interview and record review it was determined the facility failed exercise reasonable care for the protection of resident property from loss or theft for 3 of 4 residents (#s 14, 24, 63) reviewed for personal property. This placed residents at risk for lost or stolen personal property. Findings include: a. Resident 63 admitted to the facility 3/2019 with diagnoses including stroke. The 6/28/19 MDS indicated Resident 63 was cognitively intact. On 7/18/19 at 12:43 PM Resident 63 stated her/his wheelchair was missing for weeks, her/his son had reported it to Staff 21 (Admissions) and the resident had not heard anything back regarding the missing wheelchair. A review Resident 63's clinical record revealed a blank inventory sheet with only the resident's name on it. On 7/24/19 at 9:53 AM two wheelchairs were observed in Resident 63's bathroom. Resident 63 stated neither belonged to Resident 63. On 7/24/19 at 9:59 AM Staff 7 (RNCM) stated an inventory sheet was to be completed by CNA staff when residents were admitted to the facility. Staff 7 stated the inventory list was to include personal wheelchairs with the serial number. Staff 7 was unaware Resident 63 had a missing wheelchair and believed the wheelchair in the bathroom belonged to the resident. On 7/24/19 at 10:14 AM Staff 21 (Admissions) stated Resident 63's family reported a missing wheelchair about two weeks prior and Staff 21 was unaware if the wheelchair had been found. Staff 21 stated he reported the information to Staff 13 (Social Services) and Staff 7 but did not complete a Missing Items form. On 7/24/19 at 12:24 PM Staff 13 stated an inventory sheet was to be completed for all residents on admission. Staff 13 acknowledged Resident 63's inventory sheet was not completed. Staff 13 stated if a resident reported a missing item a Missing Item form was to be completed. Staff 13 further stated she was unaware of Resident 63 missing a wheelchair and confirmed there was no Missing Item form filled out for the resident. b. Resident 14 readmitted to the facility 2/2019 with diagnoses including bipolar disorder. The 5/2/19 Resident Council Minutes indicated residents had reported missing toiletries. The 6/6/19 Resident Council Minutes indicated the toiletries were searched for and items were checked for residents' personal labels. There no indication if the items were found or replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/19 at 1:33 PM during a resident council meeting, Resident 14 stated the staff had not followed up with her/him regarding the resident's missing toiletries and stated the items were not replaced. A review of Resident 14's record revealed there was no inventory sheet completed for Resident 14. On 7/26/19 at 9:03 AM Staff 13 (Social Services) stated the process for residents who report missing items was to review the resident's inventory sheet and to complete a Missing Items report. Staff 13 stated she believed she replaced the missing toiletries for Resident 14 but confirmed there was no inventory sheet or Missing Item report for Resident 14. c. Resident 24 admitted to the facility 1/2019 with diagnoses including morbid obesity. A review of Resident 24's clinical record indicated an inventory sheet was not completed. On 7/24/19 at 12:24 PM Staff 13 (Social Services) stated inventory sheets were to be completed for all residents on admission of the resident's personal property. Staff 13 confirmed there was no inventory sheet for Resident 24. 2. Based on observation and interview it was determined the facility failed to ensure a clean, homelike environment for 1 of 1 conference room and 2 of 3 shower rooms reviewed for environment. This placed residents at risk for an unhomelike and unclean environment. Findings include: a. From 7/18/19 through 7/25/19 the facility conference room was observed to have a foul smell of urine. On 7/25/19 at 2:23 PM Staff 22 (Maintenance) confirmed the conference room was utilized by residents and family members and confirmed the room smelled of urine. Staff 22 stated the facility previously had a cat, which was likely the cause of the urine scent. 41468 b. An observation on 7/22/19 at 3:18 PM of the 100 hall shower room revealed a cupboard door was missing from a clean linen closet and an unwrapped sandwich and beverage were on a shelf in the linen closet. On 7/22/19 at 3:29 PM Staff 6 (RNCM) confirmed the door was missing and food was not to be on the shelf with clean linen. On 7/25/19 at 2:25 PM Staff 22 (Maintenance) confirmed the linen cupboard door was missing and clean linen was in the closet.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 34324 Based on interview and record review it was determined the facility failed to comprehensively assess for psychotropic medications and accidents for 4 of 10 sampled residents (#s 1, 6, 13 and 37) reviewed for medications and accidents. This placed resident at risk for unassessed needs. Findings include: 1. Resident 37 was admitted to the facility in 2017 with diagnoses including dementia and depression. Review of Resident 37's 11/15/18 Admission MDS Psychotropic Medication Use CAA indicated the resident used antipsychotic and antidepressant medication for depression and dementia. The CAA further indicated the medication could affect a person's function and the goal was to find balance. The CAA failed to include the resident's history related to the use of the medication, how the resident's symptoms manifested, whether the medication was effective and what interventions were in place. On 7/24/19 at 9:01 AM Staff 7 (RNCM) confirmed Resident 37's 11/15/18 CAA was not comprehensive and needed to be expanded. 34702 2. Resident 13 was admitted to the facility in 2017 with diagnoses including stroke. The care plan, last updated 8/23/18, indicated Resident 13 had swallowing precautions, was not to have straws or bread, was to eat meals in the dining room with indirect supervision and was a choking risk. The 1/17/19 Annual MDS Nutritional Status CAA indicated Resident 13 ate independently in the dining room. The CAA did not include information regarding Resident 13's swallowing precautions or current diet texture. On 7/23/19 at 10:24 AM Staff 6 (RNCM) acknowledged the Nutritional CAA was not comprehensive and did not include information regarding Resident 13's swallowing precautions or diet texture. 