STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385224	A. Building B. Wing	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Health & Rehabilitation Center	820 Cottage 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to notify the physician and family of a burn for 1 of 9 sampled residents (#13) reviewed for accidents. This placed residents at risk for delayed treatment and responsible parties at risk for not being informed. Findings include: Resident 13 admitted to the facility on [DATE] with diagnoses including stroke and hemiparesis (weakness to one side of the body). The 10/2022 Skin Integrity Policy indicated if a skin impairment was noted staff were to complete and document notifications to the physician and resident representative. An 8/4/22 Progress Note Late Entry [for 8/3/22] completed by Staff 19 (LPN) indicated Resident was drinking coffee last night at around 8 PM and spilled coffee on [her/his] chest. CNA reported to LN [licensed nurse]. The coffee caused a first-degree burn on resident's chest. Slight separation of skin. The 8/3/22 at 8:00 PM Non-Pressure Skin Investigation completed by Staff 19 indicated Witness 2 (Family Member) was notified of the burn on 8/4/22 at 6:30 PM. The 8/4/22 at 11:46 PM Nursing Progress Note indicated [Resident 13] had a large burn on her/his chest and right groin. The chest burn was approximately 12 [cm] x 6 [cm] and started at her/his chest and down to her/his right breast. Resident's chest was open, red around the edges and the area that goes down to her/his right breast was blistered. The area on her/his right groin was approximately 4 [cm] x 2 [cm] and was blistered. Resident had no bandage on and no treatment orders. Dressing was applied and a call was placed to the on-call physician, awaiting call back for treatment orders. On 11/29/22 at 1:34 PM Staff 19 (LPN) stated Resident 13 received a burn on 8/3/22 and he notified the family of Resident 13's burn the day after it occurred (8/4/22), but did not notify the physician of the burn. On 12/5/22 at 1:29 PM Staff 2 (Regional RN) acknowledged the burn occurred on 8/3/22 and Witness 2 was not notified until 8/4/22 at 6:30 PM and the physician was not notified until 8/4/22 at 11:46 PM.

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

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

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F 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. 34324 Based on observation and interview it was determined the facility failed to ensure a clean and sanitary environment for 1 of 2 shower rooms (North Hall) reviewed for environment. This placed residents at risk for cross contamination. Findings include: Resident 17 admitted to the facility in 2019 with diagnoses including paraplegia. The 8/31/20 Care Plan indicated Resident 17 received a shower three to four times a week. On 11/29/22 at 9:43 AM Resident 17 stated the shower room in the North Hall was not cleaned between uses. Resident 17 stated the shower chairs were dirty with visible speckles on them. On 11/30/22 at 9:23 AM the shower room in the North Hall was observed to have three shower chairs. One of the shower chairs was observed to have several visible crusted brown speckles on the right corner of the chair. Staff 5 (LPN) confirmed the brown speckles were feces and the chair was not cleaned. Staff 5 stated CNA staff were to clean the shower chairs after each use.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40767 Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect. The facility failed to ensure residents who had documented swallowing issues were assessed, residents were free from burns, skin assessments were completed, treatments were implemented, fall investigations were thoroughly investigated, care plan interventions were updated to prevent further accidents, physician orders were followed, medications were available (including emergency and pain medications), pharmacy recommendations were addressed by the physician, controlled medications were disposed of appropriately, failed to respond in a timely manner to call lights, ensure sufficient staff were available to meet resident needs, and ensure staff adhered to professional standards. The cumulative effect of these failures in providing care and services contributed to an environment of neglect for 7 of 15 sampled residents (#s 1, 7, 13, 15, 17, 23, and 181) reviewed for care and services. Findings include: According to the Centers for Medicare & Medicaid Services (CMS), S483.5, Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. ASPIRATION Resident 13 The 1/25/22 Speech Therapy Evaluation indicated Resident 13 had the following history: -2/13/19 diagnoses included pneumonitis due to inhalation of food and vomit. -1/25/22 diagnoses included dysphagia. On 11/30/22 at 9:17 AM and 12/1/22 at 2:57 PM Resident 13 stated she/he sometimes coughed after drinking coffee and after eating food. Resident 13 stated this happened throughout the day during meals or between meals. Resident 13 further stated it had been a while since speech therapy evaluated her/him. On both occasions Resident 13 was observed to be alone in her/his room with candy and multiple drinks with straws on the bedside table within reach. A review of Swallowing Tasks Sheets indicated staff were to monitor coughing or choking during meals or when swallowing and staff were to document yes or no. Documentation was completed three times daily by CNA staff. Resident 13 had a progression of choking or coughing incidents as follows: *August 2022: 13 occasions *September 2022: 10 occasions *October 2022: 13 occasions *November 2022: 26 occasions (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The last speech therapy evaluation was completed on 2/24/22. On 12/1/22 at 1:12 PM Staff 11 (SLP) stated he was unaware of Resident 13's 26 choking/coughing episodes from 11/1/22 through 11/29/22 and this could result in Resident 13 aspirating on food or fluids. The facility identified two additional residents at risk for aspiration risk not including Resident 13. On 12/1/22 at 3:10 PM Staff 1 (Administrator), Staff 2 (Regional RN), and Staff 30 (Regional RN) stated they were not made aware of swallowing concerns for Resident 13 and were notified of immediate jeopardy (IJ) situation. Refer to F689, example 1. BURNS Resident 13 An 8/4/22 Progress Note Late Entry [for 8/3/22] indicated Resident was drinking coffee last night at around 8:00 PM and spilled coffee on [her/his] chest. CNA reported to LN [licensed nurse]. The coffee caused a first-degree burn on resident's chest. Slight separation of skin. The 8/4/22 11:46 PM Nursing Progress Note indicated Resident 13 had a large burn on her/his chest and right groin. Chest burn is approximately 12 [cm] x 6 [cm] and starts at her/his chest and down to her/his right breast. Resident's chest is open, red around the edges and the area that goes down to her/his right breast is blistered. The area on her/his right groin is approximately 4 [cm] x 2 [cm] and is blistered. Resident had no bandage on and no treatment orders. Dressing applied and placed call to on-call physician, awaiting call back for treatment orders. There was no indication the physician was notified the day the burn occurred on 8/3/22 and no indication treatments were implemented except for triple antibiotic ointment on 8/2/33. No skin assessments were found in Resident 13's clinical record to indicate the burns on her/his chest and groin were monitored and measured. On 12/5/22 at 1:29 PM Staff 2 (Regional RN) acknowledged Resident 13 received a burn and notes indicated there was separation of skin indicating at least a second- degree burn. Staff 2 further acknowledged the physician was not notified of the burn on 8/3/22 when it occurred, and treatments were not put in place on 8/3/22 by Staff 19 (LPN). Staff 2 further acknowledged the physician and Witness 2 were not notified until 8/4/22 and there was no indication besides the progress note on 8/4/22 that the area was measured and assessed and there was no ongoing monitoring for the burn. Refer to F689, example 2. FALLS Resident 23 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5/26/22 Fall Investigation completed by Staff 19, indicated that evening, Resident 23 had a witnessed fall by an unidentified CNA. The resident stated, my mattress is slippery and moves when I roll to the side, that is probably what caused it. A summary completed by Staff 4 (Former DNS) indicated Resident 23 had a witnessed fall from bed with a CNA present and sustained no serious injuries. The investigation did not include witness statements, a mental status or pain level assessment, predisposing factors, the root cause of the fall, interventions to prevent further falls, and if the care plan was updated. The investigation was dated as completed on 6/2/22 (seven days after the incident). On 11/28/22 at 11:18 AM Resident 23 stated she/he believed in April 2022, the resident's mattress was not on the bed properly and the resident fell off. On 11/30/22 at 10:26 AM Staff 4 (Former DNS) was unable to state the root cause of Resident 23's fall. Staff 4 confirmed the investigation was not thorough. Staff 4 confirmed there were no new interventions put in place to prevent further falls and stated the expectation was to complete investigations within five days. Refer to F689, example 3. Resident 15 A 11/19/22 Fall Investigation indicated Resident 15 was found in between the bed and the bathroom. The investigation did not include information related to potential factors contributing to the fall such as environmental, physiological, situational or when the resident was last visualized and received cares. The investigation did not include the name of the witness or a witness statement. On 12/2/22 at 12:18 PM Staff 2 (Regional RN) stated a book with witness statements was kept but was unable to be located. Staff 2 confirmed the 11/19/22 fall investigation for Resident 15 was not thorough. Refer to F689, example 3. MEDICATIONS Safe Disposal of Controlled Medication On 12/2/22 at 8:19 AM Staff 23 (CMA) was observed to remove buprenorphine 15 mcg patch (opioid pain patch) from Resident 19 using gloves. Staff 23 then turned the gloves inside out, folding the patch inside of the gloves, and disposed of it in the trash located on the side of the medication cart in the hallway. On 12/2/22 at 8:20 AM Staff 23 stated the used pain patch should probably go in the sharps container, but since it's cloth I don't put it in there. On 12/5/22 at 1:41 PM Staff 2 (Regional RN) stated the expectation was for staff to use the Drug Buster for disposal of pain patches and a witness was needed to destroy the patch. Staff 2 stated opioid pain patches were not to be discarded into the trash. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 A. The resident had an order for Depakote (antiepileptic medication used to treat bipolar disorder) 250 MG to be administered daily. The 10/2022 and 11/2022 MARs indicated Depakote was not administered on 10/25/22 through 11/3/22. On 12/2/22 at 12:18 PM Staff 2 (DNS) stated the expectation was for staff to contact the pharmacy and physician for a delay in medications being delivered and acknowledged Resident 1 did not receive Depakote for the identified 12 days. B. Resident 1 had a 10/26/22 order to administer Novolog Flexpen Solution (diabetic medication) 100 Unit/ML every six hours and a 10/24/22 order to administer Glucose Gel 40% PRN for hypoglycemia for CBGs less than 70. The 11/2022 MAR indicated Resident 1 experienced CBGs outside parameters on the following dates: * 11/19/22: CBG 64. * 11/23/22: CBG 62. There was no indication glucose gel was administered on 11/19/22 or 11/23/22. On 12/2/22 at 2:40 PM Staff 2 (Regional RN) stated physician orders were expected to be followed and acknowledged glucose gel was not administered for Resident 1 on the identified dates the resident experienced low CBGs. C. Resident 1 had a 10/25/22 Physician Order for Insulin Glargine Solution 100 Unit/ML (diabetic medication) to be administered 23 units 10:00 AM and 20 units at 9:00 PM. On 11/28/22 at 10:39 AM Resident 1 stated yesterday on 11/27/22 she/he did not receive a dose of her/his insulin. The 11/2022 TAR indicated Insulin Glargine was not administered on 11/27/22 at 10:00 AM and the reason was marked as 9 referring the reader to read the resident's progress notes. A 11/27/22 at 4:13 PM Nursing Progress Note completed by Staff 27 (RN) indicated the insulin was not administered because reported given previous shift. There was no indication in Resident 1's medical record the 10:00 AM dose of Insulin was administered on 11/27/22. On 12/2/22 at 9:20 AM Staff 27 stated Resident 1 was not administered Insulin Glargine at 10:00 AM because she was informed the previous nurse had already administered the injection. Staff 27 was unable to recall the previous nurse and acknowledged there was no indication the insulin was administered to Resident 1 for the 10:00 AM dose on 11/27/22. