STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385161	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Freewater Health and Rehabilitation	120 Elzora Street Milton Freewater, OR 97862

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review it was determined the facility failed to prevent drug diversion for 2 of 2 residents (#s 29 and 38) reviewed for misappropriation. This placed residents at risk for misappropriation of personal medications. Findings include:A facility policy regarding misappropriation dated 3/2025 stated the following:Each resident has the right to be free from misappropriation of resident property.Misappropriation of resident property includes diversion of a resident's medications for staff use or personal gain.1. Resident 38 was admitted to the facility in 2/2025 with diagnoses including loss of a lower extremity below the knee as result of frost bite.A 10/22/25 Physician Order stated hydrocodone-acetaminophen 5-325 mg to be provided as needed to address Resident 38's pain.An 11/11/25 Quarterly MDS revealed Resident 28 had normal cognitive function.Review of Resident 38's 11/2025 MAR revealed Resident 38 was documented as having received four doses of hydrocodone-acetaminophen at the following times on 11/20/25: 1:38 AM, 6:56 AM, 7:00 PM, and 11:30 PM.An 11/21/25 Grievance Form completed by Resident 38 stated her/his pain was managed by receiving one dose of her/his pain medication in the morning and one in the evening. Resident 38 stated, I don't ever ask for an extra [pain pill] because I know eventually they wont work for me anymore. Even if I need an extra, I distract myself until it is time for the regular dose.An 11/26/25 Incident Report stated Resident 38 was approached by Staff 17 (CMA) on 11/21/25 to determine if her/his pain had been reduced after she/he had received hydrocodone at 11:30 PM on 11/20/25. Resident 38 stated she/he had not requested or received additional hydrocodone medication outside of her/his normal routine on 11/20/25. After Staff 17 was provided this information, Staff 2 (DNS) was notified of the discrepancy of records and Resident 38's report and reviewed medication administration records for all residents from 10:00 PM on 11/20/25 to 3:30 AM on 11/21/25 and identified eight total residents who were reported to have requested and received PRN hydrocodone which was outside of their normal routine. Six of the eight residents were reported to be mostly non-verbal and did not have a history of requesting PRN pain medications.Attempts to interview Resident 38 were unsuccessful as Resident 38 no longer lived in the facility and did not respond to phone calls.Attempts to interview Staff 18 (RN) were unsuccessful as Staff 18 no longer worked at the facility and did not respond to phone calls. On 1/13/26 at 11:40 AM Staff 17 (CMA) stated she recalled two days when Resident 38's medication records indicated she/he required additional doses of hydrocodone which were not received by Resident 38. Staff 17 stated Resident 38 did not have any cognitive deficiencies had a routine of requesting PRN hydrocodone which was around 7:00 AM and around 7:00 PM. Staff 17 stated she notified the charge nurse and DNS after records conflicted with Resident 38's statements and routine of requesting medications.On 1/13/26 at 12:08 PM Staff 2 stated Staff 17 reported concerns of drug diversion on 11/21/25. Staff 2 stated upon review of the Controlled Substance Record Book and Resident 38's MAR, there was a discrepancy in the typical routine of medication administration for Resident 38 as well as seven additional residents. Staff 2 stated Resident 38 was asked about pain levels on the morning of 11/21/25 because records indicated she/he had requested hydrocodone-acetaminophen twice outside of her/his normal routine. Staff 2 reported Resident 38 stated she/he did not request additional medications on 11/20/25 or 11/21/25.On 1/13/26 at 12:23 PM Staff 1 (Administrator) and Staff 3 (Regional RN) confirmed (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of Resident 38's medications occurred by Staff 18 on at least three administrations of pain medications. Staff 3 stated upon review of the records of eight residents, including Resident 38, a pattern of documented administration of hydrocodone-acetaminophen during the night to residents who had not requested these medications was found. Staff 1 and Staff 3 confirmed this when Resident 38 was questioned about her/his pain levels by Staff 17, and Resident 38 reported he did not request or receive additional hydrocodone on 11/20/25 or 11/21/25 from Staff 18.On 11/26/25, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a pattern of drug diversion. The Plan of Correction included: 1. Staff 18 was immediately suspended and then terminated. 