3. Resident 6 was readmitted to the facility in 2017 with diagnoses including epilepsy and hemiplegia (paralysis of one side of the body). The care plan, last updated 1/16/19, indicated Resident 6 was at risk for falls due to paralysis and the resident used a seatbelt in her/his wheelchair for mobility and safety related to seizure activity. The 12/27/18 Fall Scale document indicated Resident 6 was at a high risk for falls. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/2/19 Annual MDS did not include a fall CAA. On 7/26/19 at 1:19 PM Staff 8 (RNCM) stated Resident 6 was a high risk for falls and a fall CAA was not completed. 36496 4. Resident 1 admitted to the facility in 2014 with diagnoses including kidney disease. The 6/15/19 Annual MDS indicated Resident 1 required total dependence by two staff to transfer out of bed, and extensive assistance by one staff for toileting needs. The assessment further indicated the resident was alert and oriented. A 6/15/19 Incident Note completed at 2:23 PM indicated Resident 1 fell in her/his room while seated on the commode with a CNA in the room attempting to readjust her/him. The resident fell forward, hit her/his chin and bit her/his lip. The treatment nurse was notified of a need to look at her/his lip, and indicated there were no noted injuries aside from the resident complaint of pain on her/his right side. The progress note indicated it appeared the resident pulled something and would be placed on alert charting. On 7/18/19 Resident 1 was observed to have a commode in her/his room. The resident indicated she/he used the commode for bowel movements. The resident further stated she/he had a fall off the commode within the last few months and cracked four ribs. The 7/18/19 Falls and Urinary Incontinence CAAs indicated Resident 1 had poor balance and a fall with fracture from her/his commode which resulted in multiple fractured ribs, limited range of motion and poor center core control. Resident 1 was noted to have an overactive bladder, wore incontinence briefs and informed staff when she/he needed a brief change. The current, undated Kardex (CNA care plan) indicated Resident 1 used disposable incontinence briefs and the resident was to be changed as needed. On 7/22/19 at 1:51 PM Staff 32 (CNA) stated Resident 1 wore incontinence briefs for intermittent episodes of incontinence, but would regularly request to use a bedpan to urinate. She further stated the resident used the bedside commode for bowel movements. On 7/24/19 at 8:54 AM Staff 19 (CNA) stated the resident wore briefs, used a bedpan to urinate and the bedside commode for bowel movements. On 7/24/19 at 9:29 AM Staff 7 (RNCM) acknowledged Resident 1's Urinary Incontinence CAA did not accurately reflect the resident's actual mode of toileting.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41468 Based on interview and record review it was determined the facility failed to monitor blood pressure and pulse as ordered by the physician and failed to follow up with the physician after diagnostic testing was completed for 2 of 10 sampled residents (#s 6 and 60) reviewed for unnecessary medications and accidents. This placed residents at risk for undiscovered heart complications and unmet needs. Findings include: 1. Resident 60 was admitted to the facility in 9/2018 with diagnoses including hypertension (high blood pressure) and end stage renal disease (kidney failure). A 6/28/19 physician order indicated staff were to monitor the resident's blood pressure and pulse once weekly due to the resident receiving hypertension medication. The Vitals log revealed the last documented blood pressure and pulse for Resident 60 was entered on 6/17/19. The 6/2019 and 7/2019 MARs indicated Resident 60's blood pressure and pulse were taken (signed off as completed) but not recorded on the MAR. On 7/24/19 at 3:25 PM Staff 11 (LPN) confirmed Resident 60's blood pressure and pulse were not recorded. She further indicated it was not possible to enter blood pressure and pulse results on the MAR. On 7/25/19 at 1:15 PM Staff 2 (DNS) confirmed no blood pressure or pulse results were documented for Resident 60 since 6/17/19. 34702 2. Resident 6 was readmitted to the facility in 2017 with diagnoses including epilepsy and hemiplegia (paralysis of one side of the body). The care plan, last updated 4/8/19 indicated Resident 6 required two person assistance for mechanical lift transfers. A 4/8/19 Post Fall Assessment indicated Staff 14 and Staff 31 were present during a fall. The resident was transferred by mechanical lift from the wheelchair to the bed and the sling broke at both hook up points for the legs and the resident landed on the floor by the bed on her/his left side. The resident complained of hip and shoulder pain and had a scrape on the inside of the wrist. An X-ray of the left hip and shoulder were ordered and were negative for fracture. The report indicated the resident had faulty equipment and was given a new sling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/8/19 Radiology Report indicated shoulder and hip X-rays were completed and the resident did not have a fracture. The report further indicated to consider more sensitive imaging evaluation with a CT scan (additional imaging) as clinically directed. The form was initialed by the physician on 4/9/19 but there was no indication the physician assessed the resident or provided clinical rationale as to why a CT scan would not be completed. On 7/26/19 at 11:28 AM Staff 2 (DNS) acknowledged the radiology report indicated to consider a CT as clinically directed and there was no physician assessment after the fall or clinical rationale to indicate if the resident needed to have the CT scan completed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 34702 1. Based on observation, interview and record review it was determined the facility failed to have a system in place to ensure residents were transferred with mechanical lift slings of appropriate size based on their weight and measurements, failed to ensure slings were in good repair and failed to ensure manufacturer care instructions were followed for 3 of 5 sampled residents (#s 6, 8 and 24) reviewed for accidents. This failure, determined to