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/22 at 12:18 PM Staff 2 (Regional RN) stated the expectation was for medications to be administered and documented per physician orders. D. The 11/14/22 physician order indicated Resident 1 was NPO (nothing by mouth) and was to receive Glucose Gel 40% 15 grams via PEG tube (feeding tube placed in the stomach) as needed for CBG less than 70. On 12/2/22 at 3:30 PM Staff 2 (Regional RN) was asked if the Glucose Gel 40% 15 grams was available for Resident 1. Staff 2 was unable to locate the Glucose Gel 40% 15 grams and acknowledged the facility did not have it available. On 12/2/22 at 3:45 PM Staff 2 stated the original order for Glucose Gel was concerning for Resident 1 due to the consistency and Staff 2 contacted the physician and received the new order for Glucagon Emergency Kit. Refer to F755. E. An 11/21/22 Pharmacy Recommendation indicated a PRN order of a psychotropic drug was limited to 14 days and the PRN order may be extended if a rationale was provided by the physician. The recommendation was left blank and not signed by the physician. On 12/2/22 at 12:39 PM Staff 2 (Regional RN) stated the expectation was for physicians to follow-up with pharmacy recommendations within 72 hours. Staff 2 confirmed there was no written rationale for the continued use of PRN diazepam past 14 days. Refer to F758. F. Resident 1 had a 10/24/22 order for trazodone (depression medication) 100 MG to be administered once daily at 6 PM and a 10/25/22 order for trazadone 50 MG to be administered at 10 AM to treat anxiety and insomnia. An 11/21/22 Pharmacy Recommendation indicated Resident 1 was on an atypical dosing regimen of trazodone since at least 8/2020. The pharmacist indicated trazodone was more traditionally used for insomnia and dosed once daily. The pharmacist asked for physician clarification. There was no evidence the physician clarified the pharmacy recommendation. On 12/2/22 at 12:39 PM Staff 2 (Regional RN) stated the expectation was for physicians to follow-up with pharmacy recommendations within 72 hours. Staff 2 confirmed there was no physician clarification regarding the pharmacy recommendation related to the resident's two scheduled doses of trazodone. Refer to F580, F684, F756, and F758. Resident 23 A 5/9/22 Physician Order indicated the resident was to receive Fycompa (anticonvulsant medication) 6 mg at bedtime to prevent seizures. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/2022 MAR indicated Resident 23 did not receive Fycompa from 11/13/22 through 11/15/22 (three days) and the reason was marked OO indicating the medication was on order from the pharmacy and not available in the facility. There was no evidence in Resident 23's medical record to indicate further follow-up related to the Fycompa not being administered for three days. On 12/2/22 at 12:23 PM Staff 2 (Regional RN) stated there was a system issue related to not reordering medications timely and acknowledged Resident 23 did not receive her/his Fycompa for the identified dates, which placed the resident at risk for seizures. Refer to F760, example 1. Resident 7 A Physician Order dated 6/10/21 indicated Resident 7 was to receive rivaroxaban (blood thinner) once a day for prophylaxis (disease prevention). Review of the 11/2022 MAR indicated the rivaroxaban was On Order from Pharmacy on 11/10/22, 11/26/22 and 11/27/22. Review of Resident 7's medical record revealed no indication the resident received the rivaroxaban as ordered. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 7 did not receive the rivaroxaban as ordered for the identified dates. Refer to F760, example 2. Resident 13 The 11/23/22 Physician Order indicated Resident 13 was to receive phenazopyridine (pain reliever for urinary tract symptoms) 95 mg 2 tabs PO TID for dysuria (painful urination). The 11/2022 and 12/2022 MARs indicated Resident 13 missed one or more doses of phenazopyridine due to it not being available on the following dates: -11/23/22 through 11/30/22. -12/1/22 through 12/2/22. On 12/2/22 at 8:04 AM Staff 23 (CMA) was observed to administer morning medications to Resident 13 which did not include phenazopyridine. Staff 23 stated the phenazopyridine was not available and had not been available since November 26, 2022. On 12/5/22 at 2:16 PM Staff 2 (Regional RN) acknowledged Resident 13 missed the phenazopyridine due to it not being available on the identified 10 days and the process for receiving medications from the pharmacy needed to be more streamlined. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F755, example 2. Resident 17 Physician Orders indicated Resident 17 was to receive the following medications: - baclofen three times a day for muscle spasms dated 4/21/21. - Lyrica three times a day related to paraplegia and pain dated 12/8/21. Review of the 10/2022 MAR indicated the following medications On Order from Pharmacy: - baclofen on 10/8/22, 10/9/22 and 10/10/22. - Lyrica on 10/28/22 (one dose) and 10/31/22 (one dose). On 11/28/22 at 9:29 AM Resident 17 stated there was an issue with her/his medications running out. Resident 17 stated in the last few months she/he had run out of several medications including pain medications. Resident 17 stated it was difficult to be without her/his medications as the resident needed her/his medications to control pain. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 17 did not receive her/his baclofen and Lyrica as ordered for the identified dates. Refer to F697. STAFFING The facility had a census of 32 residents and the facility provided a list of acuity needs for residents including: *Residents who required two-person staff transfers: 4. *Residents who required a mechanical lift for transfers: 4. *Residents who were occasionally or frequently incontinent of bowel and/or bladder: 30. *Residents who had behavioral healthcare needs: 18. The facility's Safety Alarms and Call Light Response Audit indicated the goal was for five minutes or less for call bells. The audit reviewed from 10/3/22 through 10/28/22 revealed 10 instances when call lights took over 20 minutes to be answered by staff. Interviews conducted 11/28/22 through 12/5/22 with facility staff and residents indicated staffing concerns. On 12/5/22 at 3:23 PM Staff 1 (Administrator) acknowledged the identified staffing concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F725. Resident 181 On 11/28/22 at 1:39 PM Witness 3 (Complainant) stated it did not matter what shift it was, call light times were long, and Resident 181 came close to soiling her/himself. Review of the facility's Call Light Response Audit from 10/13/22 through 10/18/22 indicated on 10/14/22 it took staff 20 minutes to answer Resident 181's call light. The audit indicated the resident called the facility and was assisted with toileting by the unnamed auditor. On 11/29/22 at 11:58 AM Staff 4 (Former DNS) stated the staff were to answer call lights within 15 minutes. Staff 4 confirmed the long call light time for Resident 118 on the identified date. Refer to F725, example 2.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to ensure Staff 4 (Former DNS) and Staff 19 (LPN) adhered to professional standards regarding accidents. This resulted in delayed treatment for Resident 13's second-degree burn. Findings include: o First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling. o Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin. Resident 13 admitted to the facility on [DATE] with diagnoses including stroke and hemiparesis (weakness to one side of the body). An 8/4/22 Progress Note Late Entry [for 8/3/22] indicated Resident was drinking coffee last night at around 8:00 PM and spilled coffee on [her/his] chest. CNA reported to LN [licensed nurse]. The coffee caused a first-degree burn on resident's chest. Slight separation of skin. The 8/4/22 11:46 PM Nursing Progress Note indicated Resident 13 had a large burn on her/his chest and right groin. Chest burn is approximately 12 [cm] x 6 [cm] and starts at her/his chest and down to her/his right breast. Resident's chest is open, red around the edges and the area that goes down to her/his right breast is blistered. The area on her/his right groin is approximately 4 [cm] x 2 [cm] and is blistered. Resident had no bandage on and no treatment orders. Dressing applied and placed call to on-call physician, awaiting call back for treatment orders. The 8/3/22 at 8:00 PM Non-Pressure Skin Investigation completed by Staff 19 (LPN) indicated the following: -Resident was drinking coffee last night at around 8:00 PM and spilled coffee on her/his chest. CNA reported to licensed nurse. The coffee caused a first-degree burn on the resident's chest. Slight separation of skin. Resident unable to give a description. Assessment was done on wound. Slight separation of skin. No complaints of pain at the time of accident. Licensed nurse was able to get triple antibiotic ointment on skin and cover with bandage. CNAs were able to get an ice pack to relieve some discomfort. -Family member notified on 8/4/22 at 6:30 PM. (Noted by Staff 19). -The assessment did not include pain level, mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and witness list or witness statements. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The 8/10/22 Summary completed by Staff 4 (Former DNS) indicated Resident 13 has a history hemiplegia, dysphagia, and strokes. The resident had a diagnosis of pneumonia related to MRSA. Resident 13 was drinking hot coffee and spilled it on her/himself and had burn noted to right chest and on right groin. This seemed to be related to the cups the resident prefers to re-use from her/his favorite coffee place in the community her/his husband gets coffee from. Family notified this cup is not appropriate for re-use and to ensure that coffee is under 150 F when serving to resident to avoid burns. Hot beverage evaluation completed with resident and family and physician notified. Treatment put in place to open area. Resident is not voicing complaints of pain at this time. Abuse and neglect ruled out and resident and family educated on a new coffee mug for her/him to drink hot beverages from to avoid future issue with hot beverages. Temperature protocol utilized to ensure residents do not burn themselves. (Noted by Staff 4 (DNS)). -In an 8/16/22 interview with Staff 18 (Nursing Assistant) completed by Staff 4 (Former DNS), Staff 18 stated: I measured the temperature and it was not more than it should have been. I checked the temperature before and it was within range. I got the coffee from the break room. It went into the cups that Resident 13 always had, it's like a paper cup and at that time it felt like I could hold it in my hand easily like it wasn't too hot. I told her/him that if it feels too hot to wait a minute. I don't remember off the top of my head the temperature because it was several days ago, I just referenced the paper that was right there hanging in the break room. There was no indication a Hot Beverage Safety Evaluation was completed for the resident until 8/10/22. The safety evaluation indicated the following: -Resident demonstrated impaired orientation in one or more of the following areas: person, place or time; -The resident had a diagnosis of neuropathy or other neurological impairment; -The resident had a history of injury related to independent consumption of hot beverages. The 8/17/22 provider note indicated staff reported resident has chest burn from spilling coffee on [her/his] chest while eating. On examination, medial blister on chest .Active medical problems second degree burn. Assessment and plan second degree burn apply Silvadene cream cover with dressing, leave open to air . Diagnoses: Burn of second degree of chest wall, initial encounter. There was no indication the physician was notified the day the burn occurred on 8/3/22 and no indication treatments were implemented except for triple antibiotic ointment on 8/2/33. The 8/2022 TARs indicated the following treatment was started on 8/5/22: *Clean wound with wound cleanser, apply Silvadene cream cover with dressing and leave blisters open to air. The TARs indicated Resident 13 did not receive treatments on 8/9/22, 8/19/22 or 8/22/22. No skin assessments were found in Resident 13's clinical record to indicate the burns on her/his chest and groin were monitored and measured. The care plan was not updated to reflect the history of the burn or interventions to prevent further burns until 11/29/22. (continued on next page)

