STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385165	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Curry Village Health and Rehab of Cascadia	1 Park Avenue Brookings, OR 97415

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assessed to self-administer medications for 1 of 1 resident (#2) observed during dining observations. This placed residents at risk for an unsafe medication regimen. Findings include: Resident 2 was admitted to the facility in 6/2006 with a diagnosis of paralysis of the lower body. A 1/19/25 quarterly MDS revealed Resident 2 was cognitively intact and did not have difficulty swallowing. On 1/30/25 at 8:22 AM Resident 2 was observed in the dining room sitting alone at a table with her/his breakfast tray. Next to Resident 2's tray on a paper napkin were 12 medications and a staff member was not by her/his side to ensure she/he swallowed the medications. On 1/30/25 at 8:23 AM Staff 10 (RN) stated she always left Resident 2's medications on a napkin at breakfast because Resident 2 liked to take them while she/he ate. Staff 10 stated Resident 2 sat alone at meals. On 1/30/25 at 8:25 AM with Staff 2 (Chief Nursing Officer) and Staff 3 (Clinical Resource) Staff 2 stated if medications were left with a resident the resident was to be assessed to ensure she/he was safe to self-administer medications. Staff 3 stated a self-medication administration assessment was not completed and not in Resident 2's clinical record. On 1/30/25 at 8:59 AM Resident 2 stated she/he preferred to take her/his morning medications on her/his own time, she/he was very capable of taking the medications, and did not have issues with swallowing. Resident 2 stated she/he sat alone and other residents did not interrupt her/him during meals.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35855 Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 3 sampled residents (#36) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: Resident 36 was admitted to the facility in 1/2025 with diagnoses of Alzheimer's disease and diabetes. A review of the Admission MDS with an Aessment Review date of 1/7/25 revealed Resident 36's BIMS was six, indicating a severe cognitive impact. Resident 36 required partial to moderate assistance with personal hygiene. A review of Resident 36's care plan dated 1/7/25 revealed she/he had an ADL self-care performance deficit and required partial to moderate assistance with personal hygiene and bathing. A Documentation Survey Report from 1/2025 revealed Resident 36 received bathing on Saturdays and Tuesdays. On 1/25/25 there was no record Resident 36 was offered or refused bathing. An unnamed document dated 1/25/25 indicated Resident 36 was not assigned to a staff member for bathing on 1/25/25. On 1/27/25 at 1:00 PM Witness 2 (Family) stated she would prefer Resident 36 not have facial hair. Witness 2 did not know staff could remove the resident's facial hair. On 1/27/25 at 11:51 AM Resident 36 was observed in her/his room with facial hair approximately two inches long. Resident 36 stated she/he did not remember the last time she/he received a shower. On 1/28/25 the following occurred: -9:07 AM: Resident 36 stated she/he used to use a razor to shave but she/he no longer owned one. She/he wanted her/his facial hair removed. -12:11 PM Resident 36 was observed in the main dining room with other residents. Resident 36's facial hair was approximately two inches long. On 1/29/25 the following occurred: -7:36 AM Staff 9 (CNA) stated if a resident was diabetic, he would ask a nurse to shave the resident while in the shower. Staff 9 stated he did not have Resident 36 assigned for a shower on 1/25/25 so he did not provide her/him a shower. -7:48 AM Staff 22 (LPN) stated nurses would shave diabetic residents' facial hair if they did not have an electric razor. CNAs sometimes did not know how to get a nurse while the resident was showering. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9:02 AM Staff 17 (CNA) assisted Resident 36 into her/his room. Resident 36 was observed with approximately two-inch long facial hair. Staff 17 stated some residents had an electric razor for facial hair, but she did not know the process for residents without an electric razor. -3:20 PM Staff 1 (Chief Executive Officer), Staff 2 (Chief Nursing Officer), and Staff 3 (Clinical Resource) expected staff to offer and provide shaving for the residents. Staff 2 stated the staff member who was responsible for the assignment sheet for bathing had left unexpectedly and Resident 36's shower was missed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident received ROM for 1 of 2 sampled residents (#18) reviewed for mobility. This placed