be an immediate jeopardy situation, resulted in Residents 6 and 8 experiencing a fall and Resident 24 being placed at risk for a fall when the mechanical lift sling broke during a transfer. Findings include: a. Resident 6 was readmitted to the facility in 2017 with diagnoses including epilepsy and hemiplegia (paralysis of one side of the body). The 4/2019 MAR indicated Resident 6 received warfarin (anticoagulant medication that can prolong bleeding). The care plan, last updated 4/8/19 indicated Resident 6 required two person assistance for mechanical lift transfers. The care plan did not include which size sling the resident used. On 7/22/19 at 9:05 AM Resident 6 stated two staff were assisting her/him in the mechanical lift when the straps snapped causing the resident to fall to the floor. The resident was unable to recall the date of the fall. On 7/22/19 at 6:03 PM Staff 30 (Human Resources) stated the mechanical lift slings were ordered every 30-45 days. She stated staff were to leave the mechanical lift slings that were were not in good repair on her door. Staff 30 further stated the facility had no written audit of the mechanical lift slings. On 7/22/19 at 10:52 AM Staff 20 (CNA) stated there were issues with mechanical lift slings tearing. On 7/22/19 at 2:54 PM Staff 9 (CNA) stated the mechanical lift slings were not in good condition and when the slings wore out staff continued to use them. On 7/23/19 at 12:53 PM Staff 14 (CNA) stated she and Staff 31 (CNA) were present for Resident 6's fall when the mechanical lift sling broke on 4/8/19. She stated they were attempting to transfer the resident to bed and as soon as she/he was lifted with the mechanical lift she heard something break and the resident fell to the floor. Staff 14 stated, it was scary and . horrible when the resident fell . She further stated the mechanical lift sling loop broke off and detached from the sling and there was no time to get her/him over the bed or chair. She stated the resident sustained a bruise on her/his hip and the fall scared the resident. Staff 14 stated there were not enough slings for each resident and they were washed daily. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/25/19 at 2:07 PM Staff 31 stated she was present for Resident 6's fall when the mechanical lift sling broke on 4/8/19. She stated they were trying to get Resident 6 into bed and lift her/him with the mechanical lift when one of the sling hooks snapped and continued to rip and Resident 6 fell to the floor on her/his bottom. Staff 31 was unable to recall if the resident sustained injuries. A 4/8/19 Post Fall Assessment indicated Staff 14 and Staff 31 were present during a fall. The resident was transferred by mechanical lift from the wheelchair to the bed and the sling broke at both hook up points for the legs and the resident landed on the floor by the bed on her/his left side. The resident complained of hip and shoulder pain and had a scrape on the inside of the wrist. An X-ray of the left hip and shoulder were ordered and were negative for fracture. The report indicated the resident had faulty equipment and was given a new sling. The Alert Charting Guidelines indicated if a resident had a fall, documentation was to be completed each shift for 72 hours and include information regarding injury, change in ROM, complaints of pain, change in gait, dizziness, changes in level of consciousness, abnormal movements, abnormal blood pressure, signs and symptoms of infection and vital signs. The 4/8/19 Radiology Report indicated shoulder and hip X-rays were completed and the resident did not have a fracture. On 7/22/19 at 5:01 PM Staff 9 (CNA) stated she was unsure if there was a list of which slings should be used for the residents. She stated the green (larger size) slings were not always available to use because many residents required the larger slings. On 7/23/19 at 1:39 PM two mechanical lift slings were observed to be clean in the laundry room and were frayed and torn. On 7/23/19 at 1:42 PM Staff 15 (Laundry Supervisor) stated the mechanical lift slings were bleached with chlorine bleach if they were to be put in with white laundry. She reviewed the manufacturer's instructions which indicated chlorine bleach was not to be used on the slings. She stated she was unaware that chlorine bleach was not to be used. On 7/23/19 at 1:49 PM Staff 9 (CNA) was asked to observe the two frayed and ripped slings. She stated the one sling had a tear and she was told it was fine to use because the tear was not over the strap. She stated she would not use the other sling due to it being frayed. She stated she found a sling that needed to be thrown out about once per week. On 7/23/19 at 2:01 PM Staff 16 (CNA) was asked to observe the two frayed and ripped slings. She acknowledged the slings were in disrepair and stated she would not use the slings for residents due to the condition of the slings. On 7/23/19 at 2:16 PM Staff 2 (DNS) was asked to observe the two frayed and ripped slings. She stated the slings were not in good repair and should not be used. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/26/19 at 11:28 AM Staff 2 (DNS) and Staff 6 (RNCM) acknowledged the Post Fall Assessment was not reviewed by the RNCM until 4/15/19 (7 days later) and was not reviewed by the DNS until 5/1/19 (23 days later). Staff 2 stated fall investigations were to be completed within five days by the RNCM and DNS staff and it was not completed timely. Staff 2 and Staff 6 acknowledged there was no root cause analysis, was missing witness statements and resident interview and alert charting was not completed after the fall for Resident 6. Staff 2 and Staff 6 further acknowledged warfarin increased the resident's risk for bleeding. b. Resident 8 was admitted to the facility in 2018 with diagnoses including stroke. The 8/2018 MAR indicated Resident 8 received Plavix (antiplatelet medication that can prolong bleeding time). The care plan, last updated 10/25/18, indicated Resident 8 required two person assistance for mechanical lift transfers. The care plan did not include which size sling the resident used. On 7/22/19 at 6:03 PM Staff 30 (Human Resources) stated the mechanical lift slings were ordered every 30-45 days. She stated staff were to leave the mechanical