STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385072	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corvallis Manor	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42271 Based on interview and record review it was determined the facility failed to report injuries of unknown origin for 1 of 5 sampled residents (#10) reviewed for abuse reporting. This placed residents at risk for abuse and neglect. Findings include: Resident 10 was admitted to the facility in 2022, with diagnoses including dementia and weakness. Resident 10's 4/9/25 Care Plan revealed the resident was a two-person assist with turning and repositioning and the resident's call light was to be on the right side of the resident, clipped to blankets. A Progress Note dated 3/22/25 indicated Staff 17 (CNA) reported Resident 10 had bruising and discoloration on her/his leg (on the shin) and swelling around the left arm not observed the previous day. The Progress Note revealed Resident 10 was observed to have swelling around the left hand, pain at the shoulder, skin discoloration around the right leg not observed the previous day. An Injury of Known Cause form dated 3/22/25 revealed an investigation was initiated by Staff 16 and the DNS was notified. On 4/10/25 at 10:26 AM, Staff 10 (RN) stated on 3/22/25, Staff 12 (CNA) showed her Resident 10's swelling and a purplish coloration of the skin to Resident 10's right lower leg around the shin area and some discoloration around the resident's chest. Staff 10 stated she did not know where the bruising originated. Staff 10 stated she did an assessment, and the resident yelled in pain. Staff 10 stated she informed Staff 16 (LPN/IP) who stated she would inform Staff 2 (DNS). Staff 10 stated she did not investigate the bruises of unknown origin but filled out a risk management form. On 4/10/25 at 4:00 PM, Staff 16 (LPN/IP) stated on 3/22/25 she looked at Resident 10's left hand and stated it was concerning. Staff 16 stated she called the DNS and informed her about the bruising and the DNS had her call Staff 17 (CNA) to get a statement. Staff 16 stated her biggest concern was the bruising on Resident 10's fingers. Staff 16 stated Resident 10 was unable to describe how the bruising occurred. Staff 16 stated she had never filled out a Facility Reported Incident (FRI) Form. On 4/11/25 at 3:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated a FRI form was not completed for Resident 10.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42271 Based on observation, interview and record review it was determined the facility failed to check the Hoyer (a mechanical lift device used to transfer residents) straps to prevent a fall and failed to follow care plan interventions to prevent injury for 2 of 5 (#s 10 and 11) sampled residents. As a result, Resident 11 sustained a subarachnoid hemorrhage, (bleeding in the space between the brain and the tissue covering the brain), an intraparenchymal hemorrhage (bleeding within the brain's functional tissue) a scalp hematoma (blood clot), multilevel acute compression fractures (the back bones collapse due to a forceful impact) involving the thoracic region (middle of the back) and a compression fracture of L4 vertebra (lumbar region, lower back). Findings include: 1. Resident 11 admitted to the facility 6/2021, with diagnoses including Parkinson's disease and congestive heart failure. Resident 11's 3/25/25 MDS indicated the resident was cognitively intact. Resident 11's 4/10/25 Care Plan revealed the resident required a Hoyer lift with two-person assist for transfers and the resident preferred to not have her/his feet touch the bed when transferring. On 3/18/25 at 7:25 AM, Staff 15 (CNA) and Staff 17 (CNA) prepared to transfer Resident 11 via a Hoyer from the three-foot raised bed to a shower chair when the resident fell headfirst out of the sling. On 3/18/25 at 7:30 AM, Resident 11 was transferred via ambulance to the hospital as a trauma level patient. Resident 11 was diagnosed with a subarachnoid hemorrhage, an intraparenchymal hemorrhage, a scalp hematoma and multilevel compression fractures in the thoracic and lumbar regions of the spine. Neurosurgery concluded the brain hemorrhages were not operable and would resolve on their own. Resident 11 was admitted to the hospital for observation and pain management. On 4/9/25 at 9:47 AM, Resident 11 was observed in her/his bed. The bed was elevated about three feet off the ground. Resident 11 stated she/he preferred to have the bed raised off the ground. Resident 11 recalled the fall from the Hoyer on 3/18/25. Resident 11 stated Staff 15 (CNA) and Staff 17 (CNA) brought in the Hoyer to her/his room, the sling was placed underneath her/him and attached to the Hoyer. Resident 11 stated the head hook of the sling was loose, and three of the four straps were hooked up and she/he fell to the floor headfirst. Resident 11 stated now she/he had a fear of falling. On 4/9/25 at 11:50 AM, Staff 6 (CNA) stated she was at the nurses station when Staff 17 (CNA) urgently called for Staff 4 (LPN Charge), stating Resident 11 had fallen from the Hoyer. Staff 6 stated she placed the Hoyer out in the hall and noticed one of the straps were not hooked up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/9/25 at 12:45 PM, Staff 4 (RN) stated she was at the nurses station when Staff 17 (CNA) told her Resident 11 fell from the Hoyer and hit her/his head. Staff 4 immediately went to the room and saw Resident 11 on the floor under the Hoyer lift. Staff 4 provided first aide to the resident while staff called EMS. Staff 4 observed the Hoyer and sling were over Resident 11 and one of the slings straps were not attached. On 4/10/25 at 2:15 PM, Staff 15 (CNA) stated he was assisting Staff 17 (CNA) with Resident 11. Staff 15 stated they placed the sling underneath the resident and Staff 17 prepped the Hoyer lift. Staff 15 stated they hooked the four straps from the sling to the Hoyer. Staff 15 stated Resident 11 always preferred her/his bed elevated three feet off the ground. Staff 15 stated after hooking the sling straps to the Hoyer, they lifted the