2. The Staff 2 and Staff 3 reviewed medication administration records for all residents to determine the pattern of drug diversion. 3. Nurses and new hires were educated about drug diversion and how to follow-up with concerns related to resident concerns with not receiving pain medications. 4. Staff 2 and Staff 4 (RNCM) monitored PRN pain medications daily to determine potential diversion. 5. Medication administration of narcotics were reviewed for non-use and discontinued medications when appropriate.2. Resident 29 was admitted in 4/2025 with diagnoses including hemiplegia (loss of motor and/or sensory function of one side of the body).A 9/30/25 Annual MDS revealed Resident 29 had normal cognitive function.An 11/4/25 Physician Order stated 5-325 mg of hydrocodone-acetaminophen was to be provided to Resident 29 as needed ever four hours to reduce her/his pain.Review of Resident 29s 11/2025 MAR revealed Resident 29 was documented to have received hydrocodone-acetaminophen on 11/21/25 at 3:36 AM from Staff 18 (RN).An 11/21/25 Grievance Form completed by Resident 29 stated Resident 29 was unable to receive a pain medication when requested on 11/21/25 around 6:30 AM. Resident 29 complained that she/he had requested a pain medication in the morning on 11/20/25 and 11/21/25 and was told it was too early. Resident 29 stated she/he usually slept through the night and would have remembered waking up during the middle of the night and requesting to receive a pain medication. Resident 29 also stated she/he would have remembered tasting the hydrocodone-acetaminophen.A 11/26/25 Incident Report stated Resident 29 requested a pain medication after she/he had woken up at 6:15 AM on 11/21/25. Resident 29 was told she/he had received this medication at 3:36 AM and was unable to receive the medication until 7:36 AM. Resident 29 stated she/he did not receive the medication at 3:36 AM and stated she/he would just have to suffer until then. Staff 17 (CMA) stated this information sounded unusual.On 1/13/26 Staff 17 stated she worked on 11/21/25 when Resident 29 requested a pain medication and Staff 18 overheard the request and chimed in stating it was too early. Staff 17 stated this was unusual. Staff 17 stated after another resident was asked about her/his pain level due to having received pain medication outside of her/his routine, she suspected potential drug diversion.On 1/13/26 at 12:08 PM Staff 2 (DNS) stated Staff 17 reported concerns of drug diversion on 11/21/25. Staff 2 stated upon review of the Controlled Substance Record Book and Resident 29's MAR, there was a discrepancy in the typical routine of medication administration for Resident 29 as well as seven additional residents. Staff 2 stated Resident 29 had requested a pain pill on 11/21/25 and was told she/he had already received one a couple hours earlier. Staff 2 stated Resident 29 stated she/he had not received a dosage of pain medication around 3:00 AM.On 1/13/26 at 12:23 PM Staff 1 (Administrator) and Staff 3 (Regional RN) confirmed misappropriation of Resident 38's pain medications occurred on 11/21/25. Staff 3 stated when drug diversion was suspected, a review of medication administration was performed for all residents and was determined to have occurred by Staff 18 on 11/21/25. Upon review of the records of eight residents, including Resident 29, a pattern of documented administration of hydrocodone-acetaminophen to residents who do not request this medication during the middle of the night was found.The deficient practice was identified as Past Noncompliance based on the following:On 11/26/25, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a pattern of drug diversion. The Plan of Correction included: 1. Staff 18 was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately suspended and then terminated. 2. The Staff 2 and Staff 3 reviewed medication administration records for all residents to determine the pattern of drug diversion. 3. Nurses and new hires were educated about drug diversion and how to follow-up with concerns related to resident concerns with not receiving pain medications. 4. Staff 2 and Staff 4 (RNCM) monitored PRN pain medications daily to determine potential diversion. 5. Medication administration of narcotics were reviewed for non-use and discontinued medications when appropriate.

