STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385018	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Angel Health and Rehabilitation	540 South Main Street Mount Angel, OR 97362

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 3 of 3 sampled CNA staff (#s 11, 12, 23) reviewed for sufficient and competent nurse staffing. This placed residents at risk for a lack of competent staff. Findings include: A review of personnel records on 6/5/26 indicated the following employees did not receive their annual performance evaluations: -Staff 11 (CNA), hire date was 12/2019 and a performance review was not completed.-Staff 12 (CNA), hire date was 8/2013 and a performance review was not completed.-Staff 13 (CNA), hire date was 1/2019 and a performance review was not completed. On 6/4/26 at 4:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed annual performance reviews were not completed for Staff 11, Staff 12 and Staff 13.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to properly disinfect a shared glucometer for 1 of 3 facility staff (#5) reviewed for infection control. This placed residents at risk for exposure to blood-borne pathogens. Findings include: The 12/2025 facility Glucometer Disinfection Policy indicated to disinfect after each individual patient use with EPA disinfectant wipes. A 2017 Evencare G2 glucometer Manufacturer Manual indicated, Disinfect common use glucometers with the use of approved disinfectant wipes. The glucometer was to be wiped with the disinfecting wipe and left wet for two minutes to ensure disinfection. Resident 81 was admitted to the facility in 11/2025 with diagnoses including diabetes.On 6/3/26 at 11:33 AM, Staff 5 (LPN Resident Care Manager) was observed to return to the medication cart after checking Resident 81's CBG, and place the glucometer in the drawer. Staff 5 did not disinfect the glucometer. On 6/3/26 at 11:51 AM, Staff 5 stated she used alcohol pad wipes to clean the glucometers after she checked residents CBG. Staff 5 stated EPA disinfectant wipes were harsh on the glucometer and she preferred to use alcohol pad wipes to clean the glucometers. Staff 5 stated she occasionally worked on all units within the facility. On 6/3/26 at 12:39 PM, Staff 2 (DNS) stated staff were to use approved EPA disinfectant wipes to disinfect the glucometers.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review it was determined the facility to revise a resident's care plan for 1 of 1 sampled resident (#3) reviewed for hospice. This placed residents at risk for unmet hospice needs. Findings include: Resident 3 was admitted to the facility 2024 with diagnoses including dementia, bipolar and heart failure.The 8/14/25 Significant Change MDS indicated Resident 3 was on hospice status.Review of Resident 3's care plan referred to hospice and/or end of life in the following manner:-For ADL care hospice helped with bathing, dated 2/13/26. -For psychosocial well-being hospice was identified as one service to provide consultation, date initiated 7/3/25. -For activities, hospice was identified and indicated the resident often declined, date initiated 2/19/26. -Use of anti-anxiety medication related to end of life, dated 9/12/25. The Care Plan did not indicate Resident 3's terminal illness as a focus area with interventions including hospice services or interventions related to end of life.On 6/4/26 at 9:30 AM Staff 2 (DNS) stated her expectation was for a terminal illness to be captured with interventions including hospice services on a resident's care plan. Staff 2 acknowledged Resident 3's care plan was not revised to reflect her/his terminal illness and hospice status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to implement bowel care interventions for 2 of 5 sampled residents (#s 12 and 19) reviewed for medications. This placed residents at risk for constipation. Findings include: 1. Resident 12 admitted to the facility in 2025 with diagnoses including chronic pain and heart failure. The facility's revised 3/31/26 bowel care policy indicated the following for patients not on a daily senna bowel medication: -If no BM in two days, Miralax was to be given. -If no BM on day three, Miralax was to be repeated, and provider was to be notified. -If no BM on day four, suppository was to be administered, and provider was to be notified. -Results from all treatment were to be monitored and recorded. Review of Resident 12's 5/26/26 physician orders indicated the following bowel medications: -Lactulose as needed for constipation -Bisacodyl suppository as needed for constipation -Milk of Magnesia as needed for