lift slings that were not in good repair on her door. Staff 30 further stated the facility had no written audit of the mechanical lift slings. On 7/22/19 at 10:52 AM Staff 20 (CNA) stated there were issues with mechanical lift slings tearing. She stated there was one instance when Resident 8's mechanical lift sling tore during a transfer in November or December of 2018. Staff 20 stated the resident was not injured. On 7/25/19 at 11:41 AM Staff 23 (CNA) stated he observed Resident 8's fall on 8/24/18. He stated Witness 4 (Former CNA) was with him during the mechanical lift transfer when Resident 8 was transferred into bed and the upper part of the sling ripped and broke and the resident hit her/his toes. Staff 23 further stated it was odd because if the sling was going to rip, it usually ripped over the bed. The 8/24/18 Post Fall Assessment indicated the resident was being transported by mechanical lift via sling by Staff 23 and Witness 4 when the two upper straps broke and Resident 8 fell to the floor. The resident was assessed and had abrasions to the top of the right toes. The resident was placed on alert charting. The fall assessment did not include witness statements from Staff 23 and Witness 4. The DNS did not review the assessment until 9/10/18. The Alert Charting Guidelines indicated if a resident had a fall, documentation was to be completed each shift for 72 hours and include information regarding injury, change in ROM, complaints of pain, change in gait, dizziness, changes in level of consciousness, abnormal movements, abnormal blood pressure, signs and symptoms of infection and vital signs. On 7/22/19 at 5:01 PM Staff 9 (CNA) stated she was unsure if there was a list of which slings should be used for the residents. She further stated Resident 8 was put in a smaller purple sling and had a fall. She stated they were supposed to use the green slings for her/him which were larger. She stated the green slings were not always available because many residents required the bigger slings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/23/19 at 1:39 PM two mechanical lift slings were observed to be clean in the laundry room and were frayed and torn. On 7/23/19 at 1:42 PM Staff 15 (Laundry Supervisor) stated the mechanical lift slings were bleached with chlorine bleach if they were to be put in with white laundry. She reviewed the manufacturer's instructions which indicated chlorine bleach was not to be used on the slings. She stated she was unaware that chlorine bleach was not to be used. On 7/23/19 at 1:49 PM Staff 9 (CNA) was asked to observe the two frayed and ripped slings. She stated the one sling had a tear and she was told it was fine to use because the tear was not over the strap. She stated she would not use the other sling due to it being frayed. She stated she found a sling that needed to be thrown out about once per week. On 7/23/19 at 2:01 PM Staff 16 (CNA) was asked to observe the two frayed and ripped slings. She acknowledged the slings were in disrepair and stated she would not use the slings for residents due to the condition of the slings. On 7/23/19 at 2:16 PM Staff 2 (DNS) was asked to observe the two frayed and ripped slings. She stated the slings were not in good repair and should not be used. On 7/25/19 at 11:13 AM Resident 8 stated she/he fell twice in the past year due to slings breaking during a transfer. Resident 8 stated she/he felt scared of falling during transfers. On 7/25/19 at 2:07 PM Staff 31 (CNA) stated on one occasion almost a year ago she transferred Resident 8 and as the sling was pushed over the bed it snapped and she/he fell on top of the bed. She stated after that happened the resident got nervous during mechanical lift transfers and would hang on to her/his sling really tightly. She further stated she told her boss, Staff 30 (Human Resources), about the incident. A review of the clinical record did not reveal an investigation was completed for the fall from the mechanical lift sling to the bed. On 7/26/19 at 11:28 AM Staff 2 (DNS) and Staff 6 (RNCM) acknowledged the Post Fall Assessment was not reviewed by the RNCM until 9/6/18 (12 days later) and was not reviewed by the DNS until 9/10/18 (23 days later). Staff 2 stated fall investigations are supposed to be completed within 5 days by RNCM and DNS staff and it was not completed timely. Staff 2 and Staff 6 acknowledged there was no root cause analysis, the investigation was missing witness statements and resident interview and alert charting was not completed after the fall for Resident 8. Staff 2 and Staff 6 further acknowledged the resident's Plavix use increased her/his risk for bleeding and were unaware of the fall from the mechanical lift sling to the bed. 40767 c. Resident 24 admitted to the facility 1/2019 with diagnoses including morbid obesity and weakness. The 5/3/19 MDS indicated Resident 24 was cognitively intact and the resident was totally dependent on staff for transfers. (continued on next page)

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	38E075	A. Building B. Wing	07/26/2019

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Kardex (staff instructions) indicated Resident 24 required a mechanical lift and two staff members for transfers. The Kardex did not indicate what size mechanical lift sling the resident required. On 7/22/19 at 11:23 AM Resident 24 stated an incident occurred approximately a month prior when staff transferred the resident from her/his chair back to bed using a mechanical lift and the sling strap broke. Resident 24 stated she/he was not injured and was fearful at the time, but was not currently afraid. Observations from 7/22/19 through 7/24/19 revealed Resident 24 had a green (size large) mechanical lift sling either under her/him or in the resident's room on her/his wheelchair. Review of Resident 24's medical record did not indicate an investigation was completed for the alleged incident. On 7/22/19 at 5:01 PM Staff 9 (CNA) stated she was one of the CNAs working with Resident 24 when the mechanical lift sling strap broke. Staff 9 stated the resident did not fall out of the sling and was not injured. Staff 9 stated the other CNA who assisted her no longer worked at the facility, but Staff 10 (CNA) came and assisted them when the strap broke. Staff 