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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 interview and record review it was determined the facility failed to follow physician orders for 1 of 1 sampled residents (#1) reviewed for medication administration. This placed residents at risk for adverse side effects. Findings include:Resident 1 was admitted to the facility in 9/2023 with diagnoses including pneumonia (an infection of the lungs) and unspecified convulsions.Resident 1's 11/24/25 Annual MDS indicated the resident was cognitively intact.Resident 1's 10/2025 MAR indicated the resident was to have levetiracetam (an anticonvulsant) twice a day for unspecified convulsions. Review of Resident 1's medical record revealed the following laboratory order:- 10/4/25 levetiracetam level for two days, must be done before resident takes morning dose. Review of Resident 1's 10/2025 MAR revealed she/he did not receive levetiracetam on 10/4/25, 10/5/25 and 10/6/25. Medication administration resumed on 10/7/25.The Facility's investigation dated 10/6/25 included the following:- On 10/6/25 it was noted Resident 1's levetiracetam was not active on her/his MAR.- Resident 1 was reported to have had mild seizure activity on 10/4/25 and 10/5/25 but did not require emergency treatment or hospitalization.- It was determined Staff 9 (RN) discontinued Resident 1's levetiracetam administration order on 10/3/25, the same day a laboratory order was received to check the resident's levetiracetam level.- Staff 10 (Medical Director) was notified and Resident 1's levetiracetam administration order was reinstated.- Resident 1 was placed on a 72-hour assessment alert, and no further seizure activity was observed or reported.On 1/12/26 at 10:35 AM Resident 1 stated she/he recalled having seizures in 10/2025 of last year. Resident 1 stated her/his whole body shook for several minutes, but denied experiencing any pain, distress or injury because of the seizures. The resident stated she/he was not aware of missing any doses of levetiracetam. On 1/13/26 at 1:15 PM Staff 7 (RN) stated they were notified by Staff 13 (CNA), they observed Resident 1 having a seizure. Resident 1 was assessed and found to have no adverse effects resulting from the seizure. Following Resident 1's seizure Staff 7 reviewed the MAR and found her/his levetiracetam was discontinued. Staff 7 notified both Staff 10 and Staff 2 (DNS), and Staff 10 gave verbal orders to reinstate the resident's medication order.On 1/13/26 at 1:35 PM Staff 13 stated she observed Resident 1 having a seizure while in her/his room and notified Staff 7. Staff 13 denied Resident 1 showed any signs of pain, distress, injury or lasting effects of the seizure.On 1/14/26 at 1:30 PM Staff 2 stated they investigated the incident, and it was discovered Staff 9 (RN) discontinued Resident 1's levetiracetam rather than place it on hold for a levetiracetam level blood draw as ordered. Staff 2 acknowledged the medication administration error and stated a corrective plan was immediately implemented. Multiple attempts were made to reach Staff 9 for interview but were unsuccessful. The deficient practice was identified as Past Noncompliance based on the following:On 10/6/25 the deficient practice was identified by the facility and corrected with the following actions:- One-on-one training with Staff 9 was provided on accurately entering orders into the electronic medical record.- All other residents with seizure diagnoses were reviewed and verified there were no changes to their seizure medications.- All nursing staff were provided with education on accurately entering orders into the electronic medical record. - A two-step verification process to ensure all orders were entered accurately in the electronic medical record was implemented. - The medication error was reviewed at the facility's QAA (Quality Assessment and Assurance) meeting, and no additional trends were identified.