residents at risk for decreased ROM. Findings include: Resident 18 was admitted to the facility in 2/2024 with a diagnosis of incomplete quadriplegia (limited movement below the neck). An 8/5/24 significant change MDS revealed Resident 18 had dementia, was blind, and required assistance with ADLs due to her/his quadriplegia. Resident 18 had functional limitations in ROM to both sides to the arms and legs. A 10/22/24 quarterly MDS revealed Resident 18 continued to have functional limitation in ROM to both sides to the arms and legs. A care plan initiated 11/4/24 revealed Resident 18 had Parkinson's disease and quadriplegia. Goals included Resident 18 would remain free of complications related to Parkinson's disease and maintain optimal quality of life within limitations imposed by her/his neurological deficits. Interventions staff were to provide included passive ROM with AM and PM care. A current (as of 1/29/25) Kardex (CNA guide for resident specific care) revealed there was no ROM task set up for CNAs. On 1/29/25 at 11:14 AM Staff 17 (CNA) stated if a resident was to be provided ROM it was on the resident's Kardex. Staff 17 stated she was able to do ROM if it was on the Kardex and if there were directions for the type of ROM to be provided. On 1/29/25 at 3:04 PM Staff 14 (OT) stated Resident 18 did not tolerate therapy, had poor pain tolerance, poor insight, and was discharged from therapy services. When Resident 18 was discharged from therapy the facility did not have an RA program. Staff 14 stated CNAs were able to do simple, passive ROM. On 1/29/25 at 3:21 PM Staff 16 (CNA) stated he learned how to do ROM in her/his CNA certification class, was comfortable providing ROM, and provided ROM if it was on a resident's Kardex. On 1/29/25 at 4:01 PM Staff 14 (CNA) stated she worked with Resident 18 and she/he did not have ROM on the Kardex and she did not provide Resident 18 ROM. On 1/29/25 at 3:42 PM Staff 4 (Resident Care Manager RN) acknowledged Resident 18's care plan directed staff to provide ROM with AM and PM care. Staff 4 stated the ROM was not on the Kardex as a task and staff did not do the ROM. On 1/30/25 at 7:57 AM with Staff 2 (Chief Nursing Officer) and Staff 3 (Clinical Resource) Staff 2 stated CNAs could do ROM but were not doing ROM.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35855 Based on observation, interview, and record review it was determined the facility failed to ensure residents did not receive unnecessary psychotropic medications and failed to monitor for side effects of psychotropic medications for 2 of 5 sampled residents (#s 7 and 28) reviewed for medications. This placed residents at risk for adverse side effects of medications. Finding include: 1. Resident 7 was admitted to the facility in 10/2017 with diagnoses including anxiety disorder. A review of Resident 7's signed physician orders dated 1/15/25 instructed staff to administer Xanax (to treat anxiety) every eight hours PRN for anxiety for 90 days, starting on 10/18/24. A review of the 1/2025 MAR instructed staff to administer Xanax every eight hours PRN for anxiety for 90 days, starting on 10/18/24. The MAR indicated Resident 7 was administered Xanax on 1/17/25, 1/18/25, 1/19/25 1/22/25, 1/23/25, 1/26/25, 1/27/25 and 1/28/25. Resident 7 was administered Xanax eight times after the end date of 1/16/25. No end date was documented on the MAR. On 1/30/25 at 6:28 AM, Staff 8 (LPN) stated staff should document the end date in clinical records. On 1/30/25 at 7:55 AM Staff 1 (Chief Executive Officer), Staff 2 (Chief Nursing Officer), and Staff 3 (Clinical Resource) expected staff to document an end date in clinical records for a medication that was ordered for 90 days. 26991 2. Resident 28 was admitted to the facility in 9/2024 with a diagnosis of cancer. A 1/2025 MAR revealed Resident 28 was administered trazodone (antidepressant) daily at bedtime for sleep. A care plan dated 10/1/24 indicated Resident 28 was administered an antidepressant and the goal was for her/him to be free from adverse reactions including sedation, agitation, and confusion. A 1/2025 MAR and TAR revealed staff did not monitor Resident 28 for side effects from her/his antidepressant. On 1/28/25 at 7:49 AM, 1/28/25 at 9:55 AM, and 1/28/25 at 12:05 PM Resident 28 was observed to be alert, sitting up, at the dining room, and conversing with others. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 3:56 PM Staff 11(LPN) stated the nurses monitored residents for side effects of medications and if they observed side effects they documented in residents' progress notes. Psychotropic medications with potential side effects which were to be monitored were on the MAR or TAR. Staff 11 stated Resident 28 was administered an antidepressant but did not have side effects which were to be monitored listed on the MAR or TAR. On 1/28/25 at 4:01 PM Staff 4 (Resident Care Manager RN) stated the monitoring of psychotropic medication side effects were to be completed on the MAR or TAR. Staff 4 stated Resident 28 did not have antidepressant side effect monitoring in her/his clinical record. On 1/28/25 at 4:11 PM Staff 2 (Chief Nursing Officer) and Staff 3 (Clinical Resource) verified Resident 28's psychotropic side effect monitoring was to be documented on the MAR and TAR but was not done.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate of less than 5%. The facility administration error rate was 7.41% with two errors in 27 opportunities. This placed residents at risk for an ineffective medication regimen. Findings include: Resident 92 was admitted to the facility in 1/2025 with a diagnosis of malnutrition. A 1/27/25 hospital After Visit Summary form revealed Resident 92 was to be administered medications including Ferrous Sulfate EC (enteric coated) 324 mg (supplement) and Calcium with Vitamin D (supplement). On 1/28/25 at 7:48 AM Staff 11(LPN) was observed to administer Resident 92 medications including one Slow Iron 45 mg tablet. Staff 11 did not administer Calcium with Vitamin D. On 1/28/25 at 9:24 AM Staff 11 stated when a resident was admitted to the facility with new orders Staff 18 (Medical Records) entered the orders into a resident's clinical record and a nurse was to review the orders prior to administering the medications to ensure all the orders were entered correctly. Staff 11 reviewed Resident 92's admission orders and he acknowledged he administered the wrong dose of iron, stated the Calcium with Vitamin D was not transcribed onto the MAR, therefore, he did not administer the medication as ordered. On 1/28/25 at 9:26 AM Staff 1 (Chief Executive Officer) stated resident admission orders were entered into the clinical record by medical record staff and a nurse had to approve the orders before the medications could be administered. Staff 2 (Chief Nursing Officer) was notified the Calcium with Vitamin D was not transcribed onto the MAR. On 1/28/25 at 10:27 AM Staff 18 stated she did not enter the Calcium with Vitamin D order into Resident 92's clinical record and the nurse did not see the omitted order when they verified her/his orders.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50930 Based on observation, interview and record review it was determined the facility failed to ensure food for the residents was prepared in a manner which preserved the nutritional value for pureed texture diets. This placed residents at risk for nutritional deficits. Findings include: An observation of lunch meal service on 1/29/25 at 11:43 AM revealed pureed cranberry chicken as a main course available to residents with puree texture diets. On 1/29/25 at 3:15 PM Staff 19 (Dietary Aid) stated food was mixed with water to create the puree texture. He also stated the puree texture consistency was determined by sight. On 1/29/25 at 3:27 PM Staff 12 (Culinary Manager) stated the recipes and texture guidelines for the kitchen came from Sysco (a kitchen food and non-food product supplier). He stated the kitchen staff were instructed to use water to make the puree texture. Staff 12 stated he would bring the survey team the recipes and guidelines from Sysco. No further information was provided to the survey team. A 1/30/25 review of pureed food recipes and texture guidelines on Sysco's website revealed the following: - Pureed food texture was determined by using a two-step testing method prior to serving it - Foods were to be mixed with gravy, sauce, broth, or milk to create a puree texture.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50930 Based on observation and interview it was determined the facility failed to ensure food was stored properly in 1 of 1 resident refrigerators, failed to ensure food was stored, prepared, and handled properly in 1 of 1 kitchen, and failed to keep kitchen equipment clean. This put residents at risk for food borne illnesses. Findings include: During the initial kitchen observation on 1/27/25 at 8:15 AM the following items were found in the walk-in refrigerator: - A plastic wrapped white tube containing a soft white substance, a white tub of semi hard white substance, and a white tub with dark liquid inside did not have labels or open dates - A metal bowl covered with plastic wrap labeled streusel topping, a used jug of thickened orange juice (juice with a thickening agent mixed into it), a used jug of 1% milk, a used carton of almond milk, used bags of shredded cheddar and