9 further stated she reported the incident to the charge nurse Staff 11 (LPN). On 7/22/19 at 5:12 PM Staff 11 (LPN) stated she was unaware of the alleged incident and it was never reported to her. On 7/22/19 at 6:01 PM Staff 1 (Administrator) and Staff 2 (DNS) both stated they were unaware of the alleged incident with Resident 24. They further stated they expected staff to inform them of accidents or equipment failures. Staff 1 and 2 both confirmed the alleged incident was not investigated. On 7/22/19 at 6:04 PM Staff 10 (CNA) confirmed Resident 24's mechanical lift sling broke and he assisted Staff 9 and another CNA with Resident 24. Staff 10 stated he recalled the sling was green. He stated the green slings were not readily available in the facility. He further stated he did not report the incident to anyone and could not recall if the incident was reported by someone else. A progress note completed 7/23/19 by Staff 6 (RNCM) indicated the incident occurred 6/6/19. The report confirmed the mechanical lift sling strap broke, which jolted Resident 24, however the resident did not fall. The progress note further indicated Resident 24's daughter (Witness 1) was present during the incident. On 7/25/19 at 10:22 AM Witness 1 confirmed Resident 24's mechanical lift sling strap broke when staff transferred the resident using a mechanical lift. Witness 1 stated Resident 24 did not fall, but was hanging crooked. Witness 1 was unsure if nursing or administrative staff were notified. Witness 1 further stated sometimes the staff used a smaller sized sling to transfer Resident 24 because they did not have enough of the larger size slings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. During interviews on 7/23/19 at 11:38 AM and 1:59 PM Staff 1 (Administrator) provided a list of 38 residents in the facility who required use of a mechanical lift. The list identified five residents who required use of an extra-large sized sling. Staff 1 stated the facility only had three extra-large sized slings on hand. No evidence was found to indicate the five identified residents were provided with use of the extra-large sized slings. Based on the facility's failure to have a system in place to safely transfer residents with appropriately sized equipment in good repair, which resulted in residents experiencing multiple falls, an immediate jeopardy situation was declared on 7/23/19 at 4:41 PM. An immediate plan of correction was requested. On 7/23/19 at 5:35 PM an approved immediate plan of correction was received. The plan indicated the facility identified the appropriate size sling for each resident, ordered additional slings to be delivered the following day, care plans were to be updated to include information about the appropriate sling size, staff would be in-serviced regarding proper use of mechanical lifts and slings, housekeeping was in-serviced regarding proper cleaning of the slings and audits would be completed to ensure appropriate sling use. On 7/25/19 at 4:47 PM the immediate jeopardy situation was removed after observations and interviews revealed appropriate equipment was available, staff were trained on use and cleaning of the equipment and resident care plans were updated. 36496 2. Based on observation interview and record review it was determined the facility failed to ensure residents were free from accident hazards for 3 of 5 sampled residents (#s 1, 13 and 15) reviewed for accidents. This placed residents at risk for accidents. Findings include: a. Resident 1 admitted to the facility in 2014 with diagnoses including kidney disease. The 4/2017 Fall/Injury facility policy included the following: *Staff were to implement interventions to prevent future accidents. *Interview the resident, if appropriate, regarding the incident and include any additional information obtained. *The DNS will prepare a weekly Report to Administrator, summarizing all incidents. The 6/15/19 Annual MDS indicated Resident 1 required total dependence by two staff to transfer out of bed, and extensive assistance by one staff for toileting needs. The assessment further indicated the resident was alert and oriented. On 7/18/19 Resident 1 was observed to have a commode in her/his room. The resident indicated she/he used the commode for bowel movements. The resident further stated she/he had a fall off the commode within the last few months, and cracked four ribs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 7/18/19 Falls and Urinary Incontinence CAAs indicated Resident 1 had poor balance and a fall with fracture from her/his commode which resulted in multiple fractured ribs, limited range of motion and poor center core control. Resident 1 was noted to have an overactive bladder, to wear incontinence briefs and could inform staff when she/he needed her/his incontinence brief changed. The current, undated Kardex (CNA care plan) indicated Resident 1 used disposable incontinence briefs, and the resident was to be changed as needed. The 4/1/19 Care Plan for falls indicated the resident was at risk for falls and staff were to review information on past falls and attempt to determine the cause and document possible root causes. They were then to remove any potential causes if possible and educate the resident, family, caregivers and the interdisciplinary team. It further indicated staff were to follow the facility fall protocol, and anticipate the resident's needs. A 6/15/19 Incident Note completed at 2:23 PM indicated Resident 1 fell in her/his room while seated on the commode with a CNA in the room attempting to readjust her/him. The resident fell forward, hit her/his chin and bit her/his lip. The treatment nurse was notified of a need to look at her/his lip, and indicated there were no noted injuries aside from the resident's complaint of pain on her/his right side. The progress note indicated it appeared the resident pulled something and alert charting was implemented. A 6/15/19 Incident Note completed at 2:53 PM indicated a decision was made by the resident and her/his family member that she/he would be taken to the emergency department. A 6/16/19 Nursing Note indicated facility staff contacted the hospital and were informed Resident 1 had fractured ribs on her/his right side. The 6/15/19 revision to Resident 1's Care