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review the facility failed to ensure 1 of 2 sampled residents (#13) reviewed for urinary catheter received appropriate services when staff failed to ensure catheter tubing did not touch the floor. This failure placed residents at increased risk for urinary tract infections (UTIs) and its associated complications. The Centers for Disease Control and Prevention (CDC) website's 6/27/25 Catheter-associated Urinary Tract Infection (CAUTI) Basics revealed a CAUTI occurs when germs enter the urinary tract through a urinary catheter and cause infection. Heathcare workers and facilities can prevent CAUTIs and protect patients with proper infection control processes. The CDC's undated Indwelling Urinary Catheter Insertion and Maintenance Guide instructed urine bags to be kept off the floor and for staff to incorporate observation of urinary catheter and bag into routine rounds. Resident 13 was admitted to the facility in 6/2023 with diagnoses including presence of urogenital implants (having artificial devices in the urinary or reproductive organs, often to restore function like urinary control or erectile function) and obstructive and reflux uropathy (a urinary system problem where urine flow is blocked and/or flows backward toward the kidneys). Resident 13's 11/18/25 Quarterly MDS revealed the resident was moderately cognitively impaired and had an indwelling catheter and UTI in the past 30 days.Resident 13's 11/25/25 Care Plan indicated the following:-The resident had a superpubic catheter (a tube inserted directly into the bladder through a small incision in the lower abdomen, above the pubic bone, to drain urine when normal urination is difficult or impossible). -Staff were to position the resident's catheter bag and tubing below the level of the bladder and away from entrance to the room.-Staff were to check for a catheter strap or securement device (used to hold an indwelling catheter tube or a drainage leg bag securely against the skin).A 12/20/25 Resident Infection Report indicated Resident 13 had a UTI with an Indwelling Catheter. On 1/12/26 at 7:52 AM, Resident 13 was observed in her/his room asleep in a recliner chair. The catheter tubing that extended out from the resident's leg and connected to the catheter bag that hung on the resident's walker at the end of the recliner chair was observed to be on the floor. On 1/12/26 at 9:30 AM, Resident 13 was observed in her/his wheelchair in her/his room. Resident 13 stated she/he had a UTI about a month ago and staff told her/him it was caused by the catheter. On 1/13/26 from 9:50 AM to 10:07 AM, Resident 13 was observed in her/his wheelchair in the hallway. The resident's catheter tubing was filled with clear yellow urine and observed on the floor. At 10:01 AM, an unidentified staff member provided the resident a cup of coffee and Staff 14 (CNA) was observed in the hallway at this time and entered the room next to the resident. Neither staff assisted the resident to secure her/his catheter tubing off of the floor. On 1/13/26 at 11:23 AM, Resident 13 was observed in her/his wheelchair in her/his room and the resident's catheter tubing was on the floor. At 11:25 AM, Staff 2 (DNS) entered the resident's room and assisted her/him with her/his oxygen concentrator. At 11:27 AM, Staff 14 entered the resident's room, placed the resident's meal tray on an overbed table and exited the room. At 11:32 AM, Staff 2 exited the room. Staff 2 observed the resident's catheter tubing from the hallway outside of the resident's room, confirmed it was on the floor and stated it should not be. Staff 2 stated the tubing may have become loose when we were moving around, but Staff 2 did not confirm secure placement of the tubing before she exited the room. On 1/14/26 at 3:27 PM, Resident 13 was observed in her/his room in her/his wheelchair. The resident's catheter tubing was filled with clear yellow urine and observed on the floor. On 1/15/26 at 10:22 AM, Staff 7 (RN) stated catheter tubing should never be on the floor as it placed residents at risk for infection. On 1/15/26 at 11:04 AM, Staff 5 (RN) stated Resident 13 had a superpubic catheter and she/he had been diagnosed with a couple of UTIs recently. Staff 5 stated she had observed the resident's catheter tubing on the floor during transfers and when the resident was in her/his recliner chair. Staff 5 stated staff were expected to keep catheter tubing off of the floor as it placed residents at risk for infection. On 1/15/26 at 11:16 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Staff 16 (CNA) stated it was not okay for catheter tubing to be