STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365453	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OREGON HEALTHCARE	**3953 NAVARRE AVE OREGON, OH 43616**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, staff interview, and facility policy review, the facility failed to treat residents in a dignified manner when assisting during meal time by standing over residents when assisting the resident to eat. This affected two (#35 and #36) out of eight residents that needed assistance with eating. The facility census was 69. Finding include: Observation on 03/02/20 at 12:27 P.M. revealed State tested Nurse Aide (STNA) #410 assisting Resident #35 and Resident #36 eat lunch. STNA #410 alternated assisting Resident #35 and Resident #36 with eating spoonfuls of the meal, alternating between residents and standing over them. Resident #36 was sitting in a taller Broda chair and STNA #410 was nearly eye level with the resident. Resident #35 was sitting in a low wheelchair which was slightly reclined and STNA #410 was not at eye level. Observation on 03/02/20 at 12:30 P.M. revealed STNA #420 had began to assist Resident #36 with eating, offering spoonfuls of food to the resident. STNA #420 stood above the resident while assisting him with his meal. Interview on 03/02/20 at 12:41 P.M. with STNA #420 revealed staff both sit and stand while assisting residents with lunch. STNA #420 stated there was no space to sit, which was the reason for standing while assisting Resident #36. Interview on 03/02/20 at 12:46 P.M. with STNA #410 verified the STNA stood while assisting Resident #35 and Resident #36 eat lunch. STNA #410 stated Resident #35's chair is much taller and to assist her staff needed to stand. Review of the facility policy titled Resident Rights, revised December 2016, verified residents have the right to be treated with dignity.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, review of the bathing record, resident interview, staff interview, and review of the facility policy, the facility failed to provide a shower or bath for one (#55) of one residents reviewed for Activities of Daily Living (ADL) care. The facility census was 69. Findings include: Review of Resident #55's medical record revealed an initial admission date of [DATE] and re-entry date of 12/19/18. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 01/23/20, revealed Resident #55 was cognitively intact. The assessment revealed Resident #55 required extensive assistance of one person with personal hygiene and physical help in part of bathing with one person physical assist. Interview on 03/02/20 at 2:35 P.M. with Resident #55 revealed the resident was scheduled to receive a shower on second shift Wednesdays and Saturdays. Resident #55 reported she has gone 30 days without a shower. Interview on 03/04/20 at 9:40 A.M. with Resident #55 revealed the resident in bed wearing a hospital gown appearing slightly disheveled with unkempt hair. Resident #55 stated she would receive a shower tonight. Resident #55 stated an aide reminded her last night that her shower was on Wednesday and the resident reportedly asked the aide to ensure the shower room would be warmed up before she went in. Observation on 03/05/20 at 10:00 A.M. with Resident #55 revealed the resident appeared to be unkempt and have greasy hair. Interview on 03/05/20 at 10:01 A.M. with Resident #55 revealed the resident was not offered and did not receive a shower or bath. Review of the bathing record revealed Resident #55's shower days were Wednesday and Saturday between 2:30 P.M. and 10:30 P.M. Review of the bathing record revealed Resident #55 was provided a shower on 02/01/20 and 02/19/20. On 02/12/20, NA (not applicable) was documented for the task completed and the type of bathing. Interview on 03/05/20 at 10:25 A.M. with Registered Nurse (RN) #350 verified she could not confirm if Resident #55 received or was offered a shower or bed bath on 02/05/20, 02/08/20, 02/12/20, 02/15/20, 02/26/20, 02/29/20, and 03/04/20. Interview on 03/05/20 at approximately 11:00 A.M. with RN #350 verified when Resident #55 changed rooms the shower scheduled should have changed effective 02/10/20 from Wednesday and Saturday to Tuesday and Saturday. RN #350 verified it was not changed in the system. Review of facility policy titled Activities of Daily Living, revised March 2018, verified appropriate care and services will be provided for residents who are unable to care out ADL's independently, with the consent of the resident and in accordance with the plan of care. This includes appropriate support and assistance with hygiene including bathing, dressing, grooming, and oral care.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of a facility policy, the facility failed to provide a nutritional supplement as ordered by the physician. This affected one (#51) of three residents reviewed for nutrition. The facility identified 10 residents with physician orders [REDACTED]. Findings include: Review of Resident #51's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed Minimum Data Set (MDS) assessment, dated 02/14/20, revealed Resident #51 had severely impaired cognition and was prescribed a therapeutic diet with no nutritional concerns assessed. Review of a physician order [REDACTED].#51 was ordered a Magic Cup nutritional supplement to be provided daily at lunch. Review of Resident #51's weights obtained between September 2019 and March 2020 revealed no significant weight loss with weights consistently in the between 130 pounds and 135 pounds. Observation on 03/02/20 at approximately 12:15 P.M. revealed Resident #51 sitting in his room awaiting his lunch. Resident #51 received his lunch tray from a State tested Nurse Aide (STNA) who remained in the room to assist Resident #51 with eating. Observation of Resident #51's meal tray revealed no nutritional supplement was provided from the dietary department as part of his lunch meal. Subsequent observation on 03/02/20 between 12:15 P.M. and 1:07 P.M. revealed Resident #51 was not provided a nutritional supplement from the dietary or nursing departments. Observation on 03/04/20 at 12:06 P.M. revealed Resident #51 was once again served his lunch meal in his room by STNA #440, who remained in the room to assist him with eating. Observation of Resident #51's meal tray revealed no nutritional supplement was provided