STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385151	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Center	740 NW Hill Roseburg, OR 97471

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **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 staff adhered to professional standards related to medication administration and non-pressure wound care for 4 of 4 licensed nurses Staff 6 (RN), Staff 7 (RN), Staff 21 (LPN), and Staff 22 (RN) reviewed for medication administration and non-pressure wound care. This placed residents at risk for cross contamination. Findings include: Per OAR [PHONE NUMBER] Scope of Practice Standards for All Licensed Nurses(1) Standards related to the licensee's responsibility for safe nursing practice. The licensee shall:(A) Adhere to professional practice and performance standards;Per OAR [PHONE NUMBER] Conduct Derogatory to the Standards of Nursing Defined:Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:(2) Conduct related to achieving and maintaining clinical competency:(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;(3) Conduct related to the client's safety and integrity:(a) Developing, modifying or implementing policies that jeopardize client safety;1. Resident 17 was admitted to the facility in 7/2025 with diagnoses including depression and diabetes. On 6/3/26 at 1:05 PM, Staff 6 (RN) was observed to perform a CBG for Resident 17. Staff 6 did not sanitize his hands before entering the room and donned one glove to his left hand. Staff 6 proceeded to poke Resident 17's finger with a lancet (tiny needle to draw blood), squeezed the blood out, and placed the blood on a test strip. Staff 6 stated there was not enough blood, so he went back to the treatment cart to grab more test strips. Staff 6 returned to the room and proceeded two more times to get a blood sample from the resident with success on the second try. Staff 6 disposed of the test strips which contained blood and the lancet and threw them into a regular garbage can, not into a sharps hazard material container. Staff 6 stated he was not aware he disposed of the test strips and the lancet in the regular garbage can. On 6/5/26 at 1:17 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated they expected staff to wear gloves and gowns and never throw lancets or test strips in a regular garbage can. Hazardous materials must be disposed of in a sharps hazard material container.2. Resident 27 was admitted to the facility in 4/2026 with diagnoses including abscess of the abdominal wall and vascular dementia. A 4/21/26 care plan indicated Resident 27 was on EBP (Enhanced Barrier Precautions) due to chronic wounds, surgical wounds, and IV placement. Staff were to don gowns and gloves during high contact care activities including providing care/hygiene, changing briefs, and assisting with toileting. On 6/3/26 at 7:50 AM, Staff 7 (RN) was observed to administer medication to Resident 27. Staff 7 did not sanitize her hands or don gloves before entering the room. Resident 27 was laying on her/his side low in the bed. Staff 7 did not reposition her/him before administering medication to avoid choking. Staff 7 placed Resident 27's medication from a medication cup into the resident's hand and gave her/him a cup of water. Resident 27 put the handful of medication in her/his mouth. Some pills fell out of her/his mouth onto her/his shirt and the bed. Staff 7 picked up the medication with no gloves and gave it to her/him. Resident 27 placed the medication back in her/his mouth. After medications were administered, Resident 27 indicated to Staff 7 she/he needed to use (continued on next page)

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
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bathroom. Staff 7 did not sanitize her hands but proceeded to don gloves. Staff 7 did not don a gown and proceeded to open the resident's brief and assist with a urinal. Staff 7 stated the brief was already soiled, so she would call a CNA. Staff 7 touched the call light with dirty gloves. On 6/3/26 at 8:10 AM, Staff 7 stated she sanitized her hands when she left the room but did not see a problem when she picked up the medication with her bare hands off the bed and the resident's shirt when medication fell out of her/his mouth.On 6/5/26 at 1:12 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated staff are to sanitize their hands, don gowns and gloves, before they enter a room depending on the precautions. Staff 5 stated her expectation was for Staff 7 to don gloves and a gown before she went into the room but definitely should have had gloves on when the pills dropped out of the resident's mouth, and those pills should have been disposed of. Staff 5 stated Staff 7 should have sanitized her hands, donned gloves and a gown before she assisted the resident with her/his brief. 