on the floor, and she observed Resident 13's catheter tubing to be on the floor at least once a week. On 1/15/26 at 11:25 AM, Staff 15 (CNA) stated Resident 13 had experienced multiple UTIs lately. Staff 15 stated the resident never refused catheter care and was always concerned with the placement of her/his catheter tubing. Staff 15 stated Resident 13 required frequent checking and fixing of her/his catheter tubing. Staff 15 further stated the resident's tubing should never be on the floor as it placed her/him at risk for infection.On 1/15/26 at 12:22 PM, Staff 4 (RNCM) stated Resident 13 got UTIs too much, roughly every couple of months. Staff 4 stated Resident 13's catheter tubing was supposed to be off of the floor at all times because tubing on the floor placed the resident at increased risk of infection. On 1/15/26 at 12:39 PM, Staff 6 (IP) acknowledged the findings of this investigation and stated he expected Resident 13's catheter tubing to be off of the floor at all times and for staff to ensure proper placement of the catheter tubing with each resident interaction.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review it was determined the facility failed to ensure sufficient staffing to meet resident care needs for 3 of 3 residents (#s 1, 8 and 22) reviewed for sufficient and competent staffing. This placed residents at risk for delayed and unmet care needs. Findings include:1. Resident 8 was admitted to the facility in 12/2025 with diagnoses including colon cancer. Resident 8's 12/25/25 admission MDS revealed the resident was cognitively intact.Resident 8's 1/12/26 Care Plan indicated the resident was to be offered a shower each day during dayshift and she/he required assistance from two staff for showers. A review of Resident 8's Bathing Task Log from 12/20/25 to 1/13/26 revealed bathing activity did not occur on 12/20/25, 12/28/25, 1/2/26, 1/4/26, 1/6/26, 1/12/26 and 1/13/26. On 1/13/26 at 11:13 AM, Staff 14 (CNA) stated she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 14 stated on days when they were short staffed, she was not able to complete all of her assigned responsibilities, including resident showers. On 1/13/26 at 1:08 PM, Staff 13 (CNA) stated she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 13 stated when the facility was short-staffed, resident care was rushed and resident showers were especially impacted. Staff 13 stated today has been overwhelming and showers were not happening because we were so busy. On 1/13/26 at 1:23 PM, Staff 11 (CNA) stated when the facility was short-staffed, like today, it is really hard and 'there are things that don't get done, including showers. On 1/13/26 at 3:00 PM, Staff 19 (CNA) stated the facility was short-staffed all of the time which made it difficult to complete resident showers. On 1/14/26 at 10:42 AM, Staff 5 (RN) stated the facility was short a CNA at least weekly and the biggest area of resident care that was impacted was residents not getting showers. Staff 5 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/14/26 at 12:48 PM, Staff 11 (CNA) stated when she marked a bathing activity did not occur on a resident's Bathing Task Log that indicated she did not have time and could not complete the task. On 1/14/26 at 12:52 PM, Resident 8 was observed in her/his room in bed. Resident 8 stated she/he was scheduled to receive a bed bath on 1/13/26 but she/he was not offered one. Resident 8 further stated she/he received bed baths once a week but preferred to have them more often. On 1/14/26 at 1:08 PM, Staff 14 (CNA) stated she marked a bathing activity did not occur on a resident's Bathing Task Log when the facility was short-staffed and there was not time to offer a shower or bed bath to a resident. On 1/14/26 at 3:12 PM, Staff 8 (RN) stated resident showers were the biggest thing affected when the facility was short-staffed. Staff 8 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/15/26 at 1:21 PM, Staff 2 (DNS) acknowledged Resident 8 did not receive her/his showers as indicated in her/his care plan, and she expected resident showers to be completed even when the facility was short-staffed. Staff 2 further stated she expected residents to be offered a shower or bed bath the next shift or the next day if staff were unable to complete them as scheduled. 