STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385171	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of McMinnville	1309 NE 27th Street McMinnville, OR 97128

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 to provide sufficient nursing staff to ensure residents received medications timely for 1 of 1 facility reviewed for staffing. This placed residents at risk for adverse side effects of medication. Findings include: 1. The 2/19/26 Resident Council Minutes indicated nurses were rushing during medication pass. 2. Resident 59 admitted to the facility in 2023 with diagnoses including unspecified convulsions and dementia. The 3/2/26 physician orders indicated Resident 59 was to receive the following medications:-acetaminophen three times daily-cyanocobalamin (supplement) once daily-sennosides-docusate sodium (bowel medication) once daily-carvedilol (blood pressure medication) twice daily-duloxetine (antidepressant medication) once daily-levetiracetam (anti convulsant medication) once daily -aspirin once daily-amlodipine (blood pressure medication) once daily-cholecalciferol (supplement) once dailyOn 3/9/26 at 11:55 AM Staff 4 (LPN) stated resident's morning medications were administered late almost every day because there were not enough nursing staff.On 3/10/26 at 11:26 AM Staff 4 stated she was running behind and still passing morning medications. Staff 4 stated there were three residents who did not receive their morning medications. Staff 4 was observed to administer the following morning medications to Resident 59: -acetaminophen-cyanocobalamin-sennosides-docusate sodium-carvedilol-duloxetine-levetiracetam-aspirin-amlodipine-cholecalciferolOn 3/12/26 at 8:16 AM Staff 2 (DNS) acknowledged the identified medications were administered late to Resident 59 on 3/11/26 at 11:26 AM and acknowledged there were two additional residents who did not receive medications at that time. Staff 2 stated the expectation was for morning medications to be administered by 10:00 AM.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview and record review it was determined the facility failed to ensure residents were free of significant medication errors for 1 of 6 sampled residents (#53) reviewed for medications. This placed residents at risk for medication errors. Findings include:Resident 53 admitted to the facility in 2/2026 with diagnoses including Parkinson's and orthostatic hypotension (a sudden drop in blood pressure upon sitting or standing). The 2/26/26 admission MDS revealed a BIMS of 12 indicating a moderate cognitive impairment, but no delirium, inattention, or disorganized thinking. Resident 53 was assessed to be at risk for falls and required assistance with mobility and ADLs. The 2/26/26 Care Plan indicated Resident 53 was at risk for rehospitalization due to Parkinson's and falls. A 2/26/26 Physician Order revealed a prescription for 1.5 tablets of Carbidopa-Levodopa (a medication used to treat Parkinson's Disease) 25-200 MG every 3 hours. The facility scheduled this medication to be given at 2:00 AM, 5:00 AM, 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, 8:00 PM, and 11:00 PM.A timestamped administration history of Resident 53's Carbidopa-Levodopa from 3/1/26 at 11:00 PM through 3/10/26 at 8:00 AM showed 18 of 76 (24%) administrations exceeded the one-hour grace period. On 3/8/26 at 2:03 PM Resident 53 was observed sleeping in bed with Witness 4 (Family Member) sitting at bedside. While sleeping, Resident 53 periodically sat up, punched into the air, and demonstrated all over body tremors. Witness 4 gestured toward Resident 53 and stated she was concerned about the timing of her/his Carbidopa-Levodopa. Witness 4 stated the facility was able to give the medication an hour before or after its scheduled time, but the timing did not always work out well for the resident. On 3/9/26 at 10:21 AM Resident 53 was in her/his wheelchair awake, alert, and conversational with no involuntary movements or tremors observed. Resident 53 stated the timing for her/his Parkinson's medication was very important and bypassed her/him going into a reactionary state when given on time every three hours. Resident 53 reported she/he was in a reactionary state earlier that morning due to her/his medication being given late. Resident 53 stated her/his arms were flailing and she/he hit her/his heel on the edge of the bed, which caused pain. Resident 53 stated during a reactionary state she/he often felt jittery, anxious, fearful, and disoriented. Resident 53 acknowledged both she/he and Witness 4 communicated the importance of medication timing to the facility. On 3/11/26 at 9:10 AM Staff 3 (LPN) acknowledged a one-hour grace period for administering timed medications. Staff 3 indicated Carbidopa-Levodopa was considered a time sensitive medication but was unable to