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	12/05/2025

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 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. Based on observation, interview, and record review it was determined the facility failed to ensure a dependent resident received ADL assistance for 1 of 3 sampled residents (#1) reviewed for accidents. This placed residents at risk for unmet needs and dignity. Findings include: Resident 1 was admitted to the facility in 8/2025 with diagnoses including stroke and language deficits. The 8/7/25 admission MDS revealed Resident 1 had a BIMS assessment score of 15 (cognitively intact), was dependent on two staff for toileting assistance, and required an interpreter for communication. A 9/29/25 Grievance Report filed on behalf of Resident 1 revealed the resident was left on the commode for 30 minutes and requested staff to not leave her/him on the commode. A 9/30/25 revised care plan indicated Resident 1 preferred to have staff stay with her/him while the resident was on the commode. A 10/2/25 Grievance Report indicated Resident 1 filed a complaint related to long call lights that occurred around 1:30 PM on 10/2/25 when the resident requested commode assistance. Resident 1 indicated she/he cried and was very upset. Very frustrated. The grievance did not identify any staff who were involved.On 10/7/25 at 9:39 AM, a sign in Resident 1's room was observed on the wall that instructed staff to not leave Resident 1 alone on the commode. On 10/10/25 at 10:58 AM, Staff 10 (CNA) stated Resident 1's Kardex (care plan for CNAs) was not updated and she was unaware Resident 1 was not to be left alone on her/his commode after a 9/26/25 fall. Staff 10 explained she assisted another resident with a shower around 1:30 PM on 10/2/25 and other staff were instructed to assist Resident 1 while Staff 10 was occupied.On 10/9/25 at 4:05 PM, Staff 4 (Unit Manager-LPN) stated staff were to share resident care responsibilities especially at shift change.On 10/13/25 at 10:43 AM, Staff 2 (DNS) and Staff 12 (Regional Director of Clinical) expected an updated Kardex for Resident 1 and a thorough investigation of grievances to include statements by staff involved.

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

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	12/05/2025

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 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 ensure physician orders for eye treatments were followed for 1 of 3 sampled residents (#4) reviewed for physician orders. This placed residents at risk for eye pain and complications. Findings include:Resident 4 was admitted to the facility in 6/2025 with diagnoses including complex regional pain syndrome and anxiety.The 7/2/25 Orders at Discharge directed staff to apply one drop of Optase (Glycerin) Comfort Dry Eye Solution to Resident 4's eye twice daily. The 7/2025 MAR indicated the following:-7/2/25 through 7/10/25 Optase was unavailable or on order.A 7/7/25 OT Treatment Encounter Notes revealed Resident 4 wanted her/his eye drops which added to her/his anxiety.A 7/7/25 EpicCare Link to the facility provider identified a request to use house stock Systane to replace Resident 4's order for Optase. On 7/7/25 Resident 4's physician agreed with the request.-A 7/8/25 order for Systane Solution (dry eye drops). -Systane Solution (dry eye drops) were administered on 7/9/25. On 10/8/25 at 2:24 PM, Staff 8 (CMA) stated she contacted the facility's pharmacy each time Resident 4's Optase was not available and was not aware of a system to report issues with missing medications until recently. Staff 8 stated she was aware Staff 2 (DNS) was involved to address the need for Resident 4's Optase. On 10/9/25 at 11:53 AM, Staff 7 (LPN) stated Resident 4's call light was often on because she/he was requesting her/his eye drops. On 10/13/25 at 9:47 AM, Staff 3 (Unit Manager-LPN) acknowledged the facility had a problem obtaining eye drops for Resident 4 and Staff 3 made phone calls to address the issue. Staff 3 stated the lack of availability of eye drops for Resident 4 did not meet Staff 3's expectations. On 10/13/25 at 11:15 AM, Staff 2 (DNS) acknowledged the 7/7/25 communication to replace Resident 4's eye drop order for Optase with Systane was not implemented timely.

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	12/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review it was determined the facility failed to follow a resident's care plan to prevent falls for 1 of 3 sampled residents (#1) reviewed for accidents. This placed residents at risk for injuries from falls. Findings include:Resident 1 was admitted to the facility in 8/2025 with diagnoses including stroke and language deficits. The 8/2/25 care plan indicated Resident 1 was at risk for falls and staff were to place the resident's call light within reach.The 8/7/25 admission MDS revealed Resident 1 had a BIMS assessment score of 15 (cognitively intact), was dependent on two staff for toileting assistance, and required an interpreter to communicate. A 9/26/25 Unwitnessed Fall investigation for Resident 1 was incomplete with no information related to the cause of the fall or a conclusion to the investigation.A 9/27/25 Nursing Post Fall Risk Evaluation indicated Resident 1 stated she/he fell from the commode on 9/26/25 because her/his call light was not within reach. The fall resulted in throbbing pain to Resident 1's left ankle.A 9/29/25 Grievance Report filed on behalf of Resident 1 revealed the resident was left on the commode for 30 minutes and requested staff not to leave her/him on the commode. On 10/8/25 at 9:51 AM, Staff 9 (LPN) stated he completed a report after Resident 1's fall. Staff 9 stated he observed Resident 1's call light attached to her/his bed and not near the resident who fell off her/his commode. On 10/9/25 at 4:05 PM, Staff 4 (Unit Manager-LPN) acknowledged call lights were to be within reach of Resident 1. On 10/9/25 at 7:15 PM, Staff 13 (CNA) stated she was outside Resident 1's door on 9/26/25 when she/he was on the commode.On 10/13/25 at 10:43 AM, Staff 2 (DNS) and Staff 12 (Regional Director of Clinical) acknowledged Resident 1' s care plan was not followed and expected a thorough investigation to correctly address the root cause of the resident's fall.