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	385224	A. Building B. Wing	12/05/2022

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/28/22 at 10:31 AM Witness 2 (Family Member) stated approximately three months prior staff used the Keurig machine (single-cup coffee maker) in the staff break room, the (coffee) was boiling hot and Resident 13 spilled it all over [her/himself]. Witness 2 further stated Resident 13 did not go to the hospital afterward and felt the facility down-played it. Witness 2 stated the resident had a blister on her/his chest and on the crevice of her/his leg. Witness 2 and Resident 13 showed the surveyor the area on the upper right chest just below the collar bone that was healed, but a red area remained and was approximately the size of the palm of a hand. On 11/29/22 at 1:34 PM Staff 19 (LPN) stated he worked on 8/3/22 and Resident 13 was drinking a lot of coffee that day and Staff 18 (Nursing Assistant) made the coffee too hot and Resident 13 spilled it on her/himself because she/he was not able to hold the cup. Staff 19 stated Staff 20 (CNA) reported it to him and the resident was kind of painful and had discomfort on [her/his] chest and right thigh from the burn. Staff 19 stated the area was red and she/he was given a cold pack and medication. Staff 19 stated Resident 13 had a history of spilling stuff. Staff 19 stated he was unsure if he notified the physician of the burn and acknowledged he did not put treatments in place on 8/3/22. Staff 19 stated he did not get witness statements the evening the burn occurred (8/3/22). On 11/30/22 at 12:08 PM Staff 29 (LPN) stated when she came to work on 8/4/22 a CMA or CNA asked her to look at the burn on Resident 13 and she/he had an open area at the top of her/his chest, maybe where a blister was that opened, and it blistered as it went down to her/his right breast and also had a burn on her/his groin area, she stated the areas were not covered, it looked awful and it made me sick. Staff 29 stated Resident 13 complained that she/he was hurting. Staff 29 stated the burn was not a first degree burn because it was open and blistered and was more than red, at least a second degree burn. Staff 29 stated there were no treatment orders in place on 8/4/22 and she called the physician to get orders. She further stated the physician ordered to clean the area and apply Silvadene (burn cream). Staff 29 stated the burn happened the evening shift on 8/3/22 and she worked night shift on 8/4/22, and the resident went over a day without treatment. Staff 29 stated she made the DNS, the physician and the family aware of Resident 13's burn. She confirmed the progress note that indicated the measurements of 12 x 6 on the chest and 4 x 2 on the groin were measured in centimeters. Staff 29 stated the area was slow to heal and staff stopped giving Resident 13 coffee that was too hot and the facility got rid of the Keurig machine. On 11/30/22 at 12:26 PM and 12:42 PM Staff 4 (Former DNS) stated Resident 13 received a burn on her/his chest and leg from hot coffee spilling on her/him on 8/3/22 and he was made aware of it the next day. Staff 4 acknowledged the physician was not notified of the burn until the evening of 8/4/22, there was no indication the care plan was updated, no indication the area was treated or measured until 8/4/22, and he did not start the investigation until 8/10/22, seven days after the burn occurred. Staff 4 further acknowledged he did not interview Staff 18 (Nursing Assistant) until 8/16/22, 13 days after the burn occurred. Staff 4 acknowledged there were no witness statements for the investigation. Staff 4 further acknowledged the hot beverage assessment was not completed until 8/10/22, seven days after the burn occurred, and there was no prior hot beverage assessment. Staff 4 further acknowledged there was no ongoing monitoring or measuring of Resident 13's burn after it occurred. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/22 at 7:59 AM Staff 20 (CNA) stated she worked on 8/3/22 when the resident got the burn and Staff 18 (Nursing Assistant) got a cup of coffee from the Keurig machine and placed it in a disposable cup once she arrived to the resident's room, she further stated there was a thermometer in the break room but not everyone used it. Staff 20 stated Resident 13 required a cup with a lid and a straw due to both of her/his arms being shaky. Staff 20 further stated Resident 13 pushed her/his call light and when Staff 20 responded the resident told Staff 20 the lid was not all the way closed on the coffee cup and the resident spilled it on her/himself. Staff 20 stated Resident 13 reported getting a burn on her/his right side of the chest and groin and when she checked the burned area it was really bad, the skin was peeling off, it didn't blister it just peeled off. Staff 20 stated she reported the burn to Staff 19 (LPN). On 12/5/22 at 1:29 PM Staff 2 (Regional RN) acknowledged Resident 13 received a burn and notes indicated there was separation of skin indicating at least a second- degree burn. Staff 2 further acknowledged the physician was not notified of the burn on 8/3/22 when it occurred, and treatments were not put in place on 8/3/22 by Staff 19 (LPN). Staff 2 further acknowledged the physician and Witness 2 were not notified until 8/4/22 and there was no indication besides the progress note on 8/4/22 that the area was measured and assessed and there was no ongoing monitoring for the burn. Staff 2 acknowledged the Non-Pressure Skin Investigation was not thorough and did not include the resident's level of pain, mental status, injuries reported post incident, predisposing environmental factors, predisposing physiological factors, predisposing situation factors or witness statements. Staff 2 further acknowledged Staff 4 (DNS) indicated he knew about the burn on 8/4/22 and did not start the investigation until 8/10/22, 7 days after the burn occurred and did not interview Staff 18 (Nursing Assistant) until 8/16/22, 13 days after the burn occurred. Staff 2 further acknowledged the care plan was not updated to reflect the need for Resident 13 to have non-disposable cups, the history of the burn or the appropriate temperature for hot liquids. Staff 2 acknowledged the TARs indicated Resident 13 did not receive treatments on 8/9/22, 8/19/22 or 8/22/22. Staff 2 stated the policy was for an investigation to be completed within 72 hours.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to ensure physician orders were followed and failed to obtain labs to ensure there was no liver toxicity for 6 of 9 sampled residents (#s 1, 6, 7, 13, 17 and 26) reviewed for unnecessary medications and accidents. This placed residents at risk for adverse side effects and worsening skin conditions. Findings include: 1. Resident 1 admitted to the facility in 2020 with diagnoses including bipolar disorder and Type 1 diabetes. The 11/3/22 Significant Change MDS indicated the resident was cognitively intact. a. The 10/25/22 physician order indicated Resident 1 had an order for Depakote (antiepileptic medication used to treat bipolar disorder) 250 MG to be administered daily. The 10/2022 and 11/2022 MARs indicated Depakote was not administered from 10/25/22 through 11/3/22, except on two occasions when it was marked off as administered by Staff 25 (LPN) on 10/29/22 and 11/2/22. The reason the medication was not administered was marked as OO, indicating the medication was on order from the pharmacy and not available in the facility. On 12/2/22 at 11:52 AM Staff 25 (LPN) acknowledged she marked off the Depakote as administered on 10/25/22 and 11/3/22 but stated she did not administer the medication as it was on order from the pharmacy. Staff 25 stated she checked off the medication as administered on accident. On 12/2/22 at 12:18 PM Staff 2 (DNS) stated the expectation was for staff to contact the pharmacy and physician right away for a delay in medications being delivered and acknowledged Resident 1 did not receive Depakote for the identified 12 days. b. Resident 1 had a 10/26/22 order to administer Novolog Flexpen Solution (diabetic medication) 100 Unit/ML every six hours and a 10/24/22 order to administer Glucose Gel 40% prn for hypoglycemia for CBGs less than 70. The 11/2022 MAR indicated Resident 1 experienced CBGs outside parameters on the following dates: * 11/19/22: CBG 64. * 11/23/22: CBG 62. There was no indication glucose gel was administered on 11/19/22 or 11/23/22. On 12/2/22 at 2:40 PM Staff 2 (Regional RN) stated physician orders were expected to be followed and acknowledged glucose gel was not administered for Resident 1 on the identified dates when the resident experienced low CBGs. c. Resident 1 had a 10/25/22 Physician Order for Insulin Glargine Solution 100 Unit/ML (diabetic medication) 23 units 10:00 AM and 20 units at 9:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/28/22 at 10:39 AM Resident 1 stated yesterday on 11/27/22 she/he did not receive a dose of insulin and had high blood sugars the next morning. Resident 1 stated she/he was unsure why the insulin was not administered. The 11/2022 TAR indicated Insulin Glargine was not administered on 11/27/22 at 10:00 AM and the reason was marked as 9 referring the reader to read the resident's progress notes. A 11/27/22 at 4:13 PM Nursing Progress Note completed by Staff 27 (RN) indicated the insulin was not administered because reported given previous shift. There was no indication in Resident 1's medical record the 10:00 AM dose of Insulin was administered on 11/27/22. On 12/2/22 at 9:20 AM Staff 27 stated Resident 1 was not administered Insulin Glargine at 10:00 AM because she was informed the previous nurse had already administered the injection. Staff 27 was unable to recall the previous nurse and acknowledged there was no indication the insulin was administered to Resident 1 for the 10:00 AM dose on 11/27/22. On 12/2/22 at 12:18 PM Staff 2 (Regional RN) stated the expectation was for medications to be administered and documented per physician orders. d. The 10/7/11 Federal Drug Administration Highlights of Prescribing Information revealed Depakote had life threatening adverse reactions including hepatotocity (liver toxicity), fetal risk and pancreatitis. Section 2 indicated Depakote should be taken daily as prescribed. Section 5 indicated patients should be tested for liver function prior to and at frequent levels during the first six months of administration [to monitor for liver toxicity]. A 10/25/22 Physician Order indicated the Resident 1 received Depakote (antiepileptic medication used to treat bipolar disorder) 250 mg daily. The 10/2022 and 11/2022 MARs indicated Depakote was not administered on 10/25/22 through 11/3/22. From 11/4/22 through 12/2/22 Depakote was administered as ordered. There was no evidence in Resident 1's medical record to indicate labs were completed for Depakote prior to 12/2/22 to ensure there was no liver toxicity. On 12/2/22 at 11:42 AM Staff 2 (Regional RN) stated Resident 1's labs for Depakote levels were not completed. 34702 2. Resident 13 admitted to the facility on [DATE] with diagnoses including stroke and hemiparesis (weakness to one side of the body). An 8/4/22 Progress Note Late Entry [for 8/3/22] completed by Staff 19 (LPN) indicated Resident was drinking coffee last night at around 8:00 PM and spilled coffee on [her/his] chest. CNA reported to LN [licensed nurse]. The coffee caused a first-degree burn on resident's chest. Slight separation of skin. The progress note was created by Staff 19. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/2022 Skin Integrity Policy indicated the following: 2. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for the first four weeks, and then quarterly, or whenever there was a change in condition. 6. a. Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with skin impairment in Nurses' Notes and on the Weekly Wound Evaluation. 6. b. Notifies the Physician and if needed, obtains a Treatment Order and documents on the Treatment Administration Record (TAR) after order is implemented. 7. If a skin impairment was noted after admission (in addition to the above steps) the licensed nurse: 7. a. Initiates Alert Charting. 7. c. Completes Braden Scale and evaluated current interventions for necessary revision. The 8/4/22 11:46 PM Nursing Progress Note indicated Resident 13 had a large burn on her/his chest and right groin. Chest burn was approximately 12 [cm] x 6 [cm] and started at her/his chest and down to her/his right breast. Resident's chest was open, red around the edges and the area that goes down to her/his right breast was blistered. The area on her/his right groin was approximately 4 [cm] x 2 [cm] and was blistered. Resident had no bandage on and no treatment orders. Dressing applied and placed call to on-call physician, awaiting call back for treatment orders. The 8/2022 TARs indicated the following treatment was started on 8/5/22: *Clean wound with wound cleanser, apply Silvadene cream (burn cream) cover with dressing and leave blisters open to air daily. The TARs indicated Resident 13 did not receive treatments on 8/9/22, 8/19/22 or 8/22/22. The 8/17/22 Provider Note indicated staff reported the resident had chest burn from spilling coffee on [her/his] chest while eating. On examination, medial blister on chest .Active medical problems: second degree burn. Assessment and plan: second degree burn apply Silvadene cream cover with dressing, leave open to air .Diagnoses: Burn of second degree of chest wall, initial encounter. No skin assessments were found in Resident 13's clinical record to indicate the burns on her/his chest and groin were monitored and measured. On 12/5/22 at 1:29 PM Staff 2 (Regional RN) acknowledged Resident 13 received a burn and notes indicated there was separation of skin indicating at least a second- degree burn. Staff 2 further acknowledged the physician was not notified of the burn on 8/3/22 when it occurred, and treatments were not put in place the day they occurred. Staff 2 further acknowledged there was no indication besides the progress note on 8/4/22 that the area was measured and assessed and no ongoing monitoring was completed for Resident 13's burns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 26 was readmitted to the facility on [DATE] with diagnoses including enterococcal bacteremia (bacterial infection). The 11/17/22 Physician Orders indicated Resident 26 was to receive ampicillin (anti-infective medication) intravenously every four hours. The 11/2022 MARs indicated Resident 26 did not receive ampicillin on the following occasions: *11/18/22 at 5:00 PM; *11/24/22 at 1:00 PM; *11/25/22 at 1:00 AM, 5:00 AM and 5:00 PM; *11/27/22 at 5:00 AM. On 12/5/22 at 1:27 PM Staff 2 (Regional RN) acknowledged Resident 26 did not receive ampicillin as ordered on the identified dates. 34324 4. Resident 6 admitted to the facility in 2022 with diagnoses including cellulitis of the neck. A physician order dated 11/17/22 indicated Resident 6 was to receive Augmentin (antibiotic) two times a day for 14 days (end date of 12/1/22) related to cellulitis of the neck. Review of the 11/2022 MAR indicated the Augmentin was On Order from Pharmacy on 11/17/22 (PM), 11/18/22 and 11/19/22 (AM). The MAR indicated Resident 6 received her/his first dose on 11/19/22 (PM). Review of Resident 6's medical record revealed no indication the resident received the Augmentin. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 6 did not receive the Augmentin as ordered on the identified dates. 5. Resident 7 admitted to the facility in 2020 with diagnoses including diabetes, edema and dementia. A Physician Order dated 6/10/21 indicated Resident 7 was to receive rivaroxaban (blood thinner) once a day for prophylaxis (disease prevention). Review the 11/2022 MAR indicated the rivaroxaban was On Order from Pharmacy on 11/10/22, 11/26/22 and 11/27/22. Review of Resident 7's medical record revealed no indication the physician was notified of the missed medication. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 7 did not receive the rivaroxaban as ordered for the identified date and the physician was not notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident 17 admitted to the facility in 2019 with diagnoses including paraplegia and chronic pain. The 6/10/21 Care Plan indicated Resident 17 was cognitively intact. Physician Orders indicated Resident 17 was to receive the following medications: - baclofen three times a day for muscle spasms, dated 4/21/21. - Lyrica three times a day related to paraplegia and pain, dated 12/8/21. Review of the 10/2022 MAR indicated the following medications were On Order from Pharmacy: - baclofen on 10/8/22, 10/9/22 and 10/10/22. - Lyrica on 10/28/22 (one dose) and 10/31/22 (one dose). On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 17 did not receive her/his baclofen and Lyrica as ordered for the identified dates and the physician was not notified of the missed doses.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 1. Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assessed and interventions were implemented to prevent aspiration for 1 of 3 sampled residents (#13) reviewed for accidents. This failure resulted in an immediate jeopardy situation. This placed residents at risk for aspiration and death. Findings include: Resident 13 admitted to the facility on [DATE] with diagnoses including pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, dysphagia (difficulty swallowing), stroke and hemiparesis (weakness to one side of the body). The 1/25/22 Speech Therapy Evaluation indicated Resident 13 had the following history: -2/13/19 diagnoses included pneumonitis due to inhalation of food and vomit. -1/25/22 diagnoses included dysphagia. The 12/13/21 Care Plan indicated Resident 13 had chewing problems, swallowing problems and required limited to extensive assistance of one staff or family at meals. The 9/20/22 Quarterly MDS indicated Resident 13 was cognitively intact and required extensive assistance for eating. The 10/6/22 progress note indicated Resident 13 was assisted during meals and had a possible swallowing disorder. On 11/30/22 at 9:17 AM and 12/1/22 at 2:57 PM Resident 13 stated she/he sometimes coughed after drinking coffee and after eating food. Resident 13 stated this happened throughout the day during meals or between meals. Resident 13 further stated it had been a while since speech therapy evaluated her/him. On both occasions Resident 13 was observed to be alone in her/his room with candy and multiple drinks with straws on the bedside table within reach. A review of Swallowing Tasks Sheets indicated staff were to monitor coughing or choking during meals or when swallowing and staff were to document yes or no. Documentation was completed three times daily by CNA staff. Resident 13 had a progression of choking or coughing incidents as follows: *August 2022: 13 occasions *September 2022: 10 occasions *October 2022: 13 occasions *November 2022: 26 occasions (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No evidence was found to indicate a speech therapy evaluation was completed for Resident 13 since 2/24/22. The Therapy Quarterly Screen had a section for swallowing concerns (yes/no). The form dated 6/21/22 and 9/21/22 indicated no under swallowing concerns. There was no documented evidence a full speech therapy evaluation was completed for Resident 13 on 6/21/22 or 9/21/22. Interviews on 11/30/22 revealed the following: -9:43 AM Staff 31 (CNA) stated Resident 13 needed assistance with meals and eats candy and drinks fluids independently. Staff 31 further stated she observed the resident coughing during meals and believed the resident had a signed a risks versus benefits form for the current diet texture. -9:47 AM Staff 5 (LPN) stated Resident 13 received assistance with meals and the resident had candy at the bedside. Staff 5 stated she was not aware of Resident 13 choking or coughing at meals as no staff reported incidents to her. -9:55 AM Staff 6 (CNA) stated Resident 13 coughed after drinking fluids and she documented it on the task sheets. Staff 6 stated she did not report coughing incidents to nursing staff. -3:47 PM Staff 7 (CNA) stated he assisted Resident 13 with meals, and he observed her/him choking and coughing after taking bites of food. Staff 13 stated the resident was able to drink fluids independently and had snacks at the bedside. -4:05 PM Staff 8 (CNA) stated he observed Resident 13 to both cough and choke when eating and drinking. He stated he documented the incidents but did not report them to nursing staff unless it looks like [she/he] aspirated or it's not cleared up. He stated there was nothing rising to the level of reporting to the nurse. Staff 8 stated he saw empty candy wrappers in the resident's room but did not observed the resident to eat the candy on her/his bedside table. -4:31 PM Staff 9 (CNA) stated she observed Resident 13 cough during meals maybe a minute at most and the incidents happened while eating. Staff 9 stated Resident 13 had a hard time swallowing sometimes. Staff 9 further stated she did not see the resident eat candy, but she/he was able to consume candy independently if she/he wanted to. -4:45 PM Staff 10 (CNA) stated he observed Resident 13 cough and choke with every meal. He stated the resident coughed and aspirat[ed] kind of, more when drinking fluids. Staff 10 further stated he documented the incidents and I would think nursing staff is aware of it. On 12/1/22 at 10:40 AM Witness 2 (Family Member) stated Resident 13 liked having chocolates on her/his bedside table. Witness 2 stated Resident 13 had pneumonia from aspirating on 11/22/21 and he often observed the resident eating and drinking and she/he mainly had problems when swallowing drinks and coughed like she/he swallows it wrong and aspirating. Witness 2 stated that is how Resident 13 ended up in the hospital last time, she/he swallowed and went into lungs. On 12/1/22 at 9:59 AM Staff 2 (Regional RN) stated no Risks Versus Benefits form was completed for Resident 13's diet as the resident was on the diet that speech therapy recommended. (continued on next page)

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	385224	A. Building B. Wing	12/05/2022

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Windsor Health & Rehabilitation Center	820 Cottage Street NE Salem, OR 97301

