STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385107	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberline Post Acute	1023 6th Ave SW Albany, OR 97321

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review it was determined the facility failed to identify, treat, and care plan for a pressure injury for 1 of 3 sampled residents (#1) reviewed for pressure injuries. This placed residents at risk for worsening pressure injuries. Findings include:Resident 1 was admitted to the facility on [DATE] with diagnoses including a right ankle fracture.CMS defines a Stage I Pressure Injury as an injury to intact skin that is characterized by non-blanchable redness (redness that does not fade when pressed on).CMS defines an Unstageable Pressure Injury as a pressure wound that cannot be staged due to slough/eschar (dead or dying tissue) covering the wound bed.The 9/11/25 admission Evaluation indicated on admission to the facility; Resident 1 had a soft mass on the middle of her/his back on the spine which appeared red and non-blanchable. There was no documentation found in the clinical record of orders implemented or of notification to the provider of the wound.A 9/12/25 care plan indicated Resident 1 was at risk for pressure injuries.A 9/15/25 progress note indicated an abrasion was discovered on Resident 1's back.A 9/23/25 provider progress note indicated Resident 1 had a pressure injury to the middle of her/his back on the spine. A 9/23/25 Skin and Wound Evaluation indicated Resident 1 had a non-stageable pressure injury to the middle of her/his back on the spine.On 10/15/25 at 10:38 AM, Staff 8 (LPN) stated she completed Resident 1's admission on [DATE]. Staff 8 stated Resident 1 did not have wounds upon admission to the facility but did have a red non-blanchable soft mass on the middle of her/his back on the spine. Staff 8 stated she did not let the wound care nurse or the provider know about the non-blanchable area upon admission and did not obtain treatment orders.On 10/15/25 at 12:15 PM, Staff 2 (DNS) stated when a pressure injury was discovered upon admission, the nurse was to monitor the wound weekly, during wound rounds, enter a treatment on the TAR, notify the provider, notify the RN, and complete a care plan for the wound. Staff 2 stated a RN would follow up with a wound assessment the next day. Staff 2 stated Resident 1 was admitted with a non-blanchable red area on the spine in the middle of her/his back that met the definition for a stage 1 pressure injury. Staff 2 stated Resident 1's wound was not assessed after admission by the RN, it was not monitored weekly during wound rounds, it was not added to the TAR, the provider was not notified, the RN was not notified, and Resident 1 was not care-planned for having a pressure injury. Staff 2 stated she was unaware how the 9/15/25 abrasion on Resident 1's back occurred and stated there was no investigation completed. Staff 2 stated on 9/23/25 an unstageable pressure injury was discovered on the soft mass on Resident 1's back. Staff 2 stated she was unsure if the unstageable pressure injury was new or worsened from admission and stated there was no investigation completed.

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
	385107	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberline Post Acute	1023 6th Ave SW Albany, OR 97321

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, it was determined the facility failed to follow infection control practices when providing wound care to 1 of 3 sampled residents (#3) reviewed for pressure injuries. This placed residents at risk for infection. Findings include:Resident 3 was admitted to the facility in 12/2023 with diagnoses including diabetes.On 10/8/25 at 10:25 AM, Staff 6 (LPN) was observed to don a gown, gloves, and a face mask before entering Resident 3's room. With gloved hands, Staff 6 cleaned a wound on Resident 3's right thumb. With the same gloves and without performing hand hygiene, Staff 6 placed a clean dressing on Resident 3's right thumb wound, cleaned a wound on Resident 3's left big toe and applied a clean dressing to the toe. Staff 6 removed her gloves and, without completing hand hygiene, donned a pair of clean gloves and applied a cream to Resident 3's knee. Staff 6 removed her gloves, left Resident 3's room, and then performed hand hygiene.On 10/8/25 at 10:54 AM, Staff 6 stated her normal process for wound care was to complete hand hygiene, don gloves, remove old dressing, clean the wound, apply a new dressing, remove gloves, and complete hand hygiene. Staff 6 stated she usually changed her gloves in between wounds but acknowledged she did not change her gloves between Resident 3's wounds. Staff 6 stated she completed hand hygiene before and after wound care.On 10/8/25 at 10:58 AM Staff 14 (RN, Infection Preventionist) stated the expectation was for hand hygiene to be completed before and after donning gloves. Staff 14 stated gloves were to be changed before wound care started, after the wound was cleaned, before a clean dressing was applied, after wound and care and between each wound on a resident. Staff 14 stated the above observation could cause cross-contamination and increased the risk of infection.