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	12/19/2025

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

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to make prompt efforts to resolve resident grievances for 1 of 1 facility reviewed for grievances. This placed residents at risk for unresolved grievances. Findings include:The facility's 1/7/25 Grievance Program policy detailed expectations for a prompt effort to resolve grievances and maintain a recordkeeping system with grievance receipt date, grievance summary statement, investigation steps, pertinent findings or conclusions, whether grievance was confirmed or not confirmed, and decision date. A review of facility grievances from 7/2025, 8/2025, 9/2025, 10/2025, and 11/2025 revealed six grievance forms with incomplete documentation to indicate the grievances were resolved. On 12/18/2025 at 1:39 PM Staff 1 (Administrator) said the process for addressing grievances was to fill out a Concern and Comment card, submit the card to the Social Services Director, complete an investigation, then once all steps toward resolution were finished the Administrator signed off on the card. Staff 1 said once her signature was on the card the investigation was considered closed. Staff 1 reviewed the six incomplete grievances and confirmed documentation toward resolution was incomplete.

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 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 ensure proper hand hygiene was completed during meals for 1 of 1 dining room reviewed for dining. This placed residents at risk for cross contamination. Findings include:The 10/28/25 Hand Hygiene Policy and Procedure indicates the facility must establish and maintain an infection prevention and control program designed to maintain to provide as a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Procedure:2. Associates perform hand hygiene (even if gloves are used) in the following situations:a. Before and after contact with the resident;b. After contact with blood, body fluids or visibly contaminated surfaces;c. After contact with objects and surfaces in the resident's environment;On 12/18/25 at 12:11 PM Staff 20 (CNA) was observed in the dining room delivering a lunch tray to a resident. Staff 20 removed lids from the bowls and cut up items on the plate for the resident. Staff 20 touched the resident's shoulder and asked if she/he needed anything else. Staff 20 touched her face, twirled her hair and adjusted her clothing while waiting for another lunch tray to be prepared by the dietary staff. Staff 20 retrieved another lunch tray and delivered the tray to a resident.On 12/18/25 at 12:20 PM Staff 20 stated she was uncertain when she was supposed to complete hand hygiene. Staff 20 acknowledged she did not sanitize her hands between delivery of the lunch trays and touching of other surfaces.On 12/18/25 at 12:40 PM Staff 2 (DNS) stated she expected staff to complete hand hygiene before they entered and left a room, in the dining room, in between handing out trays and when staff were in contact with the residents or their environment.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to provide information regarding the risks and benefits for the use of psychotropic medications prior to administration for 2 of 5 sampled residents (#s 5 and 24) reviewed for medications. This placed residents at risk for lack of informed consent. Findings include:1. Resident 5 was admitted to the facility in 3/2025 with a diagnosis of fibromyalgia (widespread chronic pain). Resident 5's 9/16/25 Quarterly MDS indicated the resident was cognitively intact with a BIMS score of 13. Resident 5's 10/2025 physician orders included amitriptyline (antidepressant) 50 mg once daily at bedtime, started on 10/21/25. There was no evidence in Resident 5's health record to indicate the resident was informed of the risks, benefits, and side effects of amitriptyline prior to administration. On 12/17/25 at 9:12 AM, Resident 5 was unable to recall details of her/his medications. On 12/18/25 at 3:02 PM, Staff 4 (LPN Resident Care Manager) reviewed Resident 5's health record and confirmed there was no evidence Resident 5 was provided the risks and benefits for the amitriptyline. 2. Resident 24 admitted to the facility in 9/2024 with diagnoses including anxiety and diabetes. A 6/5/25 physician order included sertraline 50 MG (used to treat anxiety) one time daily and a 9/16/25 physician order included trazodone 25 MG (used to treat anxiety and insomnia) at bedtime. Resident 24's 6/2025 through 12/2025 MARs revealed the resident received sertraline 50 MG daily since 6/6/25. Resident 24's 9/2025 through 12/2025 MARs revealed the resident received trazodone 25 MG nightly since 9/16/25. A review of Resident 24's medical record revealed no documentation that Resident 24 was informed of the risks and benefits for use of sertraline and trazodone prior to administration. On 12/19/25 at 8:36 AM Staff 2 (DNS) confirmed Resident 24 was not provided with the risk and benefits for use of sertraline and trazodone.