3. Resident 35 was admitted to the facility in 5/2026 with diagnoses including diabetes and bullous pemphigoid (an autoimmune disease-causing fluid-filled blisters). A 5/27/26 Wound Care Evaluation indicated Resident 35 had multiple blisters to her/his labia, left hand, left leg, right leg, right foot, left foot, right thumb, and left gluteal fold. On 6/3/26 at 1:45 PM, an observation of Resident 35's dressings was completed before the dressings were changed. The observation revealed both lower extremities had wraps around them with bright red blood breaking through the dressings. Resident 35's toes had dark purple/black spots, which appeared to be blood blisters, on the bottom, top, and in-between her/his toes. There was blood on the blanket on her/his bed. On 6/3/26 at 2:00 PM, Staff 21 (RN) and Staff 22 (LPN) were observed to perform dressing changes for Resident 35's multiple wounds. Staff 21 did not prepare a clean barrier for supplies. Staff 21 brought in a basin of packaged dressings and sat them directly on the resident's bedside table which contained a television remote, paperwork, and a water cup. Staff 21 removed the wrap from the resident's right leg and proceeded to grab a wound cleanser bottle off the bedside table, sprayed the abdominal wound pads on the wounds due to the pads sticking to the wounds, removed the dressings, and set them on the bed with the wound cleaner. Staff 22 held Resident 35's leg when Staff 21 cleaned the wound to the right leg. Staff 21 and Staff 22 were stopped due to not washing their hands and changing their gloves before cleaning the wounds. Staff 21 and Staff 22 changed their gloves and proceeded to clean the wounds. Staff 21 reached into her pocket to grab her cell phone to take photos with measurements of the wounds. Staff 21 then grabbed dirty dressing packages from the dressing basin and placed them on the bed. Staff 21 and Staff 22 were stopped again due to touching the cell phone and dirty dressing wrappers. Staff 21 washed her hands and donned clean gloves. Staff 22 went to change her gloves at this time but did not sanitize her hands and was stopped. Staff 22 washed her hands and donned clean gloves. Staff 21 placed open dressing packages on the bed and garbage bags for the old dressings. Staff 21 and Staff 22 were unaware a bed could not be used as a clean barrier because the bed was dirty. Staff 21 and Staff 22 stated they realized they made multiple mistakes while changing the wound dressings. On 6/5/26 at 1:21 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated nursing staff were to follow all infection control procedures for wound care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to follow proper infection control techniques for urinary catheter bags containing bodily fluid for 2 of 2 sampled residents (#s 2 and 54), failed to perform proper use of PPE when administering medications for 2 of 31 sampled residents (#s 17 and 27) reviewed for medication administration and ensure proper hand hygiene was completed during a dressing change for 1 of 2 sampled residents (#35). This placed residents at risk for cross-contamination and infection. Findings include: 1. Resident 2 was admitted to the facility in 4/2026 with diagnoses including flaccid bladder (a condition where the bladder cannot contract, leading to an inability to urinate) and ulcerative colitis (inflammatory bowel disease). A 10/9/25 Care Plan revealed Resident 2 had a catheter with interventions to include position catheter bag and tubing below the level of the bladder and away from the door entrance. Resident 2 also had a rectal tube bag with interventions to include ensure patency (preventing obstruction) of the tube by repositioning her/him. Random observations from 6/1/26 at 11:44 AM through 6/2/26 at 11:49 AM on day and evening shifts revealed Resident 2's catheter bag and rectal tube bag drains touched the floor. On 6/4/26 at 12:35 PM, Staff 14 (CNA) and Staff 15 (CNA) stated any bag drains with bodily fluids should not touch the floor due to infection control protocol. On 6/4/26 at 5:14 PM, Staff 3 (Unit Manager/RN) stated all bag drains with bodily fluids must never touch the floor due to infection control and cross contamination. On 6/5/26 at 1:09 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated all bag with drains containing bodily fluids must always be off the ground. 