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/1/22 at 11:19 AM Staff 12 (Therapy Director) stated she was unaware of the 26 documented choking/coughing episodes from 11/1/22 through 11/29/22 for Resident 13. Staff 12 stated the expectation was for staff to report incidents of choking/coughing to therapy after a resident had 1-2 coughing/choking episodes so speech therapy could evaluate the resident and possibly alter their diet as soon as possible for safety. On 12/1/22 at 1:12 PM Staff 11 (SLP) stated he was unaware of Resident 13's 26 choking/coughing episodes from 11/1/22 through 11/29/22, which placed Resident 13 at risk for aspirating on food or fluids. The facility identified two additional residents at risk for aspiration risk not including Resident 13. On 12/1/22 at 3:10 PM Staff 1 (Administrator), Staff 2 (Regional RN), and Staff 30 (Regional RN) was notified of an immediate jeopardy (IJ) situation and were provided a copy of the IJ template related to the facility's failure to ensure residents were adequately assessed regarding meals. An immediate plan of correction (POC) was requested. On 12/1/22 at 6:43 PM the facility submitted a final POC. The IJ Removal Plan included: -Provider contacted for speech therapy orders for Resident 13 to evaluate and treat as indicated; -Facility staff spoke with Resident 13 regarding downgrading diet for safety pending speech therapy evaluation and treatment. Resident refused to accept a modified texture diet even on a temporary basis and a risk vs. benefit was completed with resident and provider was informed; -Resident 13 assessed for signs/symptoms of aspiration; none noted; -Candy and drinks were removed from bedside 12/1/22; Resident 13 was not agreeable to this and demanded the return of [her/his] items so [she/he] could have them as [she/he] chooses. Risk vs. benefit done with resident including the risk vs. benefits of consuming candy or drinks on [her/his] own in [her/his] room; -Call was placed to Resident 13's spouse and discussed the risk vs. benefit completed; -Resident 13's care plan reviewed and updated regarding episodes of coughing/choking that have a noted increase in frequency per documentation; -Resident 13 was placed on alert monitoring x 72 hours for signs/symptoms of aspiration; -Staff education was started regarding the need to communicate noted changes in coughing/choking episodes observed during meals. Staff would sign in-service attendance sheet acknowledging they understand the information provided and have had the opportunity to ask questions. Staff list would be cross-referenced to validate that all staff receive education. This would include current agency staff; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-New hires and agency staff new to the center would be educated on the need to communicate noted changes in coughing/choking episodes observed during meals. Staff would sign in-service sheet acknowledging they received and understood the education provided; -Residents in center were reviewed for any changes/increases in coughing/choking episodes during meals by reviewing POC documentation for the past 90 days; -Residents in center would be reviewed to identify those with an active diagnosis of dysphagia and/or aspiration pneumonia as an active problem upon admission to ensure care plan accurately identifies the risk factors and interventions for noted residents; -Speech therapy to evaluate residents in center to determine aspiration risk; -Residents in center at risk for aspiration reviewed to ensure care plan is current and accurately identifies the resident's risk factors and interventions. On 12/2/22 the immediacy was removed based on implementation of the IJ removal plan. 2. Based on interview and record review it was determined the facility failed to ensure residents were free from accident hazards for 1 of 3 sampled residents (#13) reviewed for accidents. This failure resulted in Resident 13 spilling coffee on her/himself and receiving a second-degree burn. This placed residents at risk for accidents. Findings include: o First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling. o Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin. Resident 13 admitted to the facility on [DATE] with diagnoses including stroke and hemiparesis (weakness to one side of the body). The 9/20/22 Quarterly MDS indicated Resident 13 was cognitively intact. The 12/13/21 Care Plan indicated Resident 13 required limited to extensive assistance of one staff or family at meals. An 8/4/22 Progress Note Late Entry [for 8/3/22] indicated Resident was drinking coffee last night at around 8:00 PM and spilled coffee on [her/his] chest. CNA reported to LN [licensed nurse]. The coffee caused a first-degree burn on resident's chest. Slight separation of skin. The 8/4/22 11:46 PM Nursing Progress Note indicated Resident 13 had a large burn on her/his chest and right groin. Chest burn is approximately 12 [cm] x 6 [cm] and starts at her/his chest and down to her/his right breast. Resident's chest is open, red around the edges and the area that goes down to her/his right breast is blistered. The area on her/his right groin is approximately 4 [cm] x 2 [cm] and is blistered. Resident had no bandage on and no treatment orders. Dressing applied and placed call to on-call physician, awaiting call back for treatment orders. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 8/3/22 at 8:00 PM Non-Pressure Skin Investigation completed by Staff 19 (LPN) indicated the following: -Resident was drinking coffee last night at around 8:00 PM and spilled coffee on her/his chest. CNA reported to licensed nurse. The coffee caused a first-degree burn on the resident's chest. Slight separation of skin. Resident unable to give a description. Assessment was done on wound. Slight separation of skin. No complaints of pain at the time of accident. Licensed nurse was able to get triple antibiotic ointment on skin and cover with bandage. CNAs were able to get an ice pack to relieve some discomfort. -Family member notified on 8/4/22 at 6:30 PM. (Noted by Staff 19). -The assessment did not include pain level, mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and witness list or witness statements. -The 8/10/22 Summary completed by Staff 4 (Former DNS) indicated Resident 13 had a history hemiplegia, dysphagia, and strokes. The resident had a diagnosis of pneumonia related to MRSA. Resident 13 was drinking hot coffee and spilled it on her/himself and had burn noted to right chest and on right groin. This seemed to be related to the cups the resident prefers to re-use from her/his favorite coffee place in the community her/his husband gets coffee from. Family notified this cup is not appropriate for re-use and to ensure that coffee is under 150 F when serving to resident to avoid burns. Hot beverage evaluation completed with resident and family and physician notified. Treatment put in place to open area. Resident is not voicing complaints of pain at this time. Abuse and neglect ruled out and resident and family educated on a new coffee mug for her/him to drink hot beverages from to avoid future issue with hot beverages. Temperature protocol utilized to ensure residents do not burn themselves [Noted by Staff 4 (DNS)]. -In an 8/16/22 interview with Staff 18 (Nursing Assistant) completed by Staff 4 (Former DNS), Staff 18 stated: I measured the temperature and it was not more than it should have been. I checked the temperature before and it was within range. I got the coffee from the break room. It went into the cups that Resident 13 always had, it's like a paper cup and at that time it felt like I could hold it in my hand easily like it wasn't too hot. I told her/him that if it feels too hot to wait a minute. I don't remember off the top of my head the temperature because it was several days ago, I just referenced the paper that was right there hanging in the break room. There was no indication a Hot Beverage Safety Evaluation was completed for the resident until 8/10/22. The safety evaluation indicated the following: -Resident demonstrated impaired orientation in one or more of the following areas: person, place or time; -The resident had a diagnosis of neuropathy or other neurological impairment; -The resident had a history of injury related to independent consumption of hot beverages. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 8/17/22 provider note indicated staff reported resident has chest burn from spilling coffee on [her/his] chest while eating. On examination, medial blister on chest .Active medical problems second degree burn. Assessment and plan second degree burn apply Silvadene cream cover with dressing, leave open to air . Diagnoses: Burn of second degree of chest wall, initial encounter. There was no indication the physician was notified the day the burn occurred on 8/3/22 and no indication treatments were implemented except for triple antibiotic ointment on 8/2/33. On 11/28/22 at 10:31 AM Witness 2 (Family Member) stated approximately three months prior staff used the single-cup coffee maker in the staff break room, the coffee was boiling hot and Resident 13 spilled it all over [her/himself]. Witness 2 further stated Resident 13 did not go to the hospital afterward and felt the facility down-played it. Witness 2 stated the resident had a blister on her/his chest and on the crevice of her/his leg. Witness 2 and Resident 13 showed the surveyor the area on the upper right chest just below the collar bone that was healed, but a red area remained and was approximately the size of the palm of a hand. On 11/29/22 at 1:34 PM Staff 19 (LPN) stated he worked on 8/3/22 and Resident 13 was drinking a lot of coffee that day. Staff 18 (Nursing Assistant) made the coffee too hot and Resident 13 spilled it on her/himself because she/he was not able to hold the cup. Staff 19 stated Staff 20 (CNA) reported it to him and the resident was kind of painful and had discomfort on [her/his] chest and right thigh from the burn. Staff 19 stated the area was red and she/he was given a cold pack and medication. Staff 19 stated Resident 13 had a history of spilling stuff. Staff 19 stated he was unsure if he notified the physician of the burn and acknowledged he did not put treatments in place on 8/3/22. Staff 19 stated he did not get witness statements the evening the burn occurred (8/3/22). On 11/30/22 at 12:08 PM Staff 29 (LPN) stated when she came to work on 8/4/22 a CMA or CNA asked her to look at the burn on Resident 13 and she/he had an open area at the top of her/his chest, maybe where a blister was that opened, and it blistered as it went down to her/his right breast and also had a burn on her/his groin area, she stated the areas were not covered, it looked awful and it made me sick. Staff 29 stated Resident 13 complained that she/he was hurting. Staff 29 stated the burn was not a first degree burn because it was open and blistered and was more than red, at least a second degree burn. Staff 29 stated there were no treatment orders in place on 8/4/22 and she called the physician to get orders. She further stated the physician ordered to clean the area and apply Silvadene (burn cream). Staff 29 stated the burn happened the evening shift on 8/3/22 and she worked night shift on 8/4/22, and the resident went over a day without treatment. Staff 29 stated she made the DNS, the physician and the family aware of Resident 13's burn. She confirmed the progress note that indicated the measurements of 12 x 6 on the chest and 4 x 2 on the groin were measured in centimeters. Staff 29 stated the area was slow to heal and staff stopped giving Resident 13 coffee that was too hot and the facility got rid of the single-cup coffee machine. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/30/22 at 12:26 PM and 12:42 PM Staff 4 (Former DNS) stated Resident 13 received a burn on her/his chest and leg from hot coffee spilling on her/him on 8/3/22 and he was made aware of it the next day. Staff 4 acknowledged the physician was not notified of the burn until the evening of 8/4/22, there was no indication the care plan was updated, no indication the area was treated or measured until 8/4/22, and he did not start the investigation until 8/10/22, seven days after the burn occurred. Staff 4 further acknowledged he did not interview Staff 18 (Nursing Assistant) until 8/16/22, 13 days after the burn occurred. Staff 4 acknowledged there were no witness statements for the investigation. Staff 4 further acknowledged the hot beverage assessment was not completed until 8/10/22, seven days after the burn occurred, and there was no prior hot beverage assessment. Staff 4 further acknowledged there was no ongoing monitoring or measuring of Resident 13's burn after it occurred. On 12/5/22 at 7:59 AM Staff 20 (CNA) stated she worked on 8/3/22 when the resident was burned and Staff 18 (Nursing Assistant) got a cup of coffee from the single-cup coffee maker and placed it in a disposable cup once she arrived to the resident's room. She further stated there was a thermometer in the break room but not everyone used it. Staff 20 stated Resident 13 required a cup with a lid and a straw due to both of her/his arms being shaky. Staff 20 further stated Resident 13 pushed her/his call light and when Staff 20 responded the resident told her the lid was not all the way closed on the coffee cup and the resident spilled it on her/himself. Staff 20 stated Resident 13 reported being burned on her/his right side of the chest and groin and when she checked the burn, it was really bad, the skin was peeling off, it didn't blister it just peeled off. Staff 20 stated she reported the burn to Staff 19 (LPN). On 12/5/22 at 1:29 PM Staff 2 (Regional RN) acknowledged Resident 13 received a burn and notes indicated there was separation of skin indicating at least a second- degree burn. Staff 2 further acknowledged the physician was not notified of the burn on 8/3/22 when it occurred, and treatments were not put in place on 8/3/22 by Staff 19 (LPN). Staff 2 further acknowledged the physician and Witness 2 were not notified until 8/4/22 and there was no indication besides the progress note on 8/4/22 that the area was measured and assessed and there was no ongoing monitoring for the burn. Staff 2 acknowledged the Non-Pressure Skin Investigation was not thorough and did not include the resident's level of pain, mental status, injuries reported post incident, predisposing environmental factors, predisposing physiological factors, predisposing situation factors or witness statements. Staff 2 further acknowledged Staff 4 (DNS) indicated he knew about the burn on 8/4/22 and did not start the investigation until 8/10/22, 7 days after the burn occurred and did not interview Staff 18 (Nursing Assistant) until 8/16/22, 13 days after the burn occurred . Staff 2 further acknowledged the care plan was not updated to reflect the need for Resident 13 to have non-disposable cups, the history of the burn or the appropriate temperature for hot liquids. Staff 2 acknowledged the TARs indicated Resident 13 did not receive treatments on 8/9/22, 8/19/22 or 8/22/22. Staff 2 stated the policy was for an investigation to be completed within 72 hours. 