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to ensure allegations of abuse were reported to the State Agency within two hours for 1 of 2 sampled residents (#52) reviewed for abuse. This placed residents at risk for continued abuse. Findings include:Resident 52 admitted to the facility in 11/2024 with diagnoses including anxiety and adult failure to thrive.An 11/4/25 Annual MDS revealed a BIMS score of 14 which indicated the resident had no cognitive impairment.Resident 52 passed away in the facility on 11/25/25.On 12/18/25 at 9:51 AM and at 1:49 PM Staff 16 (CNA) stated she witnessed Staff 17 (CNA) showing pictures of Resident 52's genitals to Staff 18 (CNA) on Staff 17's personal cell phone. Staff 16 stated the incident occurred in 11/2025, and she reported it to Staff 1 (Administrator) the following Monday.No evidence was found to indicate the incident was reported to the State Agency.On 12/18/25 at 11:27 AM Staff 1 and Staff 2 (DNS) stated they were unaware of any allegations of abuse related to Resident 52. Staff 1 stated she spoke with Staff 16 recently regarding a separate incident but was not told about an incident regarding Resident 52.On 12/18/25 at 2:15 PM Staff 1 and Staff 2 stated they just learned Staff 19 (Staffing Coordinator) was aware of the allegation of abuse involving Resident 52 in 11/2025 and it was not reported to the State Agency.On 12/18/25 at 2:28 PM Staff 19 stated on 12/8/25 in the morning before 8:30 AM, Staff 16 told her about an incident that occurred over the weekend that was already reported to Staff 1 and proceeded to tell Staff 19 about a different incident that involved Staff 17, Staff 18, and Resident 52 that occurred in 11/2025. Staff 19 stated she told Staff 16 to go report that incident to Staff 1 immediately. Staff 19 stated she did not follow up with Staff 1 to confirm the allegation of abuse was reported.On 12/18/25 at 5:33 PM Staff 2 stated she expected all staff to report any allegations of abuse immediately to their supervisor so the State Agency could be notified timely.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to notify the resident in writing of the reason for transfer to the hospital for 2 of 2 sampled residents (#s 8 and 66) reviewed for hospitalization. This place residents at risk for lack of information related to transfer. Findings include:1. Resident 8 admitted to the facility in 5/2024 with diagnoses including bipolar disorder and diabetes. A review of Resident 8's medical record revealed she/he was transferred to the hospital on [DATE] due to confusion and unrelieved pain. Resident 8 re-admitted to the facility from the hospital on [DATE] with a diagnosis of septic arthritis in the right hip. A review of Resident 8's medical record revealed no indication the resident was notified in writing of the reason she/he was transferred to the hospital. On 12/18/25 at 4:34 PM Staff 2 (DNS) stated Resident 8 was not notified in writing of the reason she/he went to the hospital. 2. Resident 66 admitted to the facility in 9/5/25 with a diagnosis of pneumonia. A 10/9/25 Progress Note revealed Resident 66 experienced a change of condition and was sent to the hospital. A review of the medical record revealed no indication a written Notice of Transfer was issues to Resident 66 or her/his resident representative. On 12/18/25 at 4:53 PM Staff 24 (LPN) stated she did not issue a written Notice of Transfer to Resident 66 when she sent her/him to the hospital and was not aware it was required.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review it was determined the facility failed to ensure residents received restorative therapies for 1 of 1 sampled resident (#1) reviewed for rehab services and falls. This placed residents at risk for a decline in ADLs and falls. Findings include:Resident 1 was admitted to the facility in 9/2025 with diagnoses including right leg fracture and sepsis (life-threatening medical emergency caused by the body's overwhelming response to an infection).A 9/23/25 admission MDS revealed a BIMS score of 15 which indicated the resident had no cognitive impairment.On 12/15/25 at 12:47 PM Resident 1 stated she/he was supposed to receive restorative services after skilled therapy ended, but staff had not walked or done any exercises with her/him in several weeks. On 12/16/25 at 1:20 PM Staff 21 (CNA) stated the facility had two RAs (Restorative Aides) and they completed all the restorative therapies for the residents. Staff 21 stated she did not do any exercises or ambulation with Resident 1. On 12/17/25 at 9:28 AM Staff 22 (CNA) stated there were RAs who completed all the restorative programs for the residents.On 12/17/25 at 1:43 PM Staff 4 (LPN, Unit Care Coordinator) stated Resident 1's restorative program was completed by the CNAs and there were no RAs in the facility. On 12/18/25 at 12:44 PM Staff 2 (DNS) Staff 2 stated she expected CNAs to read the care plan before each shift and follow the care plan related to the restorative program.