2. Resident 54 was admitted to the facility in 11/2025 with diagnoses including bladder neck obstruction, MRSA (methicillin-resistant staphylococcus aureus bacteria that has developed resistance to many common antibiotics), and EBP (Enhanced Barrier Precautions). An 11/20/25 revised Care Plan indicated Resident 54 will be free from acute infection in spite of colonization of MRSA and observe standard precautions for infection control.Observations revealed:- On 6/1/26 at 10:18 AM Resident 54's catheter bag drain was hanging off her/his wheelchair and touched the floor.-On 6/2/26 at 9:45 AM Resident 54 was escorted to activities in her/his wheelchair with her/his catheter bag drain dragging on the floor underneath her/his wheelchair.-On 6/3/26 at 12:53 PM Resident 54's catheter bag drain was laying on the floor in her/his room under her/his wheelchair.On 6/4/26 at 12:35 PM, Staff 14 (CNA) and Staff 15 (CNA) stated any bags containing bodily fluids should not touch the floor due to infection control protocol. Staff 14 went into Resident 54's room and grabbed the catheter bag from under the resident's wheelchair and stated, the bag is full of urine. Staff 14 proceeded to grab the urinal to empty the catheter bag. Staff 14 was not wearing any PPE including gloves. Staff 15 stopped Staff 14 and Staff 14 donned full PPE before emptying Resident 54's catheter bag. On 6/4/26 at 5:14 PM, Staff 3 (Unit Manager/RN) stated all bag drains with bodily fluids must never touch the floor due to infection control and cross contamination. On 6/5/26 at 1:09 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated all bag with drains containing bodily fluids must always be off the ground. 3. Resident 17 was admitted to the facility in 7/2025 with diagnoses including depression and diabetes. On 6/3/26 at 1:05 PM, Staff 6 (RN) was observed to perform a CBG for Resident 17. Staff 6 did not sanitize his hands before entering the room and donned one glove to his left hand. Staff 6 proceeded to poke Resident 17's finger with a lancet (tiny needle to draw blood), squeezed the blood out, and placed the blood on a test strip. Staff 6 stated there was not enough blood, so he went back to the treatment cart to get more test strips. Staff 6 returned to the room and proceeded two more times to get a blood sample from the resident with success on the second try. Staff 6 disposed of the test strips which contained blood and the lancet and threw them into a regular garbage can, not into a sharps hazard material container. Staff 6 stated he was not aware he disposed of the test strips and the lancet in the regular garbage can. On 6/5/26 at 1:17 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated they expected staff to wear gloves and gowns and never throw lancets or test strips in a regular garbage can. Hazardous materials must be disposed of in a sharps hazard (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	material container. 4. Resident 27 was admitted to the facility in 4/2026 with diagnoses including abscess of the abdominal wall and vascular dementia. A 4/21/26 Care Plan indicated Resident 27 was on EBP (Enhanced Barrier Precautions) due to chronic wounds, a surgical wound, and IV (intravenous) placement and staff were to don gowns and gloves during high-contact care activities including providing care/hygiene, changing briefs, or assisting with toileting. On 6/3/26 at 7:50 AM, Staff 7 (RN) was observed to administer medication to Resident 27. Staff 7 did not sanitize her hands or don gloves before entering the room. Resident 27 was lying on her/his side low in the bed. Staff 7 did not reposition her/him before administering medication to avoid choking. Staff 7 placed Resident 27's medication from a medication cup into the resident's hand and gave her/him a cup of water. Resident 27 put the handful of medication into her/his mouth. Some pills fell out of her/his mouth onto her/his shirt and bed. Staff 7 picked up the medication with no gloves and gave the medication back to her/him. Resident 27 placed the medication back in her/his mouth. After medications were administered, Resident 27 indicated to Staff 7 she/he needed to use the bathroom. Staff 7 did not sanitize her hands but proceeded to don gloves. Staff 7 did not don a gown and proceeded to open the resident's brief and assist with a urinal. Staff 7 stated the brief was already soiled, so she would call a CNA. Staff 7 touched the call light with dirty gloves. On 6/3/26 at 8:10 AM, Staff 7 stated she sanitized her hands when she left the room but did not see a problem when she picked up the medication with her bare hands off the bed and the resident's shirt when medication fell out of her/his mouth. On 6/5/26 at 1:12 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated staff were to sanitize their hands and don gowns and gloves before they enter a room depending on the precautions. Staff 5 stated her expectation was for Staff 7 to don gloves and a gown before she went into Resident 27's room to administer medications. Staff 5 noted Staff 7 should have had gloves on when the pills dropped out of her/his mouth, and those pills should have been disposed of. Staff 5 stated Staff 7 should have sanitized her hands, donned gloves and a gown before she assisted Resident 27 with her/his brief. Staff 5 stated a lot of infection control practices were broken. 