STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385157	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Coos Bay	2890 Ocean Blvd Coos Bay, OR 97420

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 keep a resident free from physical restraint for 1 of 1 sampled resident (#6) reviewed for physical restraints. This placed residents at risk for potential abuse or neglect. Findings include:Resident 6 was admitted to the facility in 11/2025 with diagnoses including Alzheimer's disease. A 11/25/25 admission MDS indicated Resident 6 was severely impaired and rarely made decisions, had disorganized thinking, and altered level of consciousness. The facility's 12/8/25 investigation documented that Resident 6 had been found in bed with blankets tucked in on both sides of her/his body, restricting movement. The investigation concluded that abuse and neglect had not been substantiated, but the rolled blankets had limited the resident's movement, and staff had significantly deviated from resident-rights standards and facility policy. The investigation included the following written staff statements:-Staff 3 (CNA) reported Staff 3 and Staff 4 found Resident 6 in a praying position, lying sideways on the bed. Staff 3 and 4 assisted Resident 6 back into the center of the bed. Two subsequent times, staff found Resident 6 in a weird position, though not on the floor. Staff 3 and Staff 4 folded blankets and placed them on both sides of Resident 6 to keep the resident in a safe position in bed.-Staff 4 (CNA) documented during resident rounds she had seen Resident 6 lying sideways in a weird position. Staff 3 asked about using pillows, and Staff 11 (RN) stated it was okay. No pillows were available, so blankets were rolled up and placed under the resident on each side, with a sheet tucked in at the foot of the bed. -Staff 11 (RN) reported Resident 6 was hard of hearing and very wiggly. Staff had found the resident in weird positions at night, with her/his head on one side of the bed and feet off the other side, but not on the floor. Staff 3 had suggested using pillows, but none were available, so staff had tucked blankets under the mattress at the foot of the bed. On 4/15/26 at 9:13 AM, Staff 4 confirmed her written statement was accurate. Staff 4 stated she would never place blankets under a resident on that way again because it was considered a restraint, and Resident 6 could not exit the bed if she/he wanted to. On 4/16/26 at 7:55 AM, Staff 3 confirmed her written witness statement was accurate. Staff 3 stated she and Staff 4 were unable to find pillows, so they used blankets rolled up. Staff 3 stated she was educated and now knows it was not permitted to roll blankets as it was a restraint for Resident 6. On 4/16/25 at 8:41 AM, Staff 5 (CNA) stated when she entered Resident 6's room on 12/8/25, the resident grasped her arm and had a concerned expression. Usually, Resident 6 smiled when Staff 5 entered the room. Staff 5 stated she observed blankets waded at both sides of Resident 6 and a sheet wrapped over the top of her/him and tucked under the blankets in a manner which restricted the resident's movement. On 4/16/26 at 12:38 PM, Staff 2 (DNS) confirmed Staff 3 and Staff 4 should not have placed blankets under Resident 6 restricting her/his movement.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, it was determined the facility failed to provide a safe and orderly discharge for 1 of 3 sampled residents (#5) reviewed for discharge. This placed residents at risk for unsafe discharge. Findings included:Resident 5 was admitted to the facility in 3/2026 with diagnoses including multiple sclerosis (MS) (an autoimmune disease that affects the central nervous system, leading to damage of the nerve fibers, resulting in a range of physical and cognitive symptoms). A 3/18/26 MDS indicated Resident 5 was cognitively intact. A 3/17/26 Event Note indicated Staff 20 (Assistant DNS) was notified Resident 5 had marijuana in her/his room. Resident 5 stated her/his friend brought it in. Staff 20 educated Resident 5 on the importance and side effects with medication. Resident 5 informed Staff 20 she/he would have her/his friend pick up and remove the marijuana from the facility. Staff 20 documented Residentˆ5's friend removed the marijuana from the