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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 follow physician orders for 2 of 7 sampled residents (#s 24 and 45) reviewed for medications and skin. This placed residents at risk for worsening wounds and unmet medical needs. Findings include: Resident 24 admitted to the facility in 9/2024 with diagnoses including chronic pulmonary embolism (when blood clots in the lung arteries don't dissolve leading to blocked blood flow) and diabetes. A review of the 12/2025 MAR revealed a 6/5/25 physician order for Eliquis (an anticoagulant) 5 MG one tablet by mouth two times a day for chronic pulmonary embolism. The 12/11/25, 12/12/25, and 12/13/25 MAR indicated the 8 AM dose was not given to Resident 24 and coded as, Other/See Progress Note by Staff 21 (LPN). A review of Resident 24's progress notes for 12/11/25, 12/12/25, and 12/13/25 revealed Eliquis 5 MG tablet was on order. No further information was documented. On 12/17/25 at 1:30 PM and on 12/18/25 at 4:49 PM Staff 21 stated if a resident was out of a medication the pharmacy and physician was notified, and she checked the Omnicell machine (an automated medication management system to securely store, track, dispense, and manage pharmaceuticals) to see if the medication was on hand. Staff 21 stated if she notified the physician and pharmacy, she would have made a progress note in the resident's chart. Staff 21 stated she did not recall if she checked the Omnicell on 12/11/25, 12/12/25, and 12/13/25 for Resident 24's Eliquis medication. On 12/18/25 at 5:28 PM Staff 2 (DNS) stated if a resident was out of a medication the nurse was to verify it was re-ordered and check if the medication was available in the Omnicell. If the medication was not available, the nurse was to call the pharmacy to satellite the order, notify the physician of a missed dose of medication and the nurse on-call was to be notified. Staff 2 stated Eliquis 5 MG tablet was a medication available in the Omnicell and stated she was the nurse on-call during the weekday. Staff 2 stated she was not notified by Staff 21 that Resident 24 missed a dose of Eliquis on 12/11/25, 12/12/25, and 12/13/25. On 12/19/25 at 8:36 AM Staff 2 provided an Omnicell Transaction by Item, Eliquis 5 MG tablet 1 each, report for a date range of 12/7/25 through 12/13/25. This report revealed the following two transactions: -12/12/25 at 7:43 PM one Eliquis 5 MG tablet was dispensed from the Omnicell for Resident 24 and there was a total of eight Eliquis 5 MG tablets on hand in the Omnicell. -12/13/25 at 7:30 PM one Eliquis 5 MG tablet was dispensed from the Omnicell for Resident 24 and there was a total of seven Eliquis 5 MG tablets on hand in the Omnicell. On 12/19/25 at 11:25 AM Staff 2 confirmed Eliquis 5 MG tablet was available in the Omnicell and should have been given to Resident 24 on 12/11/25, 12/12/25, and 12/13/25 per the physician order. 2. Resident 45 admitted to the facility in 7/2024 with a diagnosis of diabetes. A 12/3/25 physician order revealed Resident 45 was to receive wound care on her/his right shin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every three days. The 12/2025 MAR revealed Resident 45 was documented to have received wound care on her/his right shin on 12/12/25 by Staff 21 (LPN) and on 12/15/25 by Staff 25 (LPN). On 12/15/25 at 4:24 PM Resident 45's right shin was observed with a dressing in place with 12/8 written on it. On 12/16/25 at 10:27 AM Resident 45's right shin was observed with a dressing in place with 12/8 written on it. Resident 45 stated her/his wound was last changed on whatever date was written on the dressing. On 12/16/25 at 10:31 AM Staff 25 confirmed Resident 45's wound care was scheduled to be completed every three days and the current dressing on her/his right shin was dated 12/8. Staff 25 stated Resident 45's wound care needed to be completed. On 12/18/25 at 12:55 PM Staff 21 stated she did not recall if she changed Resident 45's right shin dressing as scheduled on 12/12/25, but if she did, she would have signed and dated the dressing. On 12/18/25 at 3:00 PM Staff 2 (DNS) stated Resident 45's dressing was expected to be changed as scheduled and when the nurse changed dressings they were to sign and date the dressing. On 12/18/25 at 4:13 PM Staff 25 stated she saw Resident 45's 12/15/25 wound care was not completed and stated she if she signed the wound care as complete, she would have intended to complete the task but did not get to it. Staff 25 stated she did not recall if she asked another nurse to do Resident 45's 12/15/25 wound care.