5. Resident 35 was admitted to the facility in 5/2026 with diagnoses including diabetes and bullous pemphigoid (an autoimmune disease-causing fluid-filled blisters). A 5/27/26 Wound Care Evaluation indicated Resident 35 had multiple blisters to her/his labia, left hand, left leg, right leg, right foot, left foot, right thumb, and left gluteal fold. On 6/3/26 at 1:45 PM, an observation of Resident 35's dressings was completed before the dressings were changed. The observation revealed both lower extremities had wraps around them with bright red blood breaking through the dressings. Resident 35's toes had dark purple/black spots, which appeared to be blood blisters, on the bottom, top, and in-between her/his toes. There was blood on the blanket on her/his bed. On 6/3/26 at 2:00 PM, Staff 21 (RN) and Staff 22 (LPN) were observed to perform dressing changes for Resident 35's multiple wounds. Staff 21 did not prepare a clean barrier for supplies. Staff 21 brought in a basin of packaged dressings and sat them directly on the resident's bedside table which contained a television remote, paperwork, and a water cup. Staff 21 removed the wrap from the resident's right leg and proceeded to grab a wound cleanser bottle off the bedside table, sprayed the abdominal wound pads on the wounds due to the pads sticking to the wounds, removed the dressings, and set them on the bed with the wound cleaner. Staff 22 held Resident 35's leg when Staff 21 cleaned the wound to the right leg. Staff 21 and Staff 22 were stopped due to not washing their hands and changing their gloves before cleaning the wounds. Staff 21 and Staff 22 changed their gloves and proceeded to clean the wounds. Staff 21 reached into her pocket to grab her cell phone to take photos with measurements of the wounds. Staff 21 then grabbed dirty dressing packages from the dressing basin and placed them on the bed. Staff 21 and Staff 22 were stopped again due to touching the cell phone and dirty dressing wrappers. Staff 21 washed her hands and donned clean gloves. Staff 22 went to change her gloves at this time but did not sanitize her hands and was stopped. Staff 22 washed her hands and donned clean gloves. Staff 21 placed open dressing packages on the bed and garbage bags for the old dressings. Staff 21 and Staff 22 were unaware a bed could not be used as a clean barrier because the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed was dirty. Staff 21 and Staff 22 stated they realized they made multiple mistakes while changing the wound dressings. On 6/5/26 at 1:21 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated staff are to follow all infection control procedures for wound care. Staff 5 acknowledged the dressing change should have been completed with more infection control practices being followed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review it was determined the facility failed to ensure catheter bags and rectal tube bags were covered for 1 of 2 sampled residents (# 2) reviewed for dignity. This placed residents at risk for a loss of dignity. Findings include:Resident 2 was admitted to the facility in 4/2026 with diagnoses including flaccid bladder (a condition where the bladder cannot contract, leading to an inability to urinate) and ulcerative colitis (inflammatory bowel disease). A 10/9/25 care plan revealed Resident 2 had a urinary catheter with interventions including position catheter bag and tubing below the level of the bladder and away from the door entrance. Resident 2 also had a rectal tube bag with interventions including ensuring patency (preventing obstruction) of the tube by repositioning her/him. Random observations from 6/1/26 at 11:44 AM through 6/2/26 at 11:49 AM on day and evening shifts revealed Resident 2's urinary catheter bag and rectal tube bag were hanging off the side of the bed uncovered. On 6/4/26 at 12:35 PM, Staff 14 (CNA) and Staff 15 (CNA) stated urinary catheter bags must be covered for dignity. Staff 15 stated Resident 2's rectal tube bag must also be covered. On 6/4/26 at 5:14 PM, Staff 3 (Unit Manager/RN) stated all bags with bodily fluids must be covered for dignity. On 6/5/26 at 1:09 PM, Staff 1 (Administrator) and Staff 5 (Regional Nurse) stated all bags with bodily fluids must always be covered.