2. Resident 22 was admitted to the facility in 12/2025 with diagnoses including lymphedema (chronic swelling from a buildup of lymph fluid in soft tissues, usually the arms or legs).Resident 22's 12/11/25 admission MDS revealed the resident was cognitively intact.Resident 22's 1/13/26 Care Plan indicated the following:-The resident preferred a shower or a bed bath.-The resident's scheduled bathing days were dayshift on Tuesdays and evening shift on Fridays. A review of Resident 22's Bathing Task Log from 12/15/25 to 1/13/26 revealed a bathing activity did not occur on 12/30/25, 1/3/26 or 1/13/26.On 1/13/26 at 11:13 AM, Staff 14 (CNA) stated she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 14 stated on days when they were short staffed, she was not able to complete all of her assigned responsibilities, including resident showers. On 1/13/26 at 1:08 PM, Staff 13 (CNA) stated (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 13 stated when the facility was short-staffed, resident care was rushed and resident showers were especially impacted. Staff 13 stated today has been overwhelming and showers were not happening because we were so busy. On 1/13/26 at 1:23 PM, Staff 11 (CNA) stated when the facility was short-staffed, like today, it is really hard and 'there are things that I don't get done, including showers. On 1/13/26 at 2:06 PM, Resident 22 was observed in her/his room in her/his wheelchair. Resident 22 stated the facility was short-handed so she/he did not always receive her/his scheduled showers or bed baths. Resident 22 stated she was scheduled to receive a shower today and she/he wanted one. On 1/13/26 at 3:00 PM, Staff 19 (CNA) stated the facility was short-staffed all of the time which made it difficult to complete resident showers. On 1/14/26 at 8:51 AM, Resident 22 stated she/he did not receive either a shower or bed bath on 1/13/26 nor was she/he offered one. On 1/14/26 at 10:42 AM, Staff 5 (RN) stated the facility was short a CNA at least weekly and the biggest area of resident care that was impacted was residents not getting showers. Staff 5 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/14/26 at 12:48 PM, Staff 11 (CNA) stated when she marked a bathing activity did not occur on a resident's Bathing Task Log that indicated she did not have time and could not complete the task. On 1/14/26 at 1:08 PM, Staff 14 (CNA) stated she marked a bathing activity did not occur on a resident's Bathing Task Log when the facility was short-staffed and there was not time to offer a shower or bed bath to a resident. On 1/14/26 at 3:12 PM, Staff 8 (RN) stated resident showers were the biggest thing affected when the facility was short-staffed. Staff 8 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/15/26 at 1:21 PM, Staff 2 (DNS) acknowledged Resident 22 did not receive her/his showers as scheduled, and she expected resident showers to be completed even when the facility was short-staffed. Staff 2 further stated she expected residents to be offered a shower or bed bath the next shift or the next day if staff were unable to complete them as scheduled. 3. Resident 1 was admitted to the facility in 9/2023 with diagnoses including hemiplegia (total paralysis on one side of the body) and hemiparesis (partial weakness on one side) following a stroke. Resident 1's 11/24/25 Annual MDS revealed the resident was cognitively intact and dependent on the assistance from staff for all bathing activities. Resident 1's 12/18/25 Care Plan revealed the resident was to receive a bed bath or shower twice weekly on Tuesdays and Fridays. A review of Resident 1's Bathing Task Log from 12/15/25 to 1/13/26 revealed a bathing activity did not occur on 1/13/26. On 1/13/26 at 11:13 AM, Staff 14 (CNA) stated she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 14 stated on days when they were short staffed, she was not able to complete all of her assigned responsibilities, including resident showers. On 1/13/26 at 1:08 PM, Staff 13 (CNA) stated she worked dayshift at the facility, and they were short-staffed during her shift today. Staff 13 stated when the facility was short-staffed, resident care was rushed and resident showers were especially impacted. Staff 13 stated today has been overwhelming and showers were not happening