3. Based on observation, interview and record review it was determined the facility failed to ensure pain patches were properly disposed of for 1 of 1 observation during medication administration. This placed residents at risk for accidents. Findings include: The 8/2018 Disposal of Medications and Medication-Related Supplies indicated the following: C. Options to dispose of non-flushable prescription drugs include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2d. Use a commercially available pharmaceutical disposal system that meets Federal and State disposal requirement (e.g. Rx Destroyer or Drug Buster) for proper disposal. On 12/2/22 at 8:19 AM Staff 23 (CMA) was observed to remove buprenorphine 15 mcg patch (opioid pain patch) from Resident 19 using gloves. Staff 23 then turned the gloves inside out, folding the patch inside of the gloves, and disposed of it in the trash located on the side of the medication cart in the hallway. On 12/2/22 at 8:20 AM Staff 23 stated the used pain patch should probably go in the sharps container, but since it's cloth I don't put it in there. On 12/5/22 at 1:41 PM Staff 2 (Regional RN) stated the expectation was for staff to use the Drug Buster for disposal of pain patches and a witness was needed to destroy the patch. Staff 2 stated opioid pain patches were not to be discarded into the trash. 40767 4. Based on interview and record review it was determined the facility failed to complete a thorough fall investigations for 2 of 3 sampled residents (#s 15 and 23) reviewed for accidents. This placed residents at risk for injury. Findings include: a. Resident 23 admitted to the facility in 2021 with diagnoses including a stroke and seizures. The 4/29/22 Quarterly MDS indicated the resident was cognitively intact and had no history of falls since admission. A 5/26/22 Nursing Progress Note completed by Staff 19 (LPN) indicated the resident fell and there was no injury noted or complaints of pain voiced. There was no further information provided in the note. A 5/26/22 Fall Investigation completed by Staff 19, indicated that evening, Resident 23 had a witnessed fall by an unidentified CNA. The note indicated the resident fell off the edge of the bed and sustained a skin tear to the right knee and prn pain medication was administered. The resident was assessed with no major pain. The resident stated, my mattress is slippery and moves when I roll to the side, that is probably what caused it. A summary completed by Staff 4 (Former DNS) indicated Resident 23 had a witnessed fall from bed with a CNA present and sustained no serious injuries. Fall precautions were noted to be in place. Abuse and neglect were ruled out. The investigation did not include witness statements, a mental status or pain level assessment, predisposing factors, the root cause of the fall, interventions to prevent further falls, and if the care plan was updated. The investigation was dated as completed on 6/2/22 (seven days after the incident). The Fall Care Plan, last updated 6/23/22, indicated the resident was at moderate risk for falls due to gait/balance issues, incontinence, deconditioning, and chronic fatigue. There was no indication the resident experienced a fall. The care plan indicated Resident 23 required one staff member to turn and reposition in bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/28/22 at 11:18 AM Resident 23 stated she/he believed in April 2022, the resident's mattress was not on the bed properly and the resident fell off. Resident 23 was unable to provide more details. On 11/29/22 at 1:30 PM Staff 19 (LPN) stated a former CNA (Staff 26) informed him Resident 23 fell off the bed during a brief change. Staff 19 did not believe the resident sustained any injuries. Staff 19 was unable to recall further information but stated he did not believe a witness statement was completed by Staff 26. On 11/29/22 at 2:05 PM Staff 2 (Regional RN) confirmed there were no witness statements for Resident 23's 5/26/22 fall and Staff 26 no longer worked at the facility. Attempts were made to contact Staff 26 on 11/29/22 at 2:13 PM and 11/30/22 at 11:50 AM but the phone number was out of service. On 11/30/22 at 10:26 AM Staff 4 (Former DNS) was unable to state the root cause of Resident 23's fall. Staff 4 confirmed the investigation did not include a witness statement, mental status and pain assessments, what the predisposing factors were prior to the fall, and a discussion of care plan interventions. Staff 4 confirmed there were no new care plan interventions put in place to prevent further falls and stated the expectation was to complete investigations within five days, but the 5/26/22 investigation was not completed until the seventh day. 34324 b. Resident 15 admitted to the facility in 2021 with diagnoses including dementia and muscle weakness. The facility's 2016 Charting for Event Investigation Report Policy indicated investigations should include observable factors and what was reported by the person involved. The 1/26/22 Care Plan indicated Resident 15 had impaired cognitive function related to dementia with behaviors. The Care Plan indicated the resident was a high risk for falls due to confusion. A 11/19/22 Fall Investigation indicated Resident 15 was found in between the bed and the bathroom. It appeared the resident self-transferred and attempted to walk. Resident 15 was noted to have dementia and was unable to explain the fall. The investigation did not include information related to potential factors contributing to the fall such as environmental, physiological, situational or when the resident was last visualized and received cares. The investigation did not include the name of the witness or a witness statement. On 12/2/22 at 12:18 PM Staff 2 (Regional RN) stated a book with witness statements was kept but was unable to be located. Staff 2 confirmed the 11/19/22 fall investigation for Resident 15 was not thorough.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34324 Based on interview and record review it was determined the facility failed to administer pain medications as ordered for 1 of 6 sampled residents (#17) reviewed for medications. This placed residents at risk for increased pain. Findings include: Resident 17 admitted to the facility in 2019 with diagnoses including paraplegia and chronic pain. The 6/10/21 Care Plan indicated Resident 17 was cognitively intact. The Care Plan indicated Resident 17 used Lyrica related to paraplegia and chronic pain with an intervention to administer medication as ordered. Physician Orders indicated Resident 17 was to receive the following medications: - baclofen three times a day for muscle spasms dated 4/21/21. - Lyrica three times a day related to paraplegia and pain dated 12/8/21. Review of the 10/2022 MAR indicated the following medications On Order from Pharmacy: - baclofen on 10/8/22, 10/9/22 and 10/10/22. - Lyrica on 10/28/22 (one dose) and 10/31/22 (one dose). Review of Progress Notes indicated the following: - 10/8/22: Resident 17 called and spoke with the nurse. The resident asked about her/his baclofen that was to be picked up by her/his family. Staff informed the resident the medication was not on the medication cart. Staff spoke with pharmacy who stated the medication was to be delivered on the night run. - 10/27/22: Facility was waiting for Lyrica to be delivered. On 11/28/22 at 9:29 AM Resident 17 stated there was an issue with her/his medications running out. Resident 17 stated in the last few months she/he ran out of several medications including pain medications. Resident 17 stated it was difficult to be without her/his medications as the resident needed her/his medications to control pain. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 17 did not receive her/his baclofen and Lyrica as ordered for the identified dates.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34324 Based on observation, interview, and record review it was determined the facility failed to ensure adequate nursing staff to meet resident needs for 2 of 2 halls reviewed for staffing. This placed residents at risk for delayed care and unmet care needs. Findings include: 1. The facility had a census of 32 residents and the facility provided a list of acuity needs for residents including: *Residents who required two-person staff transfers: 4. *Residents who required a mechanical lift for transfers: 4. *Residents who were occasionally or frequently incontinent of bowel and/or bladder: 30. *Residents who had behavioral healthcare needs: 18. Resident Council Notes were reviewed from 9/2022 through 10/2022 and indicated the following: *9/15/22: One resident reported not getting early showers per preference and another resident reported she/he was left on the toilet during night shift because staff did not check on the resident. *10/20/22: One resident reported showers were not provided during the shower aide's absence and call lights took too long to answer with some noted improvement per one resident. The following interviews were conducted with residents: *On 11/28/22 at 10:39 AM Resident 1 stated staff always appeared busy and ran around like chickens with their head cut up. Resident 1 stated she/he at times waited up to an hour for assistance and medications were administered up to two hours late. *On 11/28/22 at 11:03 AM Resident 23 stated she/he felt staff were too busy and did not check on the resident enough, including for bowel movements and emptying her/his catheter bag. *On 11/28/22 at 11:37 AM Resident 8 stated the morning of 11/28/22 she/he waited an hour and 15 minutes to get out of bed and often waited a long time for assistance. *On 11/28/22 at 11:38 AM Resident 16 stated staffing could be an issue and at times it took 15-30 minutes for her/his call light to be answered by staff. Resident 16 stated it sometimes took awhile to have her/his brief changed and believed the facility needed more staff. *On 11/28/22 at 1:11 PM Resident 26 stated she/he previously called the front desk to get assistance from staff after waiting for her/his call light to be answered. Resident 26 stated a few times she/he waited up to an hour for assistance from staff after initiating her/his call light. (continued on next page)

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Windsor Health & Rehabilitation Center	820 Cottage Street NE Salem, OR 97301