Plan for falls indicated the resident had a fall that resulted in fractured ribs. A 6/28/19 revision included the resident was a high risk for falls due to gait, balance, vision, weakness and a decrease strength of core muscles. The 6/28/19 revision directed staff to continue interventions on the at-risk plan. A 6/19/19 Admission Note indicated Resident 1 readmitted after a stay at the hospital following her/his 6/15/19 fall. Multiple pain medications were noted to be ordered and the note indicated her/his care plan would be updated. The 7/16/19 Post Fall Assessment indicated Resident 1 had a witnessed fall on 6/15/19 after she/he lost balance while a staff person assisted the resident to readjust her/his position while seated on the commode. Current interventions noted to be effective were correct positioning on the commode after [she/he] has already sat down while current interventions noted to not have been effective included having to try and readjust sitting on commode after [she/he] has already sat down. Additional interventions noted to be added to the are plan included frequent checks and a toileting schedule. The summary read, [Resident 1] was on the commode trying to readjust her/his sitting position when she/he leaned forward and fell to the floor. CNA was present. Taking to the hospital. Diagnoses with fractured ribs and admitted [DATE]. The Post Fall Assessment was signed as completed by Staff 7 (RNCM) on 6/28/19 (13 days), and was not signed as completed by Staff 2 (DNS) until 7/16/19 (31 days). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/22/19 at 1:51 PM Staff 32 (CNA) stated Resident 1 wore incontinence briefs for intermittent episodes of incontinence, but would regularly request to use a bedpan to urinate. She further stated the resident used the bedside commode for bowel movements. On 7/24/19 at 8:54 AM Staff 19 (CNA) stated the resident wore briefs, used a bedpan to urinate and the bedside commode for bowel movements. On 7/24/19 at 9:29 AM at Staff 7 acknowledged Resident 1's toileting care plan was in place at the time of the fall. Staff 7 further acknowledged the following: - The Post Falls Assessment was not signed as complete by the DNS until 7/16/19. - There was no indication the Administrator had reviewed the Post Falls Assessment as per facility policy. - The investigation was not thorough. - The investigation did not include appropriate new implemented interventions or witness interviews. - The care plan was not updated to include person centered interventions related to Resident 1's 6/15/19 fall with fracture. On 7/24/19 at 9:43 AM Staff 1 (Administrator) acknowledged there was no indication she reviewed the 7/16/19 Post Fall Assessment for Resident 1. b. Resident 13 was admitted to the facility in 2017 with diagnoses including stroke. The 4/22/19 BIMS indicated Resident 13 was cognitively intact. The 4/22/19 Quarterly Summary indicated Resident 13 was not have straws due to swallowing precautions. The care plan last updated 4/23/19 indicated Resident 13 was on swallow precautions due to a stroke and trouble swallowing. The care plan further indicated she/he was not to have straws. On 7/18/19 at 10:13 AM Resident 13's room was observed with a sign on the door and above the bed indicating she/he was not to have straws due to swallowing precautions. The resident had a cup on her/his bedside table and a straw with a lid sitting next to the cup. The resident was resting. On 7/18/19 at 12:15 PM Resident 13 stated staff brought the straw in earlier in the morning and she/he was not supposed to have straws because it caused her/him to choke. The resident stated she/he did not use straw. On 7/18/19 at 12:26 PM Staff 3 (CNA) stated she was unsure if Resident 13 was to have straws. On 7/18/19 at 12:27 PM Staff 4 (CNA) stated she believed Resident 13 was able to have straws. Staff 4 then read the sign on the door and then stated Resident 13 should not have straws. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/19/19 at 9:37 AM Resident 13's room was observed to have a cup full of ice water with a straw on the bedside table, the resident was resting. On 7/19/19 at 9:37 AM Staff 5 (Hospitality Aide) stated she gave Resident 13 a cup with a straw because she had not been told otherwise. Staff 5 then went to the kitchen and returned to the room and removed the water cup with the straw from the room. Staff 5 further stated Resident 13 was not to have a straw and she just saw the sign on the door indicating the resident was not to have straws. No evidence was found to indicate Resident 13 experienced an outcome related to being given straws. On 7/23/19 at 10:24 AM Staff 6 (RNCM) acknowledged Resident 13 was not to have straws due to swallowing precautions. c. Resident 15 was admitted to the facility in 2018 with diagnoses including Alzheimer's disease. The 7/12/18 Significant Change MDS Falls CAA indicated Resident 15 had a history of falls and a progression of Alzheimer's dementia. The Alert Charting Guidelines indicated if a resident had a fall, documentation was to be completed each shift for 72 hours and include information regarding injury, change in ROM, complaints of pain, change in gait, dizziness, changes in level of consciousness, abnormal movements, abnormal blood pressure, signs and symptoms of infection and vital signs. The 6/24/19 and 7/8/19 Post Fall Assessment indicated Resident 15 was found on the floor between her/his bed and the window and attempted to get out of bed without assistance. The nurse on duty evaluated the resident and no injuries were noted and the resident was assisted off the floor. The note further indicated the resident was confused and unable to describe events related to the fall. The 6/24/19 and 7/8/19 fall summaries were written verbatim by different RNCMs. There was no CNA witness statements included in the investigations. There was no indication alert charting was completed for Resident 15 after 6/24/19 and the 7/8/19 falls. The 6/24/19 fall was not reviewed by the RNCM until 7/3/19 (9 days later) and was not reviewed by the DNS until 7/16/19 (22 days later). The 7/8/19 fall was not reviewed by the RNCM until 7/18/19 (10 days later) with no indication the DNS reviewed the fall. On 7/26/19 at 11:28 AM the findings were reviewed with Staff 2 (DNS) and Staff 6 (RNCM). Staff 2 stated she had not reviewed Resident 15's 7/8/19 fall and the expectation was for fall investigations to be completed within 5 days by the RNCM and the DNS. Staff 2 and Staff 6 acknowledged the fall investigations were not completed timely, alert charting was not completed for the falls, there was no CNA witness statements included in the investigations.