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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 accurately complete a comprehensive admission assessment to include dentures for 1 of 1 sampled resident (#34) reviewed for dental. This placed residents at risk for unmet dental needs. Findings include:Resident 34 was admitted to the facility in 2/2025 with diagnoses including stroke and dysphagia (swallowing difficulty).The 2/19/25 Nursing admission Evaluation and Inventory of Resident Personal Items revealed Resident 34 had no dental appliances.The 2/25/26 Annual MDS revealed Resident 34 had a BIMS score of 12 (moderately cognitively impaired). No concerns related to dentures were identified. A 3/30/26 progress note revealed an appointment was scheduled for Resident 34 to obtain dentures. The revised Care Plan dated 5/11/26 revealed Resident 34 was at risk for alterations in dentition, one staff member was to assist with the set-up of the resident's oral hygiene and provide supplies for tooth brushing.On 6/1/26 at 3:41 PM, Resident 34 stated her/his dentures were lost. No dentures were observed in the resident's mouth.On 6/4/26 at 12:42 PM, Staff 12 (CNA) stated she setup oral hygiene supplies for Resident 34 and was unaware the resident had dentures. On 6/4/26 at 12:48 PM, Staff 10 (CNA) stated she was aware Resident 34 had dentures. Staff 10 reported when she returned to the facility after an absence, she observed the resident's dentures in a cup and not in her/his mouth.On 6/4/26 at 1:17 PM, Staff 6 (RN) stated he did not recall his observations during the admission assessment of Resident 34 and acknowledged Resident 34 recently reported oral concerns.On 6/4/26 at 1:54 PM, Resident 34 was observed with upper dentures in her/his mouth and stated she/he possessed a complete set of dentures in 2000. On 6/4/26 at 1:55 PM, Staff 11 (CNA) stated Resident 34 frequently refused assistance with dental care and independently brushed her/his own teeth. Staff 11 stated she was unaware Resident 34 had dentures. On 6/4/26 at 2:18 PM, Staff 3 (Unit Manager-LPN) stated she was aware Resident 34 had upper dentures. Staff 3 acknowledged Resident 34's initial nursing assessment was incomplete and failed to include accurate information regarding the resident's dentures. Staff 3 acknowledged the resident's baseline care plan did not accurately reflect the resident's dental care needs and required revision.On 6/4/26 at 4:50 PM, Staff 5 (Regional Director of Clinical) acknowledged the initial inventory assessment for Resident 34 was incomplete, inaccurate, and omitted the resident's dentures. Staff 5 stated the facility audits were incomplete and needed revision.