facility. Psychosocial Notes dated 3/18/26 indicated Staff 19 (Social Services Director) stated Resident 5 told Staffˆ20 she/he had marijuana and a pipe in her/his room on 3/18/26 and used the marijuana. Staff 19 documented staff members smelled the marijuana in her/his room. Staffˆ19 went into Resident 5's room with Staff 21 (Medical Records Director) and informed Residentˆ5 the facility could no longer continue care and would discharge her/him home on 3/18/26 because she/he had used marijuana, which violated facility policy. Residentˆ5 became upset, yelled, and kicked a table. Staff 22 (LPN Unit Care Coordinator) entered the room and informed Resident 5 the facility was federally funded and could no longer keep her/him. Staff 22 explained that smoking combined with aggressive behavior meant she/he was not in the right facility. Residentˆ5 yelled and cursed, stating she/he would not leave. Staff 20, Staff 7 (LPN), and Staff 33 (LPN) also entered the room. A 3/18/26 Care Management Note indicated Staff 22 heard Resident 5 yelling, berating staff, throwing items, and kicking the bedside table. Resident 5 had smoked marijuana in the facility. Staff discussed the policy forbidding indoor smoking. Marijuana was not allowed and was confiscated by Staff 20 on 3/17/26. Reports of continued use were received on 3/18/26. Discharge was warranted, and physician orders were obtained. Staffˆattempted to discuss discharge options; Resident 5 continued to scream, curse, and verbally insult Staff 22. Residentˆ5 refused to leave. Staff 22 stated safeˆdischarge education was needed; Resident 5 responded, I'm not going anywhere. Local law enforcement was contacted to assist. Review of Resident 5's clinical round found a Notice of Involuntary Transfer dated 3/18/26 and was issued due to resident's behaviors created a serious and immediate threat. A 3/18/26 Discharge Summary indicated Resident 5 discharged to home or community reason for discharge was non-compliance with facility policy. Resident required one person with stand pivot transfers, dressing and bed mobility. Home health services was not checked. On 4/13/26 at 8:18 AM andˆ4/15/26ˆat 8:45 AM, Resident 5 stated staff searched her/his room without consent. Staffˆ20 entered with a bag and stated she/he could not have it. Residentˆ5 stated she/he did not know the contents. Resident 5 explained that a friend brought it and he/she was unaware. With multiple sclerosis, Residentˆ5 stated she/he had difficulty with emotions from raging to crying to laughing. Resident 5 stated five staff members were in her/his room, and it felt overwhelming. Resident 5 felt attacked upon learning of the discharge. With no alternatives, she/he blew a fuse. Residentˆ5 stated she/he never smoked the marijuana and did not touch the marijuana. On 4/16/26ˆatˆ9:53 AM, Staffˆ19 stated in a 3/18/26 staff meeting she had been informed the facility would discharge Residentˆ5 for using marijuana and that Staff 20 stated Residentˆ5 had smoked the marijuana. On 4/16/26 atˆ10:17 AM, Staffˆ22 stated Residentˆ5 smoked over the weekend of 3/14/26 which was reported through the 24ˆhour report. She explained they could not safely provide care due to threats to staff. On 4/16/26 at 10:25 AM, Staff 20 stated he had found Resident 5's marijuana in her/his room. Staff 20 stated Resident 5's friend came and got the marijuana. Staff stated that Resident 5 told him they had not used any of the marijuana and was upset about being discharged . Staff 20 did not hear from other staff Resident 5 had smoked (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the facility. On 4/16/26 at 10:31 AM, Staff 21 stated during staff meeting on 3/18/26 he was informed Resident 5 had been caught smoking marijuana, and it was confiscated and was caught a second time. Staff 20 confiscated the marijuana and Resident 5 was caught a second time. On 4/16/26 at 12:27 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated on 3/17/26 Resident 5 had marijuana in her/his room and it was removed. The next morning Resident 5 was smoking in her/his room. Staff 1 thought Staff 20 had seen her/him smoking. Staff 1 stated Resident 5 had made the decision to leave. Staff 1 put in a form for involuntary transfer and thought she had completed one for a 30-day and one for an immediate transfer.