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 34324 Based on interview and record review it was determined the facility failed to ensure residents were seen by a physician every 60 days for 2 of 5 sampled residents (#s 37 and 45) reviewed for medications. This placed residents at risk for unmet medical needs. Findings include: 1. Resident 45 was admitted to the facility in 2017 with diagnoses including chronic pain, depression and anxiety. Review of an After Visit Summary indicated Resident 45 was seen by a physician on 4/8/19. No further evidence was found in the resident's medical record to indicate Resident 45 was seen by physician within 60 days of the last visit. On 7/23/19 at 10:36 AM Staff 6 (RNCM) acknowledged physician visits were scheduled every 90 days (quarterly). She confirmed Resident 45 had not seen a physician since 4/8/19 (106 days). 2. Resident 37 was admitted to the facility in 2017 with diagnoses including dementia and depression. Review of an After Visit Summary indicated Resident 37 was seen by a physician on 4/23/19. No further evidence was found in the resident's medical record to indicate Resident 37 was seen by physician within 60 days of the last visit. On 7/23/19 at 10:36 AM Staff 7 (RNCM) acknowledged physician visits were scheduled every 90 days (quarterly). She confirmed Resident 37 had not seen a physician since 4/23/19 (91 days).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40767 Based on observation, interview and record review it was determined the facility failed to provide sufficient nursing staff to attain and maintain the highest practicable well being for 2 of 3 halls (100 and 200 halls) reviewed for call lights. This placed residents at risk for unmet care needs. Findings include: 1. Resident 63 was admitted to the facility 3/2019 with diagnoses including stroke and spine fractures. The 6/28/19 MDS indicated Resident 63 was cognitively intact and required extensive assistance for mobility. On 7/18/19 at 12:47 PM Resident 63 stated on average staff took 20 to 25 minutes to assist her/him when the resident used her/his call light. The resident reported she/he waited up to two hours for assistance on a few occasions. Resident 63 stated she/he timed the wait using a watch. The resident was observed to wear a watch on her/his left wrist. On 7/22/19 at 1:06 PM Resident 63 stated she/he pushed the call light and was waiting for assistance for medicated and pain medication. The resident did not report significant pain. The call light cord was observed to be unplugged from the wall. The cord was then plugged back into the wall socket and pressed for assistance. The call light was answered by CNA staff at 1:36 PM, 30 minutes after the button had been pressed. The pain medication was given to Resident 63 by nursing staff at 1:45 PM. 2. The 5/2/19 Resident Council Meeting Notes revealed resident concerns with call light wait times. The 6/6/19 Resident council Meeting Notes indicated in response to call light concerns, weekly call light audits were performed and administrative staff conducted weekly meetings with nursing staff to further train and remind staff of job duties and expectations. On 7/22/19 at 1:33 PM a resident council meeting was held. When asked about call light times, residents reported the wait times could be up to an hour long during meals and reported other times waited 35-45 minutes. Residents 1 and 55 stated 20 minutes after pressing the call light button for assistance with toileting they called the front desk from their telephones to request assistance. On 7/22/19 at 3:22 PM Staff 29 (CNA) stated lack of staff was his biggest concern. Staff 29 stated he was always rushing to get showers and meals done. Staff 29 could not recall a specific outcome to any particular resident. On 7/26/19 at 8:12 AM Staff 28 (Unit Coordinator) confirmed residents, specifically Resident 1 and Resident 32 called the front desk when they waited too long for assistance to the commode. Staff 28 stated when residents phoned her she used a walkie-talkie and called for staff to assist them.

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. 34324 Based on interview and record review, it was determined the facility failed to have policies and procedures in place in the event of a facility closure. This placed residents at risk for displacement. Findings include: On 7/26/19 at 9:00 AM Staff 1 (Administrator) was requested to provide the Facility Closure plan. On 7/26/19 at 10:33 AM Staff 1 provided a Facility Closure plan dated 7/26/19. Staff 1 confirmed the facility did not have a closure plan in place prior to 7/26/19.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34702 Based on interview and record review it was determined the facility's quality assessment and assurance committee (QAA) failed to systematically identify and correct deficiencies in the area of accidents. This resulted in immediate jeopardy and substandard quality of care. This also resulted in Resident 1 sustaining multiple fractures, Resident 8 sustaining abrasions to the foot and Resident 6 having a scrape on her/his wrist, and hip and shoulder pain. Findings include: The facility failed to have a system in place to ensure residents were transferred with mechanical lift slings of appropriate size based on their weight and measurements, failed to ensure slings were in good repair and failed to ensure manufacturer's care instructions were followed. Three residents experienced breakage of the mechanical lift slings during transfers. On 7/26/19 at 12:48 PM Staff 1 (Administrator) stated she was unaware of a pattern of the mechanical lift slings breaking. On 7/26/19 at 12:53 PM Staff 2 (DNS) stated the facility did not identify a pattern of mechanical lift slings breaking and there was no tracking system in place for falls and accidents. Refer to F689, Examples 1 a, 1 b, 1 c, 1d and 2 a.