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to accurately assess 3 of 5 sampled residents (#s 6, 34, and 103) reviewed for unnecessary medications. This placed residents at risk for unassessed needs. Findings include:1. Resident 6 was admitted to the facility in 3/2026 with diagnoses including Cerebrovascular Accident with hemiplegia and hemiparesis (stroke with weakness and paralysis). Resident 6's MDS Section C (BIMS assessment) dated 5/1/26 indicated the resident was rarely or never understood with a score of 99 (unable to assess). On 6/3/26 at 5:35 PM, Staff 15 (CNA) stated she understood Resident 6 when she/he expressed her/his needs. On 6/3/26 at 5:49 PM, Staff 16 (LPN) stated she understood Resident 6 when she/he told her what her/his needs were. On 6/5/26 at 1:45 PM, Staff 13 (MDS Coordinator) stated if a resident was able to make herself/himself understood at least 50% of the time, Section C should be completed. Staff 13 stated if the resident refused to respond, the assessor should try again later or ask another staff member to assist with the assessment. On 6/5/26 at 2:07 PM, Staff 4 (Social Services Assistant) stated she was trained a BIMS assessment could not be completed when a resident was rarely or never understood or if a resident declined to respond. On 6/5/26 at 2:15 PM Staff 1 (Administrator) stated she expected the MDS to be completed accurately. 2. Resident 34 was admitted to the facility in 2/2025 with diagnoses including Cerebrovascular Accident (CVA). Resident 34's 3/2026 Annual MDS Assessment did not list CVA in Section I. On 6/5/26 at 1:45 PM, Staff 13 (MDS Coordinator) stated the diagnosis CVA was not listed in Section I for Resident 34. Staff 13 stated it should be in the MDS. On 6/5/26 at 2:15 PM Staff 1 (Administrator) stated she expected the MDS to be completed accurately. 3. a. Resident 103 admitted to the facility on [DATE] with diagnoses including osteomyelitis (bone infection) and muscle weakness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/27/26 Physician order directed staff to change Resident 103's PICC (Peripherally Inserted Central Catheter) line and dressing. A 5/27/26 physician order directed staff to administer meropenem (antibiotic) 2 grams intravenously three times a daily for the treatment of osteomyelitis. The 5/29/26 admission MDS indicated Resident 103 did not receive intravenous antibiotic therapy. On 6/1/26 at 12:51 PM, Resident 103 stated she/he received IV therapy for an infection. On 6/5/26 at 8:40 AM, Staff 13 (MDS Coordinator) acknowledged Resident 103's MDS was inaccurate. b. A 5/28/26 Smoking Screen indicated Resident 103 smoked tobacco products two to five times per day. The 5/29/26 admission MDS indicated Resident 103 was cognitively intact and did not use tobacco products. On 6/1/26 at 12:51 PM, Resident 103 stated she/he smoked cigarettes and the facility assessed her/him for smoking. On 6/5/26 at 8:40 AM, Staff 13 (MDS Coordinator) acknowledged Resident 103's MDS was inaccurate.