provide a reason for late administrations to Resident 53. Staff 3 identified increased tremors as a possible side effect of receiving a late dose of Carbidopa-Levodopa. On 3/11/26 at 3:10 PM Staff 25 (RN) stated the facility policy allowed for medications to be administered within one hour before or after the scheduled time. Staff 25 was unable to identify any reason Resident 53's Carbidopa-Levodopa was repeatedly given outside the one-hour grace period window. Staff 24 (Medical Director) stated in a 3/11/26 email the expectation for medication administration times was within one hour either before or after the scheduled administration time. Staff 24 acknowledged possible increased rigidity or tremors if administration of Carbidopa-Levodopa exceeded one hour outside the scheduled time.On 3/11/26 at 3:54 PM Staff 2 (DNS) acknowledged the repeatedly late administrations of Carbidopa-Levodopa to Resident 53, and stated facility staff was not used to giving medications with specific administration times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review it was determined the facility failed to ensure appropriate medication storage temperatures were logged and maintained, and failed to ensure proper labeling of biologicals for 1 of 1 medication room and 1 of 3 treatment carts reviewed for medication storage. This placed residents at risk for reduced efficacy of medication. Findings include:1. On 3/9/26 at 9:02 AM an open Humalin N insulin pen was observed in the C hall treatment cart with no open date.On 3/9/26 at 9:02 AM Staff 3 (LPN) acknowledged the insulin pen was open and not labeled with an open date.On 3/12/26 8:15 AM Staff 2 (DNS) stated the expectation was for insulin pens to be labeled with open dates. 2. On 3/11/26 at 10:20 AM two open, undated vials of Tuberculin (used for the testing in the diagnosis of Tuberculosis) were observed in the medication room refrigerator. The manufacturer's instructions indicated to discard the medication 30 days after opening.On 3/11/26 at 10:20 AM Staff 3 (LPN) acknowledged the two vials of Tuberculin were open and not labeled with open dates.On 3/12/26 8:15 AM Staff 2 (DNS) stated the expectation was for Tuberculin to be labeled with an open date. 3. On 3/11/26 at 10:20 AM the medication refrigerator temperature logs were observed to be blank on the following dates: 3/1/26, 3/2/26, 3/3/26, 3/6/26 and 3/7/26. The medication refrigerator contained flu vaccines, insulin, and other medications. On 3/11/26 at 10:20 AM Staff 3 (LPN) acknowledged the temperature logs were blank on the identified dates and acknowledged the refrigerator contained flu vaccines, insulin, and other medications. On 3/12/26 at 8:15 AM Staff 2 (DNS) stated the expectation was for the medication refrigerator temperature to be checked and logged twice daily. Staff 2 acknowledged the identified dates with blank temperature logs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to ensure food items stored in unit refrigerators were not expired and refrigerator temperatures were monitored for 2 of 2 unit refrigerators reviewed for food storage. This placed residents at risk for foodborne illness. Findings include: 1. On 3/9/26 at 8:19 AM the ADL kitchen refrigerator was observed and revealed the following:-The temperature log for 2026 was on the outside of the refrigerator door and had one temperature documented for 1/14/26, but no other temperatures for January, February, and March were documented.-An individual to go container dated 2/22/26.-A snack pack with moldy food inside with a use by 2/25/26 date printed on it. -A bagged salad with a use by date of 2/25/26.-A half-gallon container of milk with a best by 2/4/26 date.-Two kefir containers, one with a best by date of 1/16/26, and the second with a best by date of 12/26/25.On 3/9/26 at 11:07 AM Staff 12 (Maintenance Director) observed the refrigerator in the ADL room and confirmed the expired contents and temperature log.On 3/10/26 at 11:16 AM Staff 11 (Dietary Director) stated food stored in the unit refrigerators was to be removed after three days. Staff 11 acknowledged the items in the refrigerator and stated they should have been discarded. 2. On 3/9/26 at 10:40 AM the snack refrigerator was observed with Staff 15 (Dietary Aide). The snack refrigerator had a container of kefir dated 2/26/26 and a carton of thick and easy with a use by date of 8/14/25.On 3/10/26 at 11:16 AM Staff 11 (Dietary Director) stated food stored in the unit refrigerators was to be removed after three days. Staff 11 acknowledged the items in the snack refrigerator and stated they should have been discarded.