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure an antibiotic was indicated for use for 1 of 5 sampled residents (#5) reviewed for medications. This placed residents at risk for antibiotic resistant organisms and unresolved infections. Findings include:The facility's 7/22/25 Antibiotic Stewardship Policy indicated the facility should follow the McGeer Criteria for assessment of residents suspected of having an infection prior to initiation of antibiotics. According to Revised McGeer Criteria for Infection Surveillance, UTI without indwelling catheter must fulfill at least one sign or symptom on a checklist. The symptoms include discomfort, fever, leukocytosis, hematuria, and/or increase in incontinence, urgency, or frequency.Resident 5 was admitted to the facility in 3/2025 with diagnoses including fibromyalgia (widespread chronic pain). Resident 5's 11/15/25-12/1/25 progress notes revealed no urinary complaints including discomfort, fever, leukocytosis, hematuria, or increased urgency/frequency/incontinence.Resident 5's health record demonstrated a UA collection occurred on 12/1/25. Resident 5's health record revealed no corresponding physician order for the UA.A 12/1/25 UA Final Result report reflected positive results for leukocytes, nitrites, protein, blood, and two or more types of bacteria. There was no evidence in the resident record to support a sensitivity was completed to identify an appropriate antibiotic to treat the UTI.A 12/4/25 Physician Order included Nitrofurantoin (antibiotic) 100 mg, one capsule by mouth twice daily for 10 days for UTI.On 12/18/25 at 4:45 PM, Staff 15 (Medical Director) reviewed the 12/1/25 UA report and confirmed it reflected positive results which supported the need for a culture and sensitivity test. Staff 15 indicated the importance of starting residents on an accurate antibiotic to eliminate bacteria causing a UTI.On 12/19/25 at 10:46 AM, Staff 2 (DNS) confirmed Resident 5's health record lacked documentation of any urinary complaints leading up to the 12/1/25 UA and acknowledged the lack of a physician order for the UA test. Staff 2 stated Resident 5's 12/1/25 UA results were indicative a culture and sensitivity should have been carried out to ensure the appropriate antibiotic was administered.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review it was determined the facility failed to ensure lab services were provided when ordered for 1 of 5 sampled residents (#24) reviewed for medications. This placed residents at risk for unnecessary blood draws. Findings include:Resident 24 admitted to the facility in 9/2024 with diagnoses including diabetes and anxiety.A 12/4/25 pharmacy recommendation revealed Resident 24 received a thyroid replacement medication but a TSH (Thyroid-Stimulating Hormone) laboratory test within the last year was not located in the resident's medical record.A 12/10/25 physician order revealed an order for a fasting lipid panel, TSH and serum magnesium concentration laboratory test scheduled for 12/10/25.A review of the 12/2025 TAR revealed the task to draw labs for a fasting lipid panel, TSH and serum magnesium concentration was completed on 12/10/25 at 5:34 AM.A review of the 12/11/25 lab results revealed results to the lipid panel and magnesium tests, but no indication of results for the TSH lab test.A review of Resident 24's record revealed no indication of the TSH lab results.On 12/18/25 at 4:15 PM Staff 4 (LPN Unit Care Coordinator) confirmed the TSH lab was not drawn for Resident 24 and should have been drawn on 12/10/25 with the lipid panel and magnesium. Staff 4 stated she expected staff to ensure lab services were provided when ordered.