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following interviews/observations were conducted with staff: *On 11/30/22 at 9:52 AM Staff 13 (CNA) stated there were staffing issues and there were 12-15 residents who required female only cares, which made it difficult when there were only four aides working the floor. *On 11/30/22 at 12:12 PM Staff 5 (LPN) stated she was the only nurse for 30 residents and had a CMA to help pass medications except in the afternoon. Staff 30 stated then she had to pass medications, complete CBGs, and complete treatments by herself, and was unable to take breaks due to the workload. *On 11/30/22 at 12:22 PM Staff 17 (CNA) stated there were three residents who ate in their rooms and required assistance with eating. Staff 17 stated showers were difficult to complete if a resident wanted one later in the day. Staff 17 further stated there were times it was difficult to finish tasks and help pass meal trays due to a lack of staffing. *On 12/5/22 at 11:38 AM Staff 28 (CNA) stated staffing had always been an issue due to resident acuity and stated the past two days the shower aide had to work the floor as there was not enough staff. *On 12/5/22 at 11:51 AM Staff 24 (CMA) appeared frazzled and hurried when the surveyor was reviewing the medication cart with her. *On 12/5/22 at 9:30 AM Staff 5 (LPN) was observed wandering down both halls of the facility stating Is there anyone here who can help me? Nope no one. *On 12/5/22 at 9:32 AM Staff 28 (CNA) was overheard talking to a CNA in training about how she was busy and needed help because she was supposed to complete three resident showers and three residents had appointments they needed to be ready for. The facility's Safety Alarms and Call Light Response Audit indicated the goal was for five minutes or less for call light response times. The audit reviewed from 10/3/22 through 10/28/22 revealed the following call light times: - 10/9/22 a call light time of 29 minutes. The audit indicated five call lights were already on when the audit started at 11:06 AM. - 10/10/22 a call light time of 25 minutes with a audit start time of 6:05 PM. - 10/14/22 call light times of 20 minutes, 31 minutes and 26 minutes. The audit was started at 7:15 (PM or AM was not indicated.) - 10/18/22 call light times of 33 minutes, 25 minutes and 25 minutes. The audit was started at 2:17 PM. - 10/27/22 call light times of 39 minutes and 26 minutes. The audit indicated six call lights were on when the audit started at 6:16 PM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/29/22 at 11:58 AM Staff 4 (Former DNS) stated the staff were to answer call lights within 15 minutes. On 12/5/22 at 3:23 PM Staff 1 (Administrator) acknowledged the identified staffing concerns. 2. Resident 181 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including chronic pain. A concern reported on 10/21/22 by Witness 3 (Complainant) indicated it took staff at least an hour to respond to call lights. The concern indicated Resident 181 needed assistance with toileting and the long call light times resulted in her/him being close to soiling her/himself. On 11/28/22 at 1:39 PM Witness 3 stated it did not matter what shift it was, call light times were long and Resident 181 came close to soiling her/himself. Review of the facility's Call Light Response Audit from 10/13/22 through 10/18/22 indicated on 10/14/22 it took staff 20 minutes to answer Resident 181's call light. The audit indicated the resident called the facility and was assisted with toileting by the unnamed auditor. On 11/29/22 at 11:58 AM Staff 4 (Former DNS) stated the staff were to answer call lights within 15 minutes. Staff 4 confirmed the long call light time for Resident 181 on the identified date. 40767 3. Resident 1 admitted to the facility in 2020 with diagnoses including bipolar disorder and Type 1 diabetes. The 11/3/22 Significant Change MDS indicated the resident was cognitively intact. On 11/29/22 at 10:53 AM Resident 1 was observed in her/his room with her/his call light initiated. A beeping sound was coming from the resident's enteral tube feeding machine. Resident 1 stated she/he had been waiting 15 minutes for her/his call light to be answered for staff to change the tube feeding bag. Resident 1 further stated it often occurred when the tube feeding was out and the machine would beep and some days it would beep all day long. On 11/29/22 at 10:58 AM Staff 5 (LPN) answered Resident 1's call light. Staff 5 stated she was made aware of Resident 1's tube feeding being out by checking once in a while, or the resident informed her. Staff 5 confirmed the resident waited a long time for her/his call light to be answered and stated the facility had a lot of residents with high care needs and Resident 1, as well as other residents, often waited a long time for call lights to be answered. Staff 5 further stated there were five CNAs and one nurse for 30 residents and there were not enough staff to meet resident care needs. On 12/5/22 at 3:23 PM Staff 1 (Administrator) acknowledged the identified staffing concerns.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40767 Based on interview and record review it was determined the facility failed to ensure CNA annual performance reviews were completed for 3 of 3 sampled CNA staff (#s 15, 16 and 17) reviewed for staffing. This placed residents at risk for a lack of competent staff. Findings include: Staff 15 was hired on 2/5/18, the last annual performance review was last completed on 5/17/21. Staff 16 was hired on 11/21/14, the last annual performance review was last completed 3/22/21. Staff 17 was hired on 11/27/18, the last annual performance review was completed on 6/14/21. On 11/29/22 at 1:28 PM Staff 2 (Regional RN) stated performance reviews were to be completed annually. Staff 2 confirmed the annual performance reviews for Staff 15, 16 and 17 were not completed annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on observation, interview and record review it was determine the facility failed to provide routine and emergency medications for 5 of 9 sampled residents (#s 1, 6, 7, 13 and 17) reviewed for medications and accidents. This placed residents at risk for medication related adverse consequences and hypoglycemia. Findings include: 1. Resident 1 admitted to the facility in 4/2020 with diagnoses including Type 1 diabetes. The 11/14/22 physician order indicated Resident 1 was NPO (nothing by mouth) and was to receive Glucose Gel 40% 15 grams via PEG tube (feeding tube placed in the stomach) as needed for CBG less than 70. On 12/2/22 at 3:24 Staff 25 (LPN) was asked if the Glucose Gel 40% 15 grams was available for Resident 1. Staff 25 was observed to look in the medication cart, treatment cart, the medication refrigerator and the automated medication dispensing system. Staff 25 was unable to locate the ordered medication. On 12/2/22 at 3:30 PM Staff 2 (Regional RN) was asked if the Glucose Gel 40% 15 grams was available for Resident 1. Staff 2 was unable to locate the Glucose Gel 40% 15 grams and acknowledged the facility did not have it available. On 12/2/22 at 3:45 PM Staff 2 provided a new physician order dated 12/2/22 at 3:35 PM for the following: *Discontinue Glucose Gel 40% 15 gram via PEG tube due to it being too thick for TF [tube feed]; *Glucagon Emergency Kit inject 1 mg subcutaneously PRN hypoglycemia if CBG is less than 90. On 12/2/22 at 3:45 PM Staff 2 stated the original order for Glucose Gel was concerning for Resident 1 due to the consistency and Staff 2 contacted the physician and received the new order for Glucagon Emergency Kit. 2. Resident 13 admitted to the facility on [DATE] with diagnoses including hemiparesis (weakness to one side of the body). The 11/23/22 Physician Order indicated Resident 13 was to receive phenazopyridine (pain reliever for urinary tract symptoms) 95 mg 2 tabs PO TID for dysuria (uncomfortable urination). The 11/2022 and 12/2022 MARs indicated Resident 13 missed one or more doses of phenazopyridine due to it not being available on the following dates: -11/23/22 through 11/30/22; -12/1/22 through 12/2/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/22 at 8:04 AM Staff 23 (CMA) was observed to administer morning medications to Resident 13 which did not include phenazopyridine. Staff 23 stated the phenazopyridine was not available even though the facility ordered it from the pharmacy. Staff 23 stated the medication never arrived from the pharmacy and was not available since November 26, 2022. On 12/5/22 at 2:16 PM Staff 2 (Regional RN) acknowledged Resident 13 missed the phenazopyridine due to it not being available on the identified 10 days and the process for receiving medications from the pharmacy needed to be more streamlined. 3. Resident 6 admitted to the facility in 2022 with diagnoses including cellulitis of the neck. A Physician Order dated 11/17/22 indicated Resident 6 was to receive Augmentin (antibiotic) two times a day for 14 days (end date of 12/1/22) related to cellulitis of the neck. Review of the 11/2022 MAR indicated the Augmentin was On Order from Pharmacy on 11/17/22 (PM), 11/18/22 (AM and PM) and 11/19/22 (AM). The MAR indicated Resident 6 received her/his first dose on 11/19/22 (PM). Review of Resident 6's medical record revealed no indication the medication was administered as ordered. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed the Augmentin was not available on the identified dates. 4. Resident 7 admitted to the facility in 2020 with diagnoses including diabetes, edema and dementia. A Physician Order dated 6/10/21 indicated Resident 7 was to receive rivaroxaban (blood thinner) once a day for prophylaxis (disease prevention). Review the 11/2022 MAR indicated the rivaroxaban was On Order from Pharmacy on 11/10/22, 11/26/22 and 11/27/22. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed the rivaroxaban was not available on the identified dates. 5. Resident 17 admitted to the facility in 2019 with diagnoses including paraplegia and chronic pain. The 6/10/21 Care Plan indicated Resident 17 was cognitively intact. Physician Orders indicated Resident 17 was to receive the following medications: - baclofen three times a day for muscle spasms, dated 4/21/21. - Lyrica three times a day related to paraplegia and pain, dated 12/8/21. Review of the 10/2022 MAR indicated the following medications were On Order from Pharmacy: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- baclofen on 10/8/22, 10/9/22 and 10/10/22. - Lyrica on 10/28/22 (one dose) and 10/31/22 (one dose). On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed the baclofen and Lyrica was not available for the identified dates.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40767 Based on interview and record review it was determined the facility failed to ensure irregularities identified by the pharmacist were acted upon for 1 of 5 sampled residents (#1) reviewed for medications. This placed residents at risk for unnecessary medications and adverse side effects. Findings include: Resident 1 admitted to the facility in 2020 with diagnoses including bipolar disorder, anxiety, and major depressive disorder (MDD). A. A 10/28/22 Physician Order indicated Resident 1 received diazepam (anti-anxiety medication) PRN for anxiety. An 11/21/22 Pharmacy Recommendation indicated a PRN order of a psychotropic drug was limited to 14 days and the PRN order may be extended if a rationale was provided by the physician. The recommendation was left blank and not signed by the physician. On 12/2/22 at 12:39 PM Staff 2 (Regional RN) stated the expectation was for physicians to follow-up with pharmacy recommendations within 72 hours. Staff 2 confirmed the facility did not act upon the pharmacist recommendation to obtain a rationale for the continued use of diaepam. B. A 10/24/22 Physician Order indicated Resident 1 received trazodone (antidepressant) 100 MG to be administered once daily at 6 PM and a 10/25/22 order for trazadone 50 MG to be administered at 10 AM to treat anxiety and insomnia. An 11/21/22 Pharmacy Recommendation indicated Resident 1 was on an atypical dosing regimen of trazodone since at least 8/2020. The pharmacist indicated trazodone was more traditionally used for insomnia and dosed once daily. The pharmacist asked for physician clarification. There was no evidence the facility acted upon the pharmacy recommendation. On 12/2/22 at 12:39 PM Staff 2 (Regional RN) stated the expectation was for the facility to follow-up with pharmacy recommendations within 72 hours. Staff 2 confirmed there was no clarification was obtained related to the resident's two scheduled doses of trazodone.