resident up and pulled the Hoyer out and the resident fell headfirst to the ground. On 4/11/25 at 10:31 AM, Staff 17 (CNA) stated on 3/18/25 it was Resident 11's shower day. Staff 17 stated he placed Resident 11 on the shower sling while the resident was in bed and positioned the shower sling per protocol and hooked it up. Staff 17 stated he and Staff 15 (CNA) started raising the resident up in the air off the raised bed, obtained a weight and started to move the resident in the sling off the bed. Staff 17 stated Resident 11 was in an open space, off to the side of the bed. Staff 17 lifted the resident's ankles to turn the Hoyer and he heard something snap. Staff 17 found the back right sling loop had come off the Hoyer and the resident fell headfirst to the floor, approximately four to five feet. Staff 17 stated there was no rip or tear in the sling. Staff 17 stated the sling's strap was not secured over the loop. On 4/11/25 at 3:15 PM, Staff 2 (DNS) stated the shower sling used for Resident 11 was set aside and now cannot be found. On 4/11/25 at 3:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Resident 11's fall from a Hoyer with significant injuries. 2. Resident 10 admitted to the facility 3/2022, with diagnoses including dementia, weakness and reduced mobility. Resident 10's 2/2025 MDS revealed the resident had severe cognitive impairment. Resident 10's 4/9/25 Care Plan revealed the resident was a two-person assist with turning and repositioning and the call light was to be placed on her/his right side and clipped to the blanket. On 4/10/25 at 1:13 PM, Staff 14 (CNA) and Staff 18 (CNA) were observed to transfer Resident 10 from the wheelchair to the bed. Resident was observed to be still and did not move any extremities before, during or after transfer. Staff 14 stated Resident 10 does not assist or move her/his legs and does not move her/his legs around when staff turn the resident from side to side. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/10/25 at 10:10 AM, Staff 13 (CNA) stated she assisted Staff 17 (CNA) with transferring Resident 10 via the Hoyer on 3/21/25 and observed the bruising and skin tear on Resident 10's left neck. Staff 13 stated Staff 17 told her the call light, which was clipped to the resident's gown on the resident's left side, caused the bruising when he pulled the blanket, and it caught the resident on the left side of the neck. Staff 13 stated Resident 10 was crying, and the resident's neck was bleeding. Staff 13 stated the nurse was notified right away. Staff 13 stated she saw the clip for the call light was broken and really sharp. Staff 13 stated when she uncovered Resident 10 she saw a bruise on the resident's right leg and bruising on her/his chest. Staff 13 informed Staff 10 (RN) and showed her the bruise on Resident 10's chest, the bruising on the leg and the swelling of the left arm. On 4/10/25 at 10:26 AM, Staff 10 (RN) stated on 3/21/25 Staff 17 (CNA) showed her Resident 10's skin tear on her/his left neck. She stated Staff 17 showed her the clip for the call light was broken and he stated the clip had cut the resident's skin. Staff 10 stated she cleaned up the wound, put a foam dressing on the skin tear and removed the sharp clip. Staff 10 stated on 3/22/25, Staff 12 (CNA) showed her Resident 10's swelling and a purplish coloration of the skin to Resident 10's right lower leg around the shin area and some discoloration around the resident's chest. Staff 10 stated she did not know where the bruising originated. On 4/10/25 at 4:00 PM, Staff 16 (LPN-IP) stated on 3/22/25 she looked at Resident 10's left hand and stated it was concerning. Staff 17 stated he felt resistance on the blanket and possibly the call light had wrapped around Resident 10's finger, when he pulled the covers back. Staff 16 stated her biggest concern was the bruising on Resident 10's fingers. Staff 16 contacted the provider and requested an x-ray. On 4/11/25 at 10:31 AM, Staff 17 (CNA) stated on 3/21/25 he assisted Resident 10, by himself, out of bed for lunch. Staff 17 stated he pulled down the covers, met some resistance, so he tugged harder. Staff 17 stated Resident 10 was care planned as a two-person assist with dressing, but he dressed the resident himself. Staff 17 stated he turned the resident by himself towards the window. He stated Resident 10 had no muscle tone and she/he started to slip off the bed. Staff 17 stated he grabbed Resident 10's left hip where Resident 10's left hand was and reached for her/his shoulder to bring her/him back to the bed. He stated he did not see bruising on Resident 10's leg because he put the pants on quickly and did not see any bruising on her/his chest. Staff 17 stated he raised the resident's left hand and Resident 10 stated it hurt. Staff 17 stated he palpated different areas of the resident's left arm and the resident stated it hurt. On 4/11/25 at 2:11 PM, Witness 20 (MD) stated she assessed Resident 10 on 3/28/25 (one week after incident). Witness 20 stated her understanding was someone tried to provide care alone and didn't remove the call light which caused a skin tear and bruising on the chest. Witness 20 stated it seemed to her not the correct way to provide care to a resident. Records revealed an Injury of Known Cause investigation form was initiated by Staff 16 (LPN-IP) on 3/22/25. The investigation revealed a skin tear to the left lateral neck and bruising with a green and purple coloration extending from the neck to the subclavicular (collar bone) and mid chest wall. Additional injuries included green bruising on Resident 10's right lower extremity and purple bruising on her/his left index finger and thumb with mild swelling. Staff 16 wrote Resident 10 was unable to describe the injuries and how they occurred. A total body assessment was conducted. Staff 2 and the provider were notified and x-rays and labs were ordered. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/11/25 at 3:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the bruises on Resident 10's neck, chest, left hand and right leg. Staff 2 acknowledged the care plan was not followed.