because we were so busy. On 1/13/26 at 1:23 PM, Staff 11 (CNA) stated when the facility was short-staffed, like today, it is really hard and 'there are things that I don't get done, including showers. On 1/13/26 at 3:00 PM, Staff 19 (CNA) stated the facility was short-staffed all of the time which made it difficult to complete resident showers. On 1/14/26 at 10:42 AM, Staff 5 (RN) stated the facility was short a CNA at least weekly and the biggest area of resident care that was impacted was residents not getting showers. Staff 5 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/14/26 at 12:48 PM, Staff 11 (CNA) stated when she marked a bathing activity did not occur on a resident's Bathing Task Log that indicated she did not have time and could not complete the task. On 1/14/26 at 1:08 PM, Staff 14 (CNA) stated she marked a bathing activity did not occur on a resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385161	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Freewater Health and Rehabilitation	120 Elzora Street Milton Freewater, OR 97862

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bathing Task Log when the facility was short-staffed and there was not time to offer a shower or bed bath to a resident. On 1/14/26 at 2:43 PM, Resident 1 was observed in her/his room in bed. Resident 1 stated she/he was scheduled to receive a bed bath on 1/13/26 but she/he was not offered one. Resident 1 stated she/he would have liked to have had one yesterday and will have to wait to receive one until her/his next scheduled day. On 1/14/26 at 3:12 PM, Staff 8 (RN) stated resident showers were the biggest thing affected when the facility was short-staffed. Staff 8 further stated when staff were unable to assist a resident with a shower or bed bath on the resident's scheduled day, the resident had to wait until their next scheduled day to receive a shower or bed bath. On 1/15/26 at 1:21 PM, Staff 2 (DNS) acknowledged Resident 1 did not receive her/his showers as scheduled, and she expected resident showers to be completed even when the facility was short-staffed. Staff 2 further stated she expected residents to be offered a shower or bed bath the next shift or the next day if staff were unable to complete them as scheduled. Refer to M185.

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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 observation, interview and record review it was determined the facility failed to ensure residents were free from unnecessary antibiotic medications for 1 of 5 sampled residents (#22) reviewed for unnecessary medications. This placed residents at risk for the development of antibiotic-resistant organisms and other serious infections. Findings include: The facility's 3/2018 Antimicrobial Stewardship Program Policy directed the following:-Applicable SBAR (Situation, Background, Assessment and Recommendation, a structured communication tool used by healthcare professionals to quickly and effectively convey critical patient information) tools are utilized to guide clinicians in the evaluation of clinical signs and symptoms potentially indicative of infection. -The clinical rationale to support the use of antibiotics, if using outside current clinical guidelines, is to be documented.-Communication with the resident and/or resident representative regarding the treatment plan and appropriate use of antibiotics is to be documented. -The DNS or IP is to collaborate with providers and Medical Director regarding resident clinical status and current treatment, communicating inappropriate treatment and need for alternative as needed.-Antibiotics are to be stopped when not pertinent or appropriate. Resident 22 was admitted to the facility in 12/2025 with diagnoses including congestive heart failure. Resident 22's 12/11/25 admission MDS revealed the resident was cognitively intact.A 12/26/25 Progress Note revealed Resident 22 was placed on alert charting related to the resident's complaint of a nonproductive cough. A review of Resident 22's clinical record from 12/26/25 to 1/4/26 revealed the resident received Mucinex (an over-the-counter medicine used for cough, cold and flu symptoms) for cough congestion each day. The clinical record further indicated she/he was afebrile (without fever), not short of breath and not observed to cough. A 1/4/26 Progress Note written by Staff 9 (RN) revealed Staff 10 (Medical Director) was notified of the following:-Resident 22 informed Staff 9 she/he had been coughing since 12/5/25 and the cough medicine she/he received was ineffective.