from the dietary department. Additional observation of the meal tray revealed Resident #51's meal ticket contained a notation under special instructions for Resident #51 to receive a Magic Cup nutritional supplement. Interview on 03/04/20 at 12:06 P.M., STNA #440 stated she assisted Resident #51 with all of his meals when she worked and confirmed he did not receive his ordered nutritional supplement with his lunch on 03/02/20 or 03/04/20. STNA #440 stated the nutritional supplement was supposed to come from the kitchen with his lunch and was usually in the form of a frozen ice cream-like dessert. STNA #440 stated Resident #51 often did not receive his nutritional supplement stating he was provided the nutritional supplement maybe one or two times weekly. Interview on 03/04/20 at 12:16 P.M. with Licensed Practical Nurse (LPN) #390 verified the nursing staff did not provided Resident #51 his nutritional supplement, and stated Resident #51's Magic Cup nutritional supplement came from the dietary department. Interview on 03/04/20 at 3:20 P.M. with Dietary Technician #800 verified Resident #51's nutritional supplement was to be supplied by the dietary department, and verified Resident #51 had no significant weight

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

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.

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) loss over the last several months. Review of a facility policy titled Food and Nutrition Services, revised October 2017, revealed meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time, and in accordance with resident's medication requirements.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure [MED] was held per physician's orders. This affected one (#53) of 20 residents who receive [MED]. The facility census was 69. Findings include: Review of Resident #53's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #53's monthly physician orders dated February 2020 revealed an order for [REDACTED]. Review of Resident #53's Medication Administration Record [REDACTED]. Again on 02/10/20 the resident's blood sugar was 78 and [MED] was administered. Interview on 03/05/20 at 11:19 A.M., the Director of Nursing (DON) verified Resident #53 had received [MED] on 02/07/20 and 02/10/20. DON verified the [MED] should have been held due to the resident's blood sugars were less than 110. Review of facility policy titled Administering Medications, dated December 2012, revealed medications must be administered in accordance with the orders.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** Based on observation, review of the dietary spreadsheet, and staff interview, the facility failed to provide proper food portions for mechanically altered diets. This affected eight residents (#12, #18, #36, #37, #48, #60, 362, #369) who receive a mechanical soft diet. The facility census was 69. Findings include: Review of the dietary spreadsheet for dinner on 03/04/20 or the mechanical soft diets revealed the protein to be offered was three ounces of corned beef. Observation on 03/04/20 at 4:57 P.M. revealed dietary staff to be using a size 16 scoop, or two ounce portion, for the mechanical soft corned beef. Interview on 03/04/20 at 5:00 P.M. with Kitchen Manager #450 verified a two ounce scoop size was used for the mechanical soft corned beef. The facility identified eight residents (#12, #18, #36, #37, #48, #60, 362, and #369) who receive a mechanical soft diet.
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of a facility menu, and review of a facility policy, the facility failed to provide therapeutic diets as ordered by the physician. This affected one (#51) of three residents reviewed for nutrition. The facility identified four residents with physician orders [REDACTED]. The census was 69. Findings include: Review of Resident #51's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed Minimum Data Set ((MDS) dated [DATE] revealed Resident #51 has severely impaired cognition and was prescribed a therapeutic diet with no nutritional concerns assessed. Review of a physician order [REDACTED].#51 was ordered a high protein renal diet with regular texture. Review of a nutritional care plan dated 01/23/20 revealed an intervention to provide and serve Resident #51 his diet as ordered. Review of the most recent dietary assessment dated [DATE] revealed Resident #51 received a high protein renal diet which included double protein at each meal. Review of a facility menu for 03/02/20 revealed the scheduled meal was chicken paprika, penne pasta, peas and carrots, dinner roll, and rice pudding. Observation on 03/02/20 at approximately 12:15 P.M. revealed Resident #51 sitting in his room awaiting his lunch. Resident #51 received his lunch tray from a State tested Nurse Aide (STNA) who remained in the room to assist Resident #51 with eating. Observation of Resident #51's meal tray revealed a single chicken breast with a yellow gravy with paprika and no additional protein source on the meal tray. Review of a facility menu for 03/04/20 revealed the scheduled meal was potato crushed fish, seasoned rice, California blend vegetables, and tropical fruit. Observation on 03/04/20 at 12:06 P.M. revealed Resident #51 was once again served his lunch meal in his room by STNA #440 who remained in the room to assist him with eating. Observation of Resident #51's meal tray revealed a single piece of breaded fish, rice, California blend vegetables, and diced peaches and pears. There were no additional protein sources on Resident #51's meal tray. Interview on 03/04/20 at 12:06 P.M. with STNA #440 stated she assisted Resident #51 with all of his meals when she worked and confirmed he did not receive a double protein with lunch on 03/02/20 or 03/04/20. Interview on 03/04/20 at 3:20 P.M., Dietary Technician (DT) #800 stated residents on a high protein renal diet should be given a double portion of the meat or protein source for each meal. DT #800 verified Resident #51 was ordered a high protein renal diet and should have been provided a double portion of chicken with lunch on 03/02/20 and a double portion of fish on 03/04/20 in additional to his ordered nutritional supplement for additional protein. Review of a facility policy titled Food and Nutrition Services, revised October 2017, revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident.