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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. 41454 1. Based on observation and interview it was determined the facility failed to ensure standards of practice were followed to maintain infection control for 1 of 1 sampled resident (#44) reviewed for urinary catheter. This placed residents at risk for cross contamination. Findings include: Resident 44 admitted to the facility in 2/2019 with diagnoses including benign prostatic hyperplasia (prostate gland enlargement) and obstructive and reflux uropathy (blockage of the normal flow of contents of the urinary tract). Resident 44 had severe cognitive impairment. On 7/23/19 at 8:00 AM Resident 44 was observed resting in bed with her/his catheter bag and catheter tubing touching with the floor. On 7/23/19 at 8:10 AM Staff 19 (CNA) acknowledged Resident 44's catheter bag and catheter tubing was touching the floor and was not to be on the floor. On 7/23/19 at 8:15 AM Staff 23 (CNA) acknowledged Resident 44's catheter bag was on the floor of the resident's room. On 7/23/19 at 8:20 AM Staff 24 (LPN) indicated Resident 44's catheter bag and catheter tubing was on the floor which increased Resident 44's risk for infection. 41468 2. Based on observation, interview and record review it was determined the facility failed to ensure infection control policies were reviewed or revised annually for 1 of 1 procedure manual, and mechanical lifts and shower rooms were cleaned for 2 of 7 mechanical lifts and 1 of 3 shower rooms reviewed for infection control. This placed residents at risk for outdated policies and procedures and an increased risk of infection. Findings include: a. A review of the facility's current Infection Prevention and Control Manual revealed an Infection Prevention policy dated 6/14/17, an Antibiotic Stewardship policy dated 11/30/16 and a Resident Flu Vaccine Program dated 10/13/17. There were no review or revision dates noted on the policies. On 7/24/19 at 8:50 AM Staff 2 (DNS) indicated policies were not reviewed or revised annually. b. An observation on 7/24/19 at 9:38 AM in the 200 hall shower room revealed a buildup of dirt and grime on the two mechanical lifts. On 7/24/19 at 11:05 AM Staff 15 (Housekeeping/Laundry Supervisor) indicated there was no written cleaning schedule for the mechanical lifts. She confirmed the two mechanical lifts were dirty. c. An observation on 7/24/19 at 9:47 AM in the 100 hall shower room revealed a deep crack creating an uncleanable surface at the transition between the shower insert and the shower room floor. There was a buildup of grime and dirt in the crack. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/19 at 2:15 PM Staff 22 (Maintenance) verified the presence of the crack and confirmed it was dirty and uncleanable.

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	07/26/2019

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 34702 Based on observation, interview and record review it was determined the facility failed to maintain resident care equipment in safe operating condition for 3 of 7 mechanical lifts reviewed. This placed residents at risk for accidents. Findings include: On 7/25/19 at 2:07 PM Staff 31 (CNA) stated mechanical lift emergency release buttons were not functioning correctly. Staff 31 demonstrated the scale mechanical lift emergency release did not function, she pushed on the lift arm and it did not lower. On 7/25/19 at 2:38 PM Staff 22 (Maintenance) tested the scale mechanical lift and stated the emergency release did not function and he was not previously aware of it not working. A review of the Mechanical Lift Audit indicated the lifts were inspected on 7/11/19. Two additional audits were provided and were undated. On 7/25/19 at 3:37 PM Staff 22 tested the additional mechanical lifts and identified one additional lift where the emergency release did not function. He further stated the facility had one mechanical lift that was out of commission. Staff 22 stated mechanical lift inspections were completed once a month and acknowledged there was no additional documentation of the audits being completed monthly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 40767 Based on observation, interview and record review the facility failed to ensure call lights were functioning for 2 of 3 halls (100 and 200 halls) reviewed for call lights. This placed resident at risk for delayed assistance and unmet meets. Findings include: 1. Resident 63 was admitted to the facility 3/2019 with diagnoses including stroke and spine fractures. A 4/14/19 Maintenance Request form indicated Resident 63's call light could not be turned off. The 4/15/19 response by Staff 22 (Maintenance) indicated the call light box had been replaced. The 6/28/19 MDS indicated Resident 63 required extensive assistance for transfers. On 7/18/19 at 9:04 AM Resident 63 stated she/he was often unable to receive assistance due to her/his call light not consistently functioning. Multiple observations from 7/19/19 through 7/25/19 in the 100 hallway revealed Resident 63's call light did not turn on when she/he pressed the call light button or the call light was not able to be turned on due to the call light cord being pulled out from the wall socket. On 7/25/19 at 10:57 AM Staff 3 (CNA) stated there were multiple issues with call lights including multiple call light cords were loose and would come out of the wall or other times the call lights would not turn off. Staff 3 further stated maintenance would fix the lights and they would work for a few days but then the lights would stop working again. On 7/25/19 at 2:23 PM Staff 22 acknowledged reoccurring issues with Resident 63's call light not functioning correctly. 2. Resident 67 admitted the facility 6/2018 with diagnoses including post traumatic stress disorder. A 6/8/19 Maintenance Request form indicated Resident 67's bathroom call light was not functioning as the light in the hallway did not turn on when the call light was used. The remarks section of the form was left blank and there was no date or signature to indicate the issue was addressed. On 7/25/19 at 1:42 PM Resident 67's bathroom call light was not observed to illuminate in the 200 hallway when used. On 7/25/19 at 2:23 PM Staff 22 (Maintenance) confirmed the Maintenance Request form response was left blank for Resident 67 and the concern was not addressed. He further acknowledged Resident 67's bathroom call light was not functioning. 3. Resident 24 admitted to the facility 1/2019 with diagnoses including morbid obesity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 1/31/19 Maintenance Department Work Order Request indicated Resident 24's call light was broken and on 2/6/19 Staff 22's (Maintenance) response to the request indicated the call light seemed to work. On 7/18/19 at 9:04 AM Resident 24 reported multiple instances of her/his call light either not turning off or the resident needed to press the call light multiple times for light to illuminate. Resident 24 stated she/he used hand mirror to check behind her/him to ensure the call light was on. The resident further stated maintenance had replaced the call light box but the call light issues continued. On 7/19/19 at 9:37 AM Resident 24 was observed to press her/his call light button multiple times before the call light turned on in the 100 hall. On 7/25/19 at 2:23 PM Staff 22 acknowledged reoccurring issues with Resident 24's call light system not functioning correctly.