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(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 observation, interview, and record review it was determined the facility failed to thoroughly assess a resident after an unwitnessed fall for 1 of 2 sampled residents (#34) reviewed for accidents. This placed residents at risk for unassessed injuries. Findings include:Resident 34 was admitted to the facility in 2/2025 with diagnoses including cardiovascular accident with hemiplegia and hemiparesis. Resident 34's clinical record revealed the resident had a BIMS of 12 (moderate impairment).Resident 34's clinical record revealed an unwitnessed fall with no injuries was reported on 5/27/26. On 6/1/26 at 3:45 PM, Resident 34 stated she/he fell in her/his room and skinned her/his knees. Resident 34 was observed to have healing scabs below her/his right knee. On 6/4/26 at 6:34 PM, Staff 16 (LPN) stated on 5/27/26 she found Resident 34 after the fall. Staff 16 stated she did not remove Resident 34's clothing to assess for injuries after the resident's fall. On 6/4/26 at 7:07 PM, Staff 6 (RN) stated he completed a skin check on 6/3/26 for Resident 34. Staff 6 stated he did not know how he would have missed injuries on Resident 34's legs. On 6/5/26 at 9:26 AM, Staff 3 (Unit Manager/LPN) stated she expected nursing staff to complete a full-body skin assessment of a resident after a fall and record weekly skin checks. Staff 3 also stated a CNA told her on 6/1/26 Resident 34 had abrasions from a fall the previous week and did not assess Resident 34. On 6/5/26 at 10:00 AM, Staff 19 (LPN) completed an assessment of Resident 34's legs and identified two small, healing abrasions on Resident 34's right knee and one small, healing abrasion on the left knee. On 6/5/26 at 10:00 AM, Resident 34 stated she/he received the injuries on her/his legs when she/he fell out of her/his wheelchair the previous week. On 6/5/26 at 1:12 PM, Staff 2 (DNS) stated Staff 3 should have done an assessment of Resident 34 after being told of her/his injuries. Staff 2 stated she expected nursing staff to complete full-body assessments of residents after falls or during weekly skin checks and for them to record their finding in the clinical record. Staff 2 stated the DNS and the wound nurse needed to be notified when a resident had injuries so wounds could be assessed and monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385151	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Center	740 NW Hill Roseburg, OR 97471

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review it was determined the facility failed to address behavioral health needs timely for 1 of 1 sampled resident (#69) reviewed for mood and behavior. This placed residents at risk for lack of behavioral health care. Findings include: Resident 69 was admitted to the facility in 10/2019 with diagnoses including chronic pain and major depressive disorder. The 10/29/25 Annual MDS revealed Resident 69 had minimal depressive symptoms. The 4/28/26 IDT (Interdisciplinary Team) Care Plan Conference Evaluation revealed Witness 1 (Family Member) was not present. The 5/1/26 Quarterly MDS revealed Resident 69 had a PHQ-9 (Patient Health Questionnaire) assessment score of 13 (moderate depression) and a BIMS score of 15 (cognitively intact). The 5/1/26 Social Services Quarterly and Annual Evaluation revealed an increased PHQ-9 score from minimal to moderate and psychological services were needed. A 5/20/26 revised Care Plan directed staff to arrange for psychological consultations for Resident 69 when indicated, provide opportunities for the resident to express concerns, and encourage Witness 1 to visit often. On 6/2/26 at 9:22 AM, Resident 69 was observed in bed and fixated on the placement of her/his incontinence brief. Resident 69 stated no staff had discussed these concerns with her/him, Witness 1 visited less frequently, and staff spoke with her/him less often. Resident 69 stated she/he was willing to consider counseling services if offered. On 6/3/26 at 12:50 PM, Staff 21 (CNA) stated she believed Resident 69's mood remained consistent and the resident relied on Witness 1 and others for emotional support. On 6/4/26 at 10:26 AM, Staff 3 (Unit Manger-LPN) stated she did not observe any recent changes in Resident 69's mood and relied on Social Services staff to address Resident 69's mood-related concerns. On 6/4/26 at 11:22 PM, Staff 4 (Social Services Assistant) acknowledged Resident 69 experienced a change in mood during the most recent care conference and quarterly review. Staff 4 acknowledged Witness 1 had personal issues at home and was unable to visit as frequently. On 6/4/26 at 11:49 AM, Staff 12 (CNA) stated Resident 69's behaviors remained consistent and she only documented changes in resident behaviors. Staff 12 stated Resident 69 continued to exhibit agitation when care was not provided according to the resident's preferences. On 6/4/26 at 6:27 PM, Staff 20 (CNA) stated Resident 69 became frustrated with newly hired staff and staff who did not provide care according to the resident's expectations. On 6/5/26 at 11:29 AM, Staff 1 (Administrator) acknowledged she was responsible to refer residents for psychological services, but no email notification was received to indicate Resident 69 needed a psychological referral. Staff 1 stated she expected an email notification immediately after staff identified Resident 69 required psychological services.