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.** Based on observation, staff interview, and facility policy review, the facility failed to ensure dietary staff serving food change gloves between tasks when plating meals. This had the potential to affect all 67 residents who receive food from the kitchen. The facility identified all residents, with the exception of Resident #13 and #271, to receive food from the kitchen. The facility census was 69. Findings include: Observation on 03/04/20 at 4:56 P.M. revealed Cook #430 wore disposable gloves while serving the dinner meal. Cook #430 placed the gloved right hand into an oven mitt, took food out of the oven, removed oven mitt with right hand, and kept the disposable gloves on. Cook #430 picked up a hamburger bun with the gloved right hand. Cook #430 touched the drawer handle to get a spatula and immediately afterwards picked up two cheese slices with the gloved hand. At no time during this observation did Cook #430 wash hands and put on new gloves. Interview on 03/04/20 at 5:01 P.M. with Cook #430 verified he/she did not hand wash or changed disposable gloves between placing gloved hand in oven mitt, opening a drawer, and touching hamburger buns and cheese. Review of the facility policy titled Preventing Foodborne Illness-Food Handling, revised July 2014, verified food will be stored, prepared, handled, and served so that the risk of foodborne illness is minimized. The facility identified Resident #13 and Resident #271 to receive no food from the kitchen.
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** Based on medical record review, observation, and staff interview, the facility failed to follow physician ordered isolation precautions for one (#16) of two residents reviewed for transmission-based precautions. The facility identified two residents with orders for transmission-based precaution. In addition, the facility failed to properly store a urine collection device in the bathroom shared by four residents (#5, #22, #36, #47). The facility census was 69. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of a lab report dated 02/17/20 for Resident #16 revealed a white blood cell count (WBC) of 1.8. The lab report indicated a normal reference range for WBC to be between 4.00 to 11.00. Review of physician orders [REDACTED].#16 revealed isolation precautions were ordered to protect the resident due to low white blood cell count. Review of the care plan, dated 03/01/20, for Resident #16 revealed the resident had impaired immunity related to low WBC and was on reverse isolation. Interventions in the care plan indicated Resident #16 was at risk for contracting infections due to impaired immune status and to keep the environment clean and people with infections away. Observation on 03/02/20 at 9:56 A.M. revealed a cart containing personal protective equipment (PPE) outside of Resident #16's room. Signage was located on the door frame instructing visitors to the room to check with nursing staff prior to entering the room. Interview on 03/02/20 at 9:57 A.M., Licensed Practical Nurse (LPN) #300 revealed Resident #16 was on transmission-based precautions due to

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) extremely low white blood cell counts, placing him at risk for infection. She stated staff were instructed to wear PPE, including gloves, gowns, and masks when entering the resident's room. Observation on 03/02/20 at 3:00 P.M. revealed State tested Nurse Aide (STNA) #400 entered Resident #16's room. STNA #400 did not don PPE prior to entering Resident #16's room. Interview on 03/02/20 at 3:03 P.M., STNA #400 confirmed she entered Resident #16's room without PPE. She stated she did not need to wear it because she was not touching the resident's urine. STNA #400 stated staff are made aware of transmission-based precautions by the nurse during shift change and she was unaware she should have worn PPE when entering the resident's room. Interview on 03/04/20 at 8:05 A.M., Registered Nurse (RN) #350 revealed when a resident was placed on transmission-based precautions, a cart with the needed PPE was placed outside of the resident's room. A sign was also placed on the door. The nurse who received the physician order [REDACTED]. Observation on 03/04/20 at 12:08 PM of the transmission-based precautions signage placed on the door frame for Resident #16 revealed gown, gloves, and face mask should be worn. 2. Review of Resident #22's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Observation on 03/03/20 at 1:45 P.M. of Resident #22's bathroom revealed a urinary collection device, used for emptying the resident's catheter bag sitting on the back of the toilet. The urine collection device was sitting on the toilet uncovered and without a barrier on the bottom of the container. Resident #22 shared this bathroom with three additional residents (#5, #36, #47). Interview on 03/03/20 at 1:47 P.M. with Director of Nursing (DON) verified the Resident #22's urine collection device was improperly stored. DON stated the urine collection device should be placed in a bag or in a bedside stand.