constipation -Docusate as needed for constipation -Senna as needed for constipation -Miralax as needed for no BM in 2 days and repeated if no BM in 3 days and notify provider. -Fleet enema as needed for constipation. Review of Resident 12's bowel records indicated the resident did not have a bowel movement from 5/28/26 through 6/1/26 (five days). Review of Resident 12's May 2026 MAR indicated Docusate was administered on 5/31/26 and was noted as ineffective. No other ordered bowel medication was noted as administered or attempted to be administered. On 6/3/26 at 9:36 AM Staff 2 (DNS) acknowledged Resident 3 did not receive bowel care interventions in a timely manner and went five days without a bowel movement. 2. Resident 19 was admitted to the facility in 5/2026 with diagnoses including kidney failure. A review of Resident 19's physician orders indicated the following bowel medications: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Miralax, one scoop every Tuesday, Thursday, Saturday and Sunday for constipation. -Senna, one tablet every Tuesday, Thursday, Saturday and Sunday for constipation. -Docusate Sodium, one tablet every Tuesday, Thursday, Saturday and Sunday for constipation. -Milk of Magnesia as needed for constipation. -Fleet enema, one application every 24 hours as needed for constipation. -Bisacodyl rectal suppository, one application as needed for constipation. If no BM (bowel movement) on day four notify the provider. A review of Resident 19's bowel records indicated the resident did not have a bowel movement from 5/10/26 through 5/20/26 (11 days) and 5/28/26 through 6/3/26 (7 days). A review of Resident 19's 5/2026 MAR revealed the resident received milk of magnesia on 5/16/26 (day 7) and one suppository on 5/21/26 (day 12) and no additional PRN bowel medication was provided. A review of Resident 19's 6/2026 MAR revealed the resident received milk of magnesia on 6/2/26 (day 5) and no additional PRN bowel medication was provided. On 6/2/26 at 9:17 AM Resident 19 stated she/he had not had a bowel movement in over seven days which caused discomfort in her/his abdomen. On 6/4/26 at 9:28 AM Staff 7 (CNA) stated Resident 19 went 22 shifts without a bowel movement. On 6/4/26 at 9:53 AM Staff 6 (LPN) stated Resident 19 was often on alert for not having a bowel movement. Staff 6 stated Resident 19 was on a scheduled bowel care regimen. Staff 6 was not able to provide additional information related to the lack of PRN bowel medications provided to the resident. On 6/4/26 at 11:58 AM Staff 2 (DNS) acknowledged Resident 19 did not receive bowel care interventions in a timely manner and went 11 and 7 days without having a bowel movement.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to provide services to prevent further decrease in ROM for 1 of 2 sampled residents (#17) reviewed for positioning. This placed residents at risk for decrease in range of motion. Findings include:Resident 17 was admitted to the facility in 2/2018 with diagnoses including osteomyelitis (inflammation in the bones).The 2/18/26 Quarterly MDS indicated the resident had a BIMS score of 00 indicating Resident 17 was severely cognitively impaired. The MDS indicated Resident 17 was unable to make daily decisions and was dependent on staff to complete daily activities including to apply splints. The MDS indicated Resident 17 had bilateral upper and lower ROM impairments. The 3/19/26 Care Plan indicated Resident 17 wore a left-hand carrot splint and a right-hand palm guard. During interviews on 6/3/26 at 11:24 AM and 6/4/26 at 10:56 AM, Resident 17's hands were observed to be curled up into a fist. Resident 17 was unable to extend her hand. Resident 17 was not wearing her/his hand splint and the splint was observed on top of the resident's bedside table. Resident 17 stated she allowed staff to apply the splint. On 6/4/26 at 12:54 PM, Staff 8 (CNA) stated Resident 17's hand contractures were stiff and difficult to manage. Staff 8 stated Resident 17 allowed staff to apply the hand splint. Staff 8 stated she did not offer to apply the brace during her shift because she forgot. On 6/5/26 at 9:28 AM, Staff 9 (LPN) stated Resident 17 used bilateral hand splints to prevent further decrease to range of motion. Staff 9 stated Resident 17 tolerated the splint and allowed staff to apply the hand splints. Staff 9 stated staff did not tell her they were unable to apply the hand splint during the day. On 6/5/26 at 10:13 AM, Staff 10 (RN Resident Care Manager) stated he was unsure of why Resident 17 did not wear the hand splint consistently and acknowledged the splints should be worn.