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	12/08/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review it was determined the facility failed to provide pain medications as ordered for 1 of 3 sampled residents (#1) reviewed for medications. This placed residents at risk for unmanaged pain. Findings include:Resident 1 was admitted to the facility in 7/2025 with diagnoses including right hip pain and fractured thigh bone.The 7/30/25 hospital Discharge Orders directed staff to administer one tablet of hydrocodone-acetaminophen (narcotic pain medication) every eight hours as needed for pain for up to five days to Resident 1.The 8/4/25 admission MDS indicated Resident 1 received scheduled and as needed pain medication and was at risk for unrelieved pain. An 8/9/25 physician order revealed a renewed prescription for Resident 1's narcotic pain medication. An 8/14/25 provider communication revealed the facility requested a refill of Resident 1's narcotic pain medication. The 8/2025 MAR revealed Resident 1 was to receive her/his scheduled narcotic pain medication at 8:00 AM and 5:00 PM. -On 8/14/25 at 8:00 AM, the dose was NA (not available).-From 5:00 PM on 8/14/25 through 8/15/25 no medication was administered.-On 8/16/25 Resident 1's medication was NA at 5:00 PM.The 8/15/25 Order Administration Notes indicated staff were waiting for the resident's narcotic pain medication and Resident 1's pain was severe.The 8/15/25 at 3:53 PM Nursing Note revealed at approximately 12:30 PM, Staff 3 (Unit Manager-LPN) was informed by a CNA of Resident 1's pain and lack of narcotic pain medication. On 10/28/25 at 1:40 PM, Staff 7 (CMA) stated she recalled Resident 1's issue with pain and a change to the resident's narcotic pain medication administration to twice daily. Staff 7 indicated notes were provided to Unit Managers to reorder medications. On 10/28/25 at 2:15 PM, Staff 3 confirmed a communication was sent to the pharmacy on 8/13/25 and Resident 1 was without narcotic pain medication by 8/15/25. Staff 3 acknowledged there were communication issues with the provider during 8/2025.On 10/30/25 at 10:27 AM, Staff 8 (RN) stated not all nurses had access to the communication format for providers and it was the responsibility of Unit Managers to follow-up with providers for medications.On 10/31/25 at 10:01 AM, Staff 2 (DNS) stated the 8/9/25 narcotic medication order for Resident 1 did not include a refill sent to the pharmacy by the provider. Staff 2 expected staff to escalate issues with medications orders to Unit Managers or Staff 2 for improved response.

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	12/08/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review it was determined the facility failed to ensure sufficient nursing staff were available to meet the needs of residents in a timely manner for 2 of 3 sampled residents (#s 11 and 12) reviewed for staffing. This placed residents at risk for delayed care. Findings include: 1. Resident 11 was admitted to the facility in 10/2025 with diagnoses including stroke and dementia. The 10/2025 TAR revealed Resident 11 was to receive polyethylene glycol (laxative medication) as needed for constipation. A 10/22/25 revised care plan directed staff to check with Resident 11 frequently to ensure her/his needs were met. On 10/29/25 at 2:42 PM, Resident 11's call light was on. Witness 2 (Family Member) stated Resident 11 had been waiting since 2:25 PM for assistance and experienced discomfort during a recent bowel movement. On 10/29/25 at 2:48 PM, Staff 9 (Agency CNA) entered Resident 11's room and turned off the resident's call light. Staff 9 was observed talking to other CNAs in the hallway. On 10/29/25 at 2:50 PM and 5:06 PM, Staff 9 stated Resident 11 requested bowel medication for constipation when she answered the call light. Staff 9 stated she did not want to interrupt Staff 10 (CMA) with the request during the change of shift and informed Staff 10 about Resident 11's request for medication around 3:30 PM. On 10/29/25 at 4:58 PM, Staff 10 stated Resident 11 received her/his requested medication at 3:18 PM (53 minutes wait), the communication between staff in the facility was not good, and there were issues on 10/29/25 with timely medications due to low nurse staffing. On 10/30/25 at 4:26 PM and 5:45 PM, Staff 1 (Administrator) stated the facility had issues with agency staff which required additional training and hiring. Staff 1 expected nursing staff to assist with call lights, staff were to answer call lights in no more than 15 minutes. Staff 1 acknowledged deeper investigations were needed to understand why resident care needs were not met timely. 2. Resident 12 was admitted to the facility in 2022 with diagnoses including heart failure and high blood pressure. A 1/27/25 revised care plan indicated Resident 12 was bedridden and unable to provide self-care. Staff were to provide one-person extensive assistance with toileting. (continued on next page)

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	12/08/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/25 at 8:51 AM, Resident 12's call light was observed to be on from 8:51 AM, until 9:36 AM, a total of 45 minutes, when staff responded. Resident 12 was observed lying in bed and appeared uncomfortable, as evidenced by facial grimacing. Resident 12 confirmed she/he pressed the call light and waited for staff to assist with a brief change. Resident 12 further reported staff previously told her/him to wait until after meals for assistance with a brief change. When asked how this made her/him feel, Resident 12 displayed an unpleasant facial expression, looked down, and declined to answer. Resident 12 stated this has been an ongoing concern. On 10/29/25 at 9:56 AM, Staff 6 (CNA) confirmed Resident 12 was dependent on staff for incontinent care and she/he preferred to be changed before meals. Staff 6 reported Resident 12 informed her staff previously told the resident she/he needed to wait until after meals to be changed. Staff 6 stated the resident expressed this made her/him feel undignified. On 10/30/25 at 4:26 PM and 5:45 PM, Staff 1 (Administrator) stated he expected nursing staff to assist with call lights after no more than 15 minutes. Staff 1 acknowledged deeper investigations were needed to understand why resident care needs were not met timely.