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review it was determined the facility failed to ensure call lights were within reach for 2 of 7 sampled residents (#s 85 and 86) reviewed for environment. This placed residents at risk for delayed treatment and unmet care needs. Findings include:1. Resident 85 was admitted to the facility in 2/2026 with diagnoses including malnutrition, leg fracture, and history of falls. The 2/9/26 Care Plan indicated Resident 85 was at risk for falls and her/his call light needed to be within reach. The 2/13/26 admission MDS revealed Resident 85 had a history of falls, required assistance with mobility, and had a BIMS score of 14 indicating no cognitive impairment. On 3/9/26 at 8:57 AM Resident 85's call light was located behind her/him, attached to the backside of her/his pillow and out of reach.On 3/9/26 at 1:31 PM Resident 85's call light was attached to the outside of the bed on the left side, but underneath the resident's blanket and out of her/his line of sight. The resident was observed unsuccessfully attempting to locate the call light. On 3/10/26 at 9:37 AM Resident 85 stated she/he needed to use the bathroom. Resident 85 attempted to locate her/his call light, but it was looped to the bed rail behind the resident and she/he was unable to locate it. On 3/10/26 at 12:17 PM Staff 20 (CNA) stated a resident's call light was to always be within reach or attached to the resident, never on the floor or across the room. On 3/10/26 at 12:46 PM Staff 19 (CNA) stated a resident's call light was to always be within reach, never on the floor or across the room, and attached to either the bed or wheelchair depending on resident location. On 3/12/26 at 10:03 AM Staff 2 (DNS) acknowledged call lights was to always be within a resident's reach, and in a location where the resident did not have to perform an unsafe lean or reach to access it. She stated a call light not within reach placed residents at risk for falls and a lack of timely care. 2. Resident 86 admitted to the facility 3/2026 with diagnoses including stroke and history of falls. The 3/6/26 Care Plan revealed Resident 86 was at a high risk for falls and her/his call light needed to be within reach.Nursing notes for 3/7/26, 3/8/26, and 3/10/26 indicated Resident 86 was alert, oriented and able to make her/his needs known. On 3/9/26 at 8:56 AM Resident 86 was in bed and a CNA was providing care. The CNA exited the room and the resident's call light was observed under the bed on the floor, not within resident's reach. On 3/10/26 at 9:40 AM Resident 86 was up in her/his wheelchair with an oxygen nasal cannula in place. Resident 86's call light was attached to the bed rail, out of her/his reach. Resident 86 was observed attempting to reach for the call light but was restricted due to the nasal cannula and distance between the wheelchair and bed.On 3/10/26 at 12:17 PM Staff 20 (CNA) stated a resident's call light was to always be within reach or attached to the resident, never on the floor or across the room. On 3/10/26 at 12:46 PM Staff 19 (CNA) stated a resident's call light was to always be within reach, never on the floor or across the room, and attached to either the bed or wheelchair depending on resident location. On 3/12/26 at 10:03 AM Staff 2 (DNS) acknowledged call lights was to always be within a resident's reach, and in a location where the resident did not have to perform an unsafe lean or reach to access it. She stated a call light not within reach placed residents at risk for falls and a lack of timely care.

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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. Based on observation, interview and record review it was determined the facility failed to accurately assess functional mobility for 1 of 1 sampled resident (#68) reviewed for positioning and mobility. This placed residents at risk for unmet needs. Findings include: Resident 68 admitted to the facility in 5/2025 with left side hemiparesis (paralysis of half of the body).A 5/19/25 hospital History and Physical revealed Resident 68 had left side hemiparesis.A 5/18/25 progress note revealed Resident 68's left side was very flaccid and she/he had no strength or independent movement to the leg or arm.A 5/23/25 admission MDS indicated Resident 68 did not have functional limitation in range of motion in her/his upper extremities. On 3/8/26 at 11:05 AM Resident 68 was observed with her/his left arm bent at 90 degrees and stated as a result of a stroke she/he could not move it. On 3/11/26 at 1:12 PM Staff 7 (RN MDS Coordinator) stated on admission to the facility Resident 68 had limited ROM on her/his left upper extremity and the admission MDS was coded inaccurately.