mozzarella cheese, a box containing opened and uncovered packages of meat, and a used package of cheese slices with hard edges wrapped in plastic wrap did not have open dates - Two uncovered trays of hamburger patties on a bottom shelf During an initial kitchen observation on 1/27/25 at 8:25 AM the walk-in freezer contained the following items without open dates: - A loosely covered pie tin containing partially eaten pie - A bag of meat opened and wrapped loosely with plastic wrap - An open bag of meat patties inside an open box On 1/27/25 at 8:32 AM Staff 12 (Culinary Manager) verified all items found and stated they would be removed and staff educated on the proper food storage policy. He stated he would bring the food storage policy to the survey team. No further documentation was provided. On 1/28/25 at 12:30 PM Staff 12 verified the following items were found in the resident refrigerator: - A used jug of 1% milk, a used carton of almond milk, two used containers of nectar consistency orange juice (juice with a thickening agent mixed into it), and a used jug of cranberry juice cocktail did not have open dates - Plastic wrapped sliced cheese with multiple hard slices did not have a label or an open date During the meal tray preparation and meal service on 1/29/25 at 11:43 AM the following were observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Staff 12 used a thermometer to check the temperatures for all items on the steam table without cleaning it between items or wearing gloves until instructed. When asked about the proper procedure for getting food temperatures, he stated the policy was to wear gloves and clean the thermometer between all items. He stated he would bring the food service policy to the survey team. No further documentation was provided. - Staff 20 (Dietary Aid) did not have her hair net properly in place until instructed. She stated she did not know if there was a policy for hair nets. - Staff 20 was not wearing gloves while portioning out brown sugar from a large container until instructed. She stated the policy was to wear gloves when handling food. - Staff 19 (Dietary Aid) collected supplies for preparation of salads while wearing gloves and did not change his gloves prior to touching the salad mix. He did not change gloves or throw away the contaminated mix until instructed. He stated he did not realize he needed to change his gloves before touching the salad mix and did not know if there was a glove wearing policy. - Staff 19 removed squashed grapes and grapes with fuzz from a large bag of grapes without wearing gloves, and did not wash his hands or put on gloves until instructed. He stated he did not think he needed gloves to remove the grapes from the bag. On 1/29/25 at 12:20 PM Staff 12 stated the expectation of all kitchen staff was to wear gloves while performing tasks involving food. He stated he would bring the glove wearing policy to the survey team. No further information was received by the survey team. On 1/29/25 at 3:15 PM Staff 19 stated the expectation of kitchen staff was to label and date all food items upon opening them, but he did not know if there was a policy for food storage. He also stated the kitchen was cleaned on an as needed basis with no set schedule for cleaning or deep cleaning. He revealed a cutting board in use on the steam table which had dark spots on the underside, and stated he could not get it clean and did not know how long it had been in that condition. A follow up observation of the kitchen walk-in refrigerator on 1/29/25 at 3:23 PM noted the items from the initial kitchen observation still present as well as a used container of skim milk and a used carton of liquid eggs without open dates. Staff 12 verified the identified items. On 1/29/25 at 3:27 PM Staff 12 stated he did not have cleaning audits or a cleaning schedule for the kitchen. He stated he did not know about the dark spots on the underside of the cutting board, and upon visualizing the dark spots he stated the cutting board would be cleaned or thrown away. A kitchen observation on 1/30/25 at 10:31 AM revealed the following: - The cutting board with the dark spots underneath was being used on the steam table - All verified undated and unlabeled items from previous observations were still in place in the walk-in refrigerator, walk-in freezer, and resident refrigerator (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A follow up kitchen observation on 1/30/25 at 11:08 AM noted Staff 21 (Regional Culinary Manager) taking the steam table cutting board to the dumpster. She stated the board would not be used again, a new board had been ordered, and a cleaning schedule had been made for the kitchen staff.