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	02/13/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview and record review it was determined the facility failed to assess and correctly utilize a restraint for 1 of 1 sampled resident (#71) reviewed for elopement. This placed residents at risk for lack of freedom from physical restraints. Resident 71 was admitted to the facility in 1/2025 with diagnoses including respiratory failure and personality disorder.The 1/10/25 admission MDS revealed Resident 71 had a BIMS score of 12 (moderately cognitively intact) and poor safety awareness. A 6/16/25 revised Care Plan indicated Resident 71 had a Wander Guard (an alarm attached to a resident at risk for wandering) and was at risk for leaving the facility without notifying staff.Review of Resident 71's clinical record revealed no consent or evaluation for the use of her/his Wander Guard.A 6/17/25 Elopement Risk Evaluation indicated Resident 71 was a low risk for elopement. Resident 71 was allowed to go outside, showed no exit seeking behaviors, and a Wander Guard was placed on the resident to alert staff when she/he left the building since she/he was at risk for falls.The 7/2025 TAR indicated Resident 71 required oxygen per nasal cannula as needed to maintain oxygen levels above 88 percent and to check placement and function of the resident's Wander Guard every shift.A 7/15/25 FRI Event Summary Report revealed Resident 71 left the facility without informing staff after removing her/his Wander Guard.A 7/15/25 Elopement investigation revealed Resident 71 was under emotional stress and used the outdoors as a coping strategy. Resident 71 left the facility and was able to safely navigate her/his power wheelchair inside and outside the building. Resident 71 initially refused the Wander Guard placement once she/he returned to the building.On 2/12/26 at 1:17 PM, Staff 4 (RNCM) stated Resident 71's Wander Guard was used to alert staff to monitor the resident for safety when the resident left the building. Staff 4 stated once Resident 71 realized she/he only needed to sign out and in for her/his safety, the resident no longer attempted to elope.On 2/12/26 at 1:50 PM, Staff 6 (Regional Nurse) stated Resident 71 was known to exit the building without her/his oxygen and staff were concerned for her/his safety. Staff 6 acknowledged the use of the Wander Guard was inappropriate for Resident 71 and confirmed there was no evaluation or consent for the use of her/his Wander Guard as expected.

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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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, interview, and record review it was determined the facility failed to implement a care plan after a comprehensive assessment for 1 of 1 sampled resident (#7) reviewed for communication. This place residents at risk for ineffective communication. Findings include: Resident 7 was admitted to the facility in 12/2025 with a diagnosis including cerebral palsy (neurological disorder affecting movement and muscle coordination).The 12/12/25 admission MDS and Communication CAA revealed Resident 7 had a BIMS score of 15 (cognitively intact), received speech therapy in the last seven days, and staff were to provide simple, short instructions to improve the resident's understanding of words. Staff were to rephrase and elevate their voices to improve communication with the resident and a care plan for effective communication was needed. A 12/23/25 facility Communications Report revealed Staff 11 (SLP) indicated to avoid speaking down to Resident 7, take time to understand the resident, and repeat her/his spoken words to confirm understanding. A 12/29/25 revised Care Plan revealed no communication focus or interventions for staff to follow for Resident 7.On 2/9/26 at 10:36 AM, Resident 7 was observed to not speak distinctly and stated it was difficult for staff to understand her/him. On 2/10/26 4:25 PM, Staff 12 (CNA) stated there were no care plan interventions to help communicate with Resident 7 and Staff 12 did not understand the resident without great effort.On 2/11/26 at 9:51 AM, Staff 11 stated she relied on nursing to create communication care plans. On 2/11/26 at 4:44 PM, Staff 2 (DNS) acknowledged Resident 7 had no care plan or interventions related to the resident's communication needs and expected staff to implement the care plan based on the accuracy of the CAA.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to develop a comprehensive care plan for 2 of 4 sampled residents (#s 3 and 6) reviewed for pain and incontinence. This placed residents at risk for unmet needs. Findings include:1. Resident 3 was admitted to the facility in 1/2026 with diagnoses including stroke. The 1/22/26 admission MDS indicated Resident 3 had a BIMS score of 14 (cognitively intact), her/his upper and lower extremities were impaired on one side, and she/he was assessed with the ability to eat independently. The 2/8/26 and 2/10/26 Daily Skilled note revealed Resident 3 had right-sided weakness and was unable to move her/his fingers or lift her/his hand or arms. On 2/10/26 at 3:33 PM, Resident 3 was observed in her/his room when an unidentified staff with a menu entered the room and left a daily menu at the resident's bedside table for her/him to complete. Resident 3 called to the staff to return to assist with the menu since the resident was unable to write. Resident 3 stated her/his stroke affected her/his dominate side. On 2/10/26 at 3:59 PM, Staff 9 (Dietary Manager) stated she completed Resident 3's food preferences but was not aware of the resident's inability to complete menus and probable need for cut food due to her/his right-sided weakness. Staff 9 stated she relied on CNAs to communicate dining needs. On 2/11/26 at 10:35 AM, Staff 5 (CNA) stated Resident 3 required cut food and straws in her/his drinks which was not indicated in the care plan. On 2/12/26 at 12:57 PM, Staff 4 (RNCM) stated communication between staff was needed to update Resident 3's care plan. Staff 4 acknowledged Resident 3's care plan was not resident-centered and required details for eating due to her/his stroke. 2. Resident 6 admitted to the facility on [DATE] with diagnoses including cancer (unspecified) and muscle weakness. The 5/28/25 admission MDS indicated Resident 6 had a BIMS score of 15 (cognitively intact), had urinary incontinence, and did not have a history of cancer. The 7/9/25 History and Physical revealed Resident 6 had a history of uterine cancer. Review of the comprehensive care plan revealed there was no focused area addressing Resident 6's history of uterine cancer. On 2/6/26 a Progress Note revealed Resident 6 had an appointment with the cancer institute. On 2/8/26 at 12:05 PM, Resident 6 stated she/he had a history of uterine cancer and expressed fears related to her/his condition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/24 at 12:28 PM Staff 3 (RNCM) acknowledged Resident 6 had a history of uterine cancer and confirmed the care plan was not resident-centered.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure proper use of antibiotics for 1 of 1 sampled resident (#6) reviewed for UTIs. This placed residents at risk for drug resistant organisms. Findings include: Resident 6 admitted to the facility in 5/2025 with diagnoses including diabetes and muscle weakness. A 1/20/26 Physician Order instructed staff to administer ciprofloxacin 500 mg (antibiotic). No additional information was provided. On 1/22/26, laboratory results were obtained indicating Resident 6 did not have a urinary tract infection (UTI). A 1/25/26 progress note indicated clarification was requested for ciprofloxacin 500 mg twice daily. No follow up was documented. On 2/10/26 at 4:16 PM, Staff 2 (DNS) reviewed the laboratory results dated [DATE] and confirmed Resident 6 did not have an (UTI). Staff 2 further confirmed there was no clinical indication for the prescribed antibiotic and staff were expected to follow up.