

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Corvallis Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  160 NE Conifer Blvd Corvallis, OR 97330	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33179</p> <p>Based on observation and interview it was determined the facility failed to provide maintenance services to maintain a safe, comfortable and homelike environment for 2 of 3 resident rooms (Room #s 117 and 118) reviewed for environment. This placed residents at risk of outside air and odors entering the resident rooms. Findings include:</p> <p>An observation on 11/5/24 at 9:20 AM, revealed the wall underneath room [ROOM NUMBER]'s window was in disrepair and the baseboard coving was missing.</p> <p>An observation on 11/5/24 at 9:23 AM, revealed the resident smoking area to be in the outdoor area, in the line of sight from room [ROOM NUMBER].</p> <p>An observation on 11/6/24 at 9:24 AM, revealed the wall underneath Resident 117's window was in disrepair and the baseboard coving was missing.</p> <p>On 11/5/24 at 9:59 AM, Witness 1 (Complainant) stated the wall underneath Resident 118's was in disrepair, had no baseboard coving and Resident 1 could feel the outside air and smell cigarette smoke. Witness 1 further stated staff placed towels around the suspected areas the outside air came in from because staff felt the air and the smoke came through the holes in the wall since the windows were always closed.</p> <p>On 11/6/24 at 9:24 AM, Resident 8 stated the baseboard coving was missing from the wall underneath the window which allowed a breeze to enter the room.</p> <p>On 11/5/24 at 9:23 AM, Staff 1 (Administrator) verified room [ROOM NUMBER]'s baseboard coving was missing along the wall underneath the window, the wall was in disrepair and stated maintenance was aware of the concern. Staff 1 stated other rooms were in the same condition.</p> <p>On 11/6/24 at 10:20 AM, Staff 4 (Social Service Director) stated the facility was aware of several rooms which had the heaters replaced and the baseboard coving was missing from the walls.</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>33179</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure sufficient nursing staff to maintain the highest practicable physical and psychosocial well-being for 3 of 3 Resident Halls reviewed for staffing. This placed residents at risk for unmet care needs and psychosocial harm. Findings include:</p> <p>An observation on 11/6/24 at 9:22 AM revealed Resident 7's call light on, the resident's door was open, and her/his bed linen was off which revealed the resident was wearing a soiled brief, leaking of the resident's bowel movement. The resident was visually anxious and distraught, called the surveyor into the room, stated she/he need immediate help because staff had not answered her/his call light and the brief was leaking all over my bed. This surveyor exited the room and immediately informed a staff member standing next to a medication cart across the hall from the resident's room. The staff member stated she was behind and could not assist the resident but would ask a CNA as soon as I see one. Four additional resident call lights were observed to be activated at that time in the 100 Hall.</p> <p>The August 2024 Resident Council Notes revealed residents' concerns of long call lights, the CNAs appeared frustrated, to busy to help, and not being available to help. Call lights were reported to be long, mostly over 20 minutes and sometimes over 40 minutes.</p> <p>The September 2024 Resident Council Notes revealed residents' concerns of call light wait times which was worse on the weekend and the staff complained to the residents about short staffing.</p> <p>The October 2024 Resident Council Notes revealed resident concerns they were told they did not need staff assistance and staff was slow to respond to call lights.</p> <p>On 11/5/24 at 9:59 AM, Witness 1 stated the facility did not have enough staff to meet resident needs in a timely manner and sometimes Resident 1 would request hot water and the staff would leave and not come back. Staff told Resident 1 they were short staffed and too busy to assist her/him.</p> <p>On 11/5/24 at 11:44 AM, Staff 8 (CNA) stated residents' complained of call lights.</p> <p>On 11/5/24 at 12:49 PM, Resident 3 stated she/he was wet earlier that morning, called for assistance, and staff took about an hour to answer the call light.</p> <p>On 11/5/24 at 1:04 PM, Resident 2 stated call light response times could be slow but she/he would call the front desk if staff did not come to assist her/him.</p> <p>On 11/6/24 at 9:22 AM, Resident 7 stated she/he had concerns with staffing and call lights.</p> <p>On 11/6/24 at 9:24 AM, Witness 3 stated staffing was a concern and Resident 8's call light took a long time to be answered. Witness 3 further stated Resident 8 was supposed to get a shower the day before and did not.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/6/24 at 9:33 AM, Resident 9 stated she/he had concerns with call light wait times and staffing.</p> <p>On 11/6/24 at 9:35 AM, Witness 4 (Family) stated Resident 8 had to wait multiple times for the call light to be answered and felt the staffing level was abysmal. Witness 4 further stated Resident 8 was a two person assist in bed and she would assist the CNA because they could never find two CNAs to help move her/him in bed.</p> <p>On 11/6/24 at 1:15 PM, Staff 2 (DNS) acknowledged the staffing concerns.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>33179</p> <p>Based on observation, interview and record review it was determined meals were not served at the proper temperature for 1 of 1 kitchens reviewed for meal service. This placed residents at risk for food not being served at the appropriate temperature. Findings include:</p> <p>The Food and Drug Administration instructed eggs to be served at 135 degrees F or above and milk at 40 degrees F or below.</p> <p>The August 2024 and September 2024 Resident Council Notes revealed residents' concerns of late meal service and cold food.</p> <p>On 11/6/24 at 8:33 AM, a breakfast test tray was completed with Staff 1 (Administrator) and Staff 17 (Dietary Manager). The meal consisted of a biscuit with gravy, hash browns, scrambled eggs and a cup of milk. All the food was cold when tasted. Staff 17 checked the temperature of the eggs to be 91 degrees F and the milk to be 45 degrees F. Staff 1 and Staff 17 verified the food was served cold.</p> <p>On 11/5/24 at 9:59 AM, Witness 1 (Complainant) stated Resident 1's meals were often served late and the food was cold.</p> <p>On 11/5/24 at 12:33 PM, Resident 4 stated the meals were cold 75% of the time.</p> <p>On 11/5/24 at 1:04 PM, Resident 2 stated the food was usually lukewarm and meals were frequently up to one hour late.</p> <p>On 11/6/24 at 9:24 AM, Resident 8 and Witness 3 (Family) stated meals were served late and cold.</p> <p>On 11/5/24 at 10:51 AM, Staff 6 (Dietary Aide) stated the food was always cold, had no seasonings, no condiments and were often served late.</p> <p>On 11/5/24 at 11:44 AM, Staff 8 (CNA) stated she received complaints from the residents about cold food.</p> <p>On 11/6/24 at 8:27 AM, Staff 17 verified the last meal cart was ready for pick-up at 8:08 AM and the last resident tray was served at 8:27 am.</p> <p>On 11/6/24 at 9:49 AM, Staff 7 (Dietary Aide) stated the meals were not served at the proper temperatures.</p>		