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Form Approved OMB
No. 0938-0391

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	02/10/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, it was determined the facility failed to investigate an unwitnessed fall and misappropriation of property for 2 of 13 sampled residents (#s 11 and 14) reviewed for falls and misappropriation. This placed residents at risk for stolen property and neglect. Findings include:1. Resident 11 was admitted to the facility in 6/2025 with diagnoses including muscle weakness and unsteadiness on feet. On 10/1/25, the State Agency received a public complaint alleging that Resident 11 slept in her/his wheelchair and staff did not transfer her/him to bed. The complaint further alleged that Resident 11 slipped out of the wheelchair onto the floor. A review of the facility's 10/1/25 Unwitnessed Fall investigation indicated that at 12:20 AM, staff found Resident 11 seated on the floor with the electric wheelchair positioned behind the resident. The investigation lacked witness statements, root cause analysis and documentation confirming whether the facility ruled out abuse or neglect. On 2/9/26 at 8:48 AM, Staff 24 (RN) stated she typically completed investigations for risk management, gathered witness statements, and submitted the packet to management. Staff 24 stated she did not recall completing the 10/1/25 unwitnessed fall investigation. On 2/10/26 at 11:20 AM, Staff 1 (Administration) confirmed the investigation should have included a root cause analysis, witness statements and documentation of excluding abuse or neglect. 2. Resident 14 was admitted to the facility in 11/2025 with diagnoses including muscle weakness and diabetes. A Grievance Report dated 12/15/25 revealed Resident 14's phone had been plugged in, and around 1:00 AM on 12/12/25, the phone went missing. On 12/30/25, the State Agency received a public complaint indicating Resident 14 reported the missing phone to the police. A review of clinical records found no documentation of an investigation into the missing phone. On?2/9/26 at?12:30?PM, Staff?17 (Social Services Director) stated an investigation should have been completed, noting the grievance focused on replacing the phone rather than how the phone went missing. On?2/10/26 at?11:23?AM, Staff?1 (Administration) confirmed an investigation should have been completed regarding Resident?14's missing phone.

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