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review it was determined the facility failed to provide personal hygiene services for 1 of 3 sampled residents (#48) reviewed for ADLs. This placed residents at risk for unmet hygiene needs. Findings include:Resident 48 was admitted to the facility in 2/2026 with diagnoses including stroke and traumatic brain injury.The 2/22/26 Care Plan indicated Resident 48 required assistance with ADLs.The 3/3/26 admission MDS for Resident 48 revealed a BIMS score of 9 indicating moderate cognitive impairment. The resident had one-sided impairment for upper extremity and required substantial to maximum assistance with personal hygiene activities. The ADL Personal Hygiene task, which included hand hygiene, was documented as completed with extensive assistance on 3/8/26, and total dependence on 3/9/26, 3/10/26, and 3/11/26.The ADL Bathing task revealed Resident 48 received a shower on 3/10/26 and was totally dependent. Resident 48 was observed to have soiled fingernails with a brown substance underneath all the fingernails on her/his right hand on 3/8/26 at 10:49 AM, 3/9/26 at 8:51 AM, 3/9/26 at 10:37 AM, 3/9/26 at 1:35 PM, 3/10/26 at 9:50 AM, 3/10/26 at 12:08 PM, and 3/11/26 at 9:11 AM. On 3/10/26 at 2:42 PM Staff 21 (CNA) stated the ADL Personal Hygiene tasks included hand hygiene, and a shower included cleaning under a resident's fingernails. Staff 21 acknowledged a resident's fingernails could be cleaned at any time and was not limited to morning hygiene tasks or a shower. Staff 21 stated Resident 48 was dependent for hand hygiene and bathing. On 3/10/26 at 3:04 PM Staff 22 (CNA) stated cleaning fingernails could be done during or after a shower, and as needed when noticed by staff. Staff 22 acknowledged providing Resident 48 with a shower at approximately 7:00 AM that morning. Staff 22 stated she cleaned Resident 48's hands with a washcloth, but did not clean under her/his fingernails. On 3/11/26 at 12:52 PM Staff 8 (LPN Unit Care Coordinator) stated the expectation was for resident fingernails to be cleaned daily, and it was unacceptable for a resident to have dirty fingernails multiple days in a row.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review it was determined the facility failed to provide pain management for 1 of 1 sampled resident (#86) reviewed for pain management. This placed residents at risk for unmanaged pain. Findings include:Resident 86 admitted to the facility in 3/2026 with diagnoses including stroke and a history of falls. The 3/6/26 Care Plan revealed a goal for Resident 86 to express pain relief, and she/he was to receive pain medication as ordered. Nursing notes from 3/7/26, 3/8/26, and 3/10/26 indicated Resident 86 was alert, oriented, and able to make her/his needs known. Physician orders revealed an order on 3/6/26 for acetaminophen 500 mg to be given every six hours as needed for pain, and an order on 3/9/26 for use of a warm compress (washcloth) to be used PRN for pain. The 3/2026 Treatment Administration Record showed documented pain ratings of zero for 3/8/26, 3/9/26, 3/10/26, and 3/11/26, and there were no documented uses of the warm compress for pain relief from 3/9/26 through 3/11/26. The 3/2026 Medication Administration Record showed no administrations of PRN acetaminophen for pain on 3/8/26 through 3/11/26. On 3/9/26 at 8:56 AM Resident 86 stated she/he had pain on the left side of her/his neck and shoulder. Resident 86 felt a heat source would help relieve the pain and stated she/he requested use of a warm towel from staff. On 3/9/26 at 1:27 PM Resident 86 stated her/his pain was at an 8 or 9 on a scale of 0-10 and she/he felt very uncomfortable. Resident 86 stated no one brought her/him the requested warm towel for pain. Resident 86 also stated she/he was in tears the previous night due to pain and staff was notified of the pain at the time. On 3/10/26 at 9:40 AM Resident 86 demonstrated facial grimacing and appearance of fatigue. Resident 86 rated her/his pain at an 8 or 9 on a scale of 0-10 and stated ongoing neck pain was causing her/him to feel tired. Resident 86 indicated she/he was not been given a warm towel the day before as requested. On 3/11/26 at 9:17 AM Resident 86 was in bed, demonstrated facial grimacing, and appeared painful. Resident 86 rated pain at a five or six on a scale of zero -10 and stated she/he was not at a zero level of pain during her/his stay in the facility. Resident 86 acknowledged the pain had an impact on her/his ability to participate in therapy due to feeling drained and low on energy. On 3/10/26 at 12:17 PM Staff 20 (CNA) acknowledged Resident 86 reported neck pain to her the previous day. Staff 20 stated she reported the pain to Staff 3 (LPN).On 3/10/26 at 2:27 PM Staff 23 (Physical Therapy Assistant) stated Resident 86 informed her of neck pain. Staff 23 indicated she reported the pain and the resident's need for pain medication to Staff 3. On 3/11/26 at 10:10 AM Staff 3 (LPN) acknowledged Resident 86 and a CNA reported the resident had pain. Staff 3 was unable to recall Resident 86's pain medication regimen or if pain medications were administered. