STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385015	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Gresham Nursing & Rehabilitation Center	5905 SE Powell Valley Rd Gresham, OR 97080

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 3 sampled resident (#98) reviewed for ADLs. This placed residents at risk for lack of personal hygiene. Findings include:Resident 98 was admitted to the facility in 7/2025 with diagnoses including congestive heart failure and anxiety. Resident 98's Significant Change MDS dated [DATE] indicated the resident was dependent on staff for personal hygiene and grooming. Resident 98 was observed on 9/15/25 at 10:45 AM, 9/16/25 at 8:50 AM and on 9/18/25 at 8:40 AM with a significant amount of visible facial hair. On 9/15/25 at 11:00 AM Resident 98 stated she/he did not want to have facial hair and would like staff to take care of her/his facial hair. Resident 98 stated she/he relied on staff to shave unwanted facial hair. On 9/18/25 at 8:43 AM, Staff 27 (CNA) stated her morning routine included reviewing the shower schedule for residents assigned to her each day, which included shaving residents. Staff 27 indicated she did not routinely assess or offer shaving assistance to resident with facial hair but waited for residents to request to be shaved. On 9/18/25 at 8:47 AM, Staff 24 (CNA) stated he obtained information to care for Resident 98 from the Kardex (bedside care plan) and acknowledged Resident 98 had a noticeable amount of facial hair. On 9/18/25 at 8:53 AM, Staff 9 (LPN) stated the facility's process for shaving residents was to complete shaving on their scheduled shower days. Staff 9 acknowledged she had noticed Resident 98's facial hair and stated she/he should have been care planned for her/his shaving needs. On 9/18/25 at 10:27 AM Staff 2 (DNS) stated it was her expectation for Resident 98 to have her/his shaving preferences followed.

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 2 of 3 sampled residents (#s 49 and 68) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include: The facility's revised 10/2022 Trauma Informed Care Policy procedure was to screen residents upon admission for trauma-informed care needs which included identifications of triggers and history of trauma. Staff were directed to utilize family/friends/responsible parties for history, triggers and interventions. Interventions for care planning were expected to include triggers for trauma. 1.Resident 68 was admitted to the facility in 3/2025 with a diagnosis including PTSD (Post Traumatic Stress Disorder). Resident 68's 3/28/25 admission MDS assessed her/him as cognitively intact, with a diagnosis including PTSD. On 9/15/25 at 12:00 PM Resident 68 acknowledged her/his diagnosis of PTSD and stated yelling may trigger a negative response for her/him. No evidence was found in Resident 68's clinical record to indicate an assessment of the resident's trauma triggers were completed or a care plan was developed to address the resident's potential for re-traumatization. On 9/17/25 at 1:00 PM Staff 11 (LPN) did not state any triggers for Resident 68. On 9/18/25 at 11:13 AM Staff 3 (Social Services Director) acknowledged Resident 48 did not have potential triggers identified for her/his trauma diagnoses. Staff 3 did not assess, or care plan interventions related to Resident 68's triggers. On 9/18/25 at 12:50 PM Staff 15 (CNA) and at 12:57 PM Staff 16 (CNA) were unaware if Resident 68 had any triggers related to her/his PTSD. On 9/19/25 at 2:18 PM Staff 1 (Administrator) confirmed he expected facility staff to assess all residents for trauma informed care at admission and triggers were to be identified and care planned to decrease the potential for re-traumatization. 2. Resident 49 was admitted to the facility in 8/2025 with diagnoses including PTSD (Post Traumatic Stress Disorder. Resident 49's 9/11/25 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 49's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/25 at 1:35 PM Resident 49 stated she/he had a diagnosis of PTSD. Resident 49 stated the facility had not asked her/him about any history of trauma or potential triggers. On 9/17/25 at 12:32 PM Staff 25 (CNA) stated she was unaware Resident 49 had PTSD because it was not listed on her/his Kardex (bedside care plan). Staff 25 further stated she did not know if Resident 49 had any specific triggers related to PTSD. On 9/17/25 at 12:59 PM Staff 9 (LPN) stated there were no specific triggers listed on Resident 49's care plan. Staff 9 stated the care plan was not resident-specific and it should have been. On 9/17/25 at 1:42 PM Staff 3 (Social Services Director) acknowledged the omission of Resident 49's potential triggers from the care plan was an oversight. Staff 3 stated she was aware of the resident's diagnosis of PTSD but did not ensure the specific triggers were identified or incorporated into the care plan. On 9/17/25 at 2:35 PM Staff 2 (DNS) stated Resident 49 should have been assessed upon admission for her/his diagnosis of PTSD, including identification of her/his potential triggers.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to follow physician orders for blood pressure medications for 1 of 5 sampled residents (#6) reviewed for unnecessary medications. This placed residents at risk for adverse side effects to blood pressure medications. Findings include:Resident 6 was admitted to the facility in 2012 with diagnoses including hypertension (high blood pressure).A review of physician orders revealed a 2/6/25 order for Metoprolol Succinate ER (a medication used to treat hypertension) with directions to hold if the blood pressure was below 100/60 or the heart rate was below 60 beats per minute and a 7/12/25 order for Prazosin HCL (a medication used to treat hypertension) with directions to hold if the blood pressure was below 100/60.A review of the 9/2025 MAR revealed on 9/18/25 Resident 6's blood pressure was 106/54 and her/his Metoprolol Succinate ER was documented as given by Staff 20 (CMA).On 9/18/25 at 12:39 PM, Staff 20 stated she had given Resident 6 Metoprolol Succinate ER during the morning pass. Staff 20 acknowledged Resident 6's blood pressure was 106/54 and the Metoprolol should have been held.A review of the 9/2025 MAR revealed Prazosin was documented as given by Staff 19 (CMA) with the following blood pressures: On 9/5/25, 122/56 On 9/10/25, 110/56 On 9/12/25, 106/56 On 9/14/25, 132/56A review of the 8/2025 MAR Revealed Metoprolol Succinate ER was documented as given by Staff 19 with the following blood pressures: 8/3/25, 104/56 8/31/25, 122/56A review of the 8/2025 MAR revealed Prazosin was documented as given by Staff 19 with the following blood pressures. 8/7/25, 138/56 8/8/25, 118/56 8/10/25, 118/56 8/12/25, 112/56 8/17/25, 116/56 8/27/25, 110/56On 9/18/25 at 2:16 PM, Staff 19 stated when she held a medication, she would put a note into the progress notes indicating why the medication was held. Staff 19 acknowledged the above blood pressures and stated, some days I probably held the medications and some days I didn't.A review of Resident 6's Progress Notes revealed no indication Metoprolol Succinate ER or Prazosin was held on the above dates.On 9/19/25 at 10:20 AM, Staff 2 (DNS) stated staff were expected to follow physician's orders and hold blood pressure medications when indicated based on the physician order. Staff 2 acknowledged on the above dates, Resident 6's blood pressures were below the ordered parameters for giving the medications and stated the medications should have been held.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review it was determined the facility failed to ensure medications were not expired for 2 of 8 medication storage areas. This placed residents at risk for decreased medication efficiency. Findings include:On 9/18/25 at 8:41 AM, an observation was made in the 300-hall medication cart with Staff 21 (CMA). An open bottle of calcium citrate plus vitamin D was observed in the medication cart with an expiration of 8/2025.On 9/18/25 at 8:52 AM, Staff 22 (LPN Resident Care Manager) acknowledged the expired bottle of calcium citrate plus vitamin D and stated medications were to be discarded when expired.On 9/18/2025 at 10:04 AM, Medication Storage room [ROOM NUMBER] was observed with Staff 26 (Infection Preventionist), the following expired medication were observed: Major Bisacodyl Suppositories with an expiration of 4/2025. Good Sense Hemorrhoidal Suppositories with an expiration of 11/2024. Antifungal cream with an expiration of 11/2024. Hydrogel with an expiration of 10/2024. Instant toothache oral pain relief gel with an expiration of 6/2025.On 9/18/2025 at 10:04, Staff 26 acknowledged the expired medications and stated he was not auditing the over-the-counter medications for expiration dates, but I suppose I should beOn 9/19/2025 at 10:26 AM, Staff 2 (DNS) acknowledged the expired medications and stated medications in the supply rooms and medication carts are expected to be discarded when expired.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review it was determined the facility failed to ensure food and beverages were labeled and stored in a manner to minimize spoilage and cross contamination for 3 of 3 unit refrigerators and 1 of 2 kitchen refrigerators reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include:Review of the US FDA 2022 Food Code indicated the following:-Food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded.-Food must be labeled with a use-by date if stored for at least 24 hours. -Time/temperature control for safety foods must be stored within refrigeration units and held at temperatures of 41 degrees F or below. The facility's Food and Safety Sanitation policy, dated 2023, revealed the following: -Perishable foods with expiration dates should be used prior to the use-by date on the package.-All time and temperature control for safety foods, including leftovers, should be labeled, covered and dated when stored. -Refrigerated food should be stored at or below 41 degrees F. 1. On 9/15/25 at 9:09 AM, a brief kitchen tour was completed and revealed the following regarding the non-produce kitchen refrigerator: -A container of meat spread was unlabeled and undated and was not marked with a use-by date. -A large pan of orange gelatin was uncovered, unlabeled and undated and was not marked with a use-by date.-A five-gallon container of yellow liquid was unlabeled and undated and was not marked with a use-by date.-A five-gallon container of orange liquid was unlabeled and undated and was not marked with a use-by date. On 9/15/25 at 9:28 AM, Staff 4 (Dietary Manager) confirmed the items identified in the non-produce kitchen refrigerator were not properly labeled and dated. 2. On 9/16/25 at 3:20 PM, the second-floor unit resident and nourishment refrigerator was reviewed and revealed the following: -A container of meat spread and a brown paper bag containing food items, marked WK, were unlabeled and undated. On 9/16/25 at 3:20 PM, Staff 23 (CMA) confirmed the items identified in the second-floor unit resident and nourishment refrigerator were not properly labeled and dated. On 9/17/25 at 8:38 AM, Staff 4 stated all food in the resident and nourishment unit refrigerators needed to be labeled, dated and discarded if expired. 3. On 9/17/25 at 8:19 AM, the Main Dining Room resident refrigerator was reviewed and revealed the following: -A 16-ounce paper cup of brown liquid was unlabeled and undated. -A partially filled bottle of Coke with initials JW was undated. -A small plastic container of light orange colored dressing was unlabeled and undated. -A pint container of an orange-colored food substance with #13 written on it was unlabeled and undated. -A black plastic take-out container with food was unlabeled and undated. -An opened 64-ounce container of vanilla coffee creamer was unlabeled and undated.-A gray striped container with food was unlabeled and undated. -A glass container of red liquid was unlabeled and undated. -A container of yogurt had a use-by date of 7/6/25. -An opened container of sour cream was undated. -A pitcher of orange liquid dated 9/13/25 had no use-by date. -An opened package of smoked salmon was undated and had no use-by date. -A plastic container of shriveled grapes dated 8/12/25 and a plastic container of mushy cantaloupe dated 8/25/25 was marked with a resident's name. -An opened strawberry parfait cup dated 9/12/25 had no used-by date. -A take-out container of Chinese food was unlabeled and undated. -A plastic container with a blue lid and one with a red lid (containing food) was unlabeled and undated. -A 56-ounce opened container of vanilla coffee creamer was unlabeled and undated. -There was no temperature monitoring log observed for this refrigerator. On 9/17/25 at 8:48 AM, Staff 4 confirmed the items identified in the Main Dining Room resident refrigerator were not properly labeled and dated and expired items were not discarded. In addition, Staff 4 stated refrigerators needed to be monitored for proper temperature control to ensure foods and liquids were being stored at 41 degrees F or less. 4. On 9/17/25 at 8:48 AM, the first-floor resident and nourishment refrigerator was reviewed and revealed the following: -Three opened containers of ice cream were unlabeled and undated. -Prepackaged cheese and meat sticks belonging to a resident were expired. -Five individual prepackaged hummus containers belonging to a resident were expired. -The last temperature monitoring log was dated July 2024. On 9/17/25 at 8:48 AM, Staff 4 confirmed the items identified in the first-floor resident and nourishment refrigerator were not properly labeled and dated and expired items were not discarded. In addition, Staff 4 stated refrigerators needed to be monitored for proper temperature control to ensure foods and liquids were being stored at 41 degrees F or less.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure infection control practices were implemented for 1 of 3 residents (#49) reviewed for catheter care. This placed residents at risk for infection. Findings include: Resident 49 was admitted to the facility in 8/2025 with diagnoses including PTSD (Post Traumatic Stress Disorder) and urine retention. Resident 49's 9/5/25 Catheter Evaluation revealed she/he required an indwelling urine catheter. On 9/15/25 at 1:41 PM, 9/17/25 at 8:40 AM and on 9/18/25 at 8:25 AM Resident 49 was observed in bed or in her/his wheelchair with her/his catheter bag and tubing in direct contact with the floor. On 9/17/25 at 8:42 AM, Staff 25 (CNA) stated Resident 49's catheter bag and tubing should not touch the floor. Staff 25 stated if she observed the catheter bag and tubing on the floor, she would pick it up.On 9/17/25 at 8:50 AM and on 9/18/25 at 8:27 AM, Staff 9 (LPN) confirmed Resident 49's catheter bag and tubing was on the floor. Staff 9 stated the bag should be kept off the floor and below the level of the bladder to prevent infection and ensure proper drainage. On 9/17/25 at 9:08 AM, Staff 2 (DNS) stated she expected Resident 49's catheter bag and tubing be kept off the floor at all times.