-Resident 22 reported she/he had been coughing up brown sputum (mucus coughed up from the lungs and lower airways).-Wheezing was noted in the resident's lungs.-The resident's vital signs were stable and the resident did not have a fever.-The resident requested antibiotics. Resident 22's 1/2026 MARs revealed the resident received doxycycline (a broad-spectrum antibiotic) twice daily from 1/5/26 to 1/10/26 for MD ordered for 5 days. On 1/14/26 at 8:51 AM, Resident 22 was observed in her/his room in bed. Resident 22 stated Staff 10 prescribed her/him an antibiotic a few weeks ago per her/his request. On 1/14/26 at 10:13 AM and 1:14 PM, Staff 5 (RN) stated Staff 10 ordered doxycycline for Resident 22 due to the resident's complaints of a cough and not feeling well. Staff 5 stated she recalled the resident to have a dry and non-productive cough with stable vital signs at the time the antibiotics were prescribed. On 1/14/26 at 10:52 AM, Staff 10 stated he prescribed doxycycline to Resident 22 because staff reported to him the resident was short of breath, had sputum production and had a fever. Staff 10 stated in the absence of these symptoms, he still would have prescribed the resident the antibiotic if she/he had diagnoses of asthma, COPD (Chronic Obstructive Pulmonary Disease) or something like that. Staff 10 further stated it would be a little more iffy to prescribe an antibiotic to a resident without either of these diagnoses and the only observed symptom being a non-productive cough. No evidence was found in Resident 22's clinical record to indicate she/he had diagnoses of asthma or COPD. On 1/14/26 at 1:03 PM, Staff 11 (CNA) stated she did not recall Resident 22 to cough or complain of a cough. Staff 11 further stated the resident always seemed like her/himself since her/his admission to the facility, and she did not recall any concerns with the resident's vital signs. On 1/14/26 at 2:50 PM Staff 8 (RN) stated she recalled Resident 22 to have a cough in 12/2025 but it seemed to get better. Staff 8 stated the resident was worried about a cough and requested to be on an antibiotic. Staff 8 further stated the resident's vital signs were within normal limits and she/he did not have a fever at the time the doxycycline was prescribed. On 1/14/26 at 3:52 PM, Staff 12 (CNA) stated she had never observed Resident 22 to cough.On 1/15/26 at 9:06 AM, Staff 9 (RN) stated Resident 22 reported to (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her on 1/4/26 she/he had been coughing stuff up and it was brown. Staff 9 stated the resident's vitals were fine, she had only observed Resident 22 to have a dry cough, and when she listened to the resident's lungs on 1/4/26, she did not hear any crackles (popping, bubbling, or rattling sounds that often signal fluid in the lungs, pneumonia or bronchitis), just some wheezing. Staff 9 further stated she did not use any type of clinical tool to gather and report symptoms to Staff 10, and Resident 22 received an order for the doxycycline because she/he asked for it. On 1/15/26 at 11:50 AM, Staff 4 (RNCM) stated she was unsure if nurses utilized a tool to evaluate clinical signs and symptoms to indicate a possible respiratory infection when providing a report of a resident's clinical status to their medical provider. Staff 4 stated the criteria for prescribing an antibiotic for a respiratory infection included a fever, low oxygen saturations, results from an x-ray that indicated pneumonia and overall risk of symptoms to the resident. Staff 4 stated the only indication for Resident 22's antibiotic prescription was a cough. On 1/15/26 at 12:30 PM, Staff 6 (IP) stated Resident 22 received an order for doxycycline because she/he requested the antibiotic, and a cough was not a sufficient indication for its' use. Staff 6 stated an x-ray should have been ordered, facility staff should have followed up with Staff 10 to challenge the antibiotic order and education should have been provided to the resident regarding the use of antibiotics unnecessarily.