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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. 40767 Based on interview and record review it was determined the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless deemed appropriate by the attending physician for 1 of 6 sampled residents (#1) reviewed for medications. This placed residents at risk for receiving unnecessary medications and adverse side effects. Findings include: Resident 1 admitted to the facility in 2020 with diagnoses including bipolar disorder, anxiety, and major depressive disorder (MDD). Resident 1's 10/28/22 Physician Order indicated the resident received diazepam (anti-anxiety medication) PRN for anxiety. A 11/21/22 pharmacy recommendation indicated a PRN order of a psychotropic drug was limited to 14 days and the PRN order may be extended if a rationale was provided by the physician. No evidence was in Resident 1's record to indicate a rationale for the continued use of the resident's diazepam past 14 days. The 11/2022 MAR indicated the resident received PRN diazepam 14 days after the order date on four occasions (11/12/22, 11/13/22, 11/16/22, and 11/28/22). On 12/2/22 at 12:39 PM Staff 2 (Regional RN)) confirmed there was no written rationale for the continued use of PRN diazepam past 14 days.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40767 Based on interview and record review it was determined the facility failed to administer seizure and anticoagulant medication according to a physician orders for 2 of 6 sampled residents (#s 7 and 23) reviewed for medications. This placed residents at risk for seizures and blood clots. Findings include: 1. Resident 23 admitted to the facility in 2021 with diagnoses including a stroke and seizures. The 4/22/22 Anticonvulsant Care Plan indicated the resident received three anticonvulsant medications to prevent seizures. Interventions included to administer anticonvulsant medications as ordered by the physician and to monitor side effects and effectiveness. A 5/9/22 Physician Order indicated the resident was to receive Fycompa (anticonvulsant medication) 6 mg at bedtime to prevent seizures. The 11/2022 MAR indicated Resident 23 did not receive Fycompa from 11/13/22 through 11/15/22 (three days) and the reason was marked OO indicating the medication was on order from the pharmacy and not available in the facility. There was no evidence in Resident 23's medical record to indicate further follow-up related to the Fycompa not being administered for three days. On 12/2/22 at 12:23 PM Staff 2 (Regional RN) stated there was a system issue related to not reordering medications timely and acknowledged Resident 23 did not receive her/his Fycompa for the identified dates, which placed the resident at risk for seizures. 34324 2. Resident 7 admitted to the facility in 2020 with diagnoses including diabetes, edema, and dementia. A Physician Order dated 6/10/21 indicated Resident 7 was to receive rivaroxaban (blood thinner) once a day for prophylaxis (disease prevention). Review the 11/2022 MAR indicated the rivaroxaban was On Order from Pharmacy on 11/10/22, 11/26/22 and 11/27/22. Review of Resident 7's medical record revealed no indication the resident received the rivaroxaban as ordered. On 11/30/22 at 1:26 PM Staff 2 (Regional RN) confirmed Resident 7 did not receive the rivaroxaban as ordered for the identified dates.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42271 Based on observation, interview and record review it was determined the facility failed to properly store vaccines at appropriate temperatures for 1 of 1 medication refrigerators which contained COVID-19 and Influenza vaccinations. This placed the residents at risk for ineffective vaccinations. Findings include: According to the CDC Vaccine Storage and Handling Toolkit, updated 4/12/22: *Proper vaccine storage and handling are important factors in preventing and eradicating many common vaccine-preventable diseases. Failure to store and handle vaccines properly can reduce vaccine potency, resulting in inadequate immune responses in patients and poor protection against disease. According to the current CDC Storage and Handling of Immunobiologics: *Vaccines, including COVID-19 and Influenza should be stored between 36 and 46 degrees Fahrenheit. The facility's 8/2018 PharMerica Medication Storage Policy indicated: -The facility should maintain a temperature log for the refrigerator in the storage area to record temperatures. -The facility should check the refrigerator in which vaccines are stored, at least two times a day and document temperatures on a temperature log. On 12/5/22 at 10:21 AM the medication refrigerator was observed to contain vaccinations for COVID-19 and Influenza for administration to residents. The refrigerator temperature was noted to be 36 degrees Fahrenheit. On 12/5/22 at 11:06 AM Staff 3 (Infection Preventionist) stated the refrigerator temperatures should be checked twice a day but was unable to locate the temperature log for the refrigerator. On 12/5/22 at 1:41 PM Staff 2 (DNS, Regional RN) stated she was unable to locate the temperature logs for the vaccine refrigerator and confirmed the temperatures for the refrigerator needed to be logged twice daily to ensure vaccine efficacy.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 40767 Based on observation, interview and record review it was determined the facility failed to ensure dental services were provided timely for 1 of 1 sampled resident (#23) reviewed for dental services. This placed residents at risk for a lack of oral hygiene. Findings include: Resident 23 admitted to the facility in 2021 with diagnoses including a stroke and muscle weakness. A 4/25/22 Progress Note indicated the resident participated in a care conference and requested to see a dentist for teeth cleaning, but Staff 22 (Social Services) was informed by the dentist office that the resident needed an identification (ID) card first for insurance purposes before scheduling. Since the resident lost her/his ID card, the card needed to be replaced before scheduling an appointment. Staff 22 attempted to assist Resident 23 with an ID card replacement but was unsuccessful due to the a lack of additional documentation. Staff 22 assisted the resident with requesting paperwork for a replacement Social Security card. The note indicated once the Social Security card was replaced, the ID card would be replaced, and then a dental appointment would be scheduled. The 9/20/22 Annual MDS indicated the resident was cognitively intact and had no dental issues. There was no evidence in Resident 23's medical record to indicate the resident received dental services after the 4/25/22 request was made. The 9/20/22 Annual MDS indicated the resident was cognitively intact and had no dental issues. On 11/30/22 at 10:39 AM Staff 22 (Social Services) stated the facility was in the process of working with the resident's caseworker to obtain guardianship and assist the resident with obtaining a Social Security card. Staff 22 did not hear from the caseworker since 9/2022. Staff 22 stated there were no facility or contracted dentists to visit residents and the facility usually referred residents out and arranged transportation. On 11/30/22 at 10:58 AM Staff 2 (Regional RN) stated she was unsure why the resident was not able to see a dentist despite not having an ID card.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40767 Based on observation, interview and record review it was determined the facility failed to ensure food was prepared for individual resident needs for 1 of 2 sampled residents (#23) reviewed for ADLs. This placed residents at risk for a lack of nutrition. Findings include: Resident 23 admitted to the facility in 2021 with diagnoses including a stroke and muscle weakness. The 9/20/22 Annual MDS indicated the resident was cognitively intact, was independent with eating, and required set up help only. The 9/2022 ADL CAA indicated Resident 23 had a recent infection and weakness. The resident's ADL Care Plan, last updated 4/22/22, indicated the resident was independent with meals. The care plan did not indicate the resident required her/his meat to be cut up prior to serving. On 11/28/22 at 11:09 AM Resident 23 stated she/he requested staff to cut her/his meat because the resident was unable to due to her/his left-hand weakness. Resident 23 stated unless she/he reminded staff the meat was not cut up. On 11/29/22 at 12:12 PM Resident 23's meal tray was observed with uncut meat. The resident confirmed she/he received uncut meat on her/his tray and stated she/he forgot to request staff assistance. Resident 23 was observed to initiate her/his call light to request assistance. The resident was observed attempting to cut up her/his meat but was unsuccessful. On 11/30/22 at 9:56 AM Staff 13 (CNA) stated she worked with Resident 23 often and the resident needed staff assistance to cut her/his meat but it was likely that other aides were not aware as the information was not on the resident's care plan. Staff 13 further stated half of the time the resident remembered to request staff assistance with cutting up her/his meat but otherwise if staff did not cut up the resident's meat the resident covered her/his head and refused to eat. Staff 13 stated she was unaware Resident 23 needed her/his meat cut up until she asked why the resident was covering her/his face one day and the resident informed her that another CNA always helped the resident cut up her/his meat. On 11/30/22 at 10:34 AM Staff 21 (Resident Care Manager) stated the expectation was for staff to inform her or administrative staff of changes to residents' ADLs so the resident could be assessed and the care plan updated. Staff 21 was unaware Resident 23 requested to have her/his meat cut up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385224	A. Building B. Wing	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Health & Rehabilitation Center	820 Cottage 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 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. 40767 Based on interview and record review it was determined the facility's QAA failed to systemically identify and correct deficiencies in the areas of accidents and medication administration. This placed residents at risk for injury and adverse consequences. Findings include: 1. The facility failed to ensure residents were free from accidents/hazards for 1 of 3 sampled residents (#13) reviewed for accidents. This resulted in Resident 13 sustaining a second-degree burn to her/his and chest and groin. Findings include: On 12/5/22 at 3:31 PM Staff 1 (Administrator) stated she was aware of Resident 13's burn incident but the identified concern was not brought to QAA for review. Refer to F689. 2. The facility failed to administer medications per physician orders, notify the physician for missed administrations, have routine and emergency medications available, and ensure safe disposal of medications for 6 of 6 sampled residents reviewed for medications. This placed residents at risk for adverse consequences. Findings include: On 12/5/22 at 3:31 PM Staff 1 (Administrator) stated she was not aware of the identified concerns related to medication and concerns were not brought to QAA for review. Refer to F684, F755, F758, and F760.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	Provide and implement an infection prevention and control program. 40767 Based on observation and interview it was determined the facility failed to ensure proper infection control practices were in place related to catheter use for 1 of 1 sampled resident (#27) reviewed for catheter care. This placed residents at risk for infection. Findings include: Resident 27 admitted to the facility in 2022 with diagnoses including a UTI and acute urinary retention. On 11/30/22 at 12:06 PM an observation was made of Resident 27 in her/his bed with a catheter bag in place. The resident's bed was in the lowest position and the catheter bag was observed to be touching the floor. On 11/30/22 at 12:07 PM Staff 5 (LPN) stated Resident 27's bed was in the lowest position due to the resident being a fall risk. Staff 5 confirmed Resident 27's catheter bag was touching the floor. Staff 5 stated she was unsure if the facility had anything to put the catheter bag in to keep it from touching the floor. On 11/30/22 at 12:25 PM Staff 2 (Regional RN) confirmed Resident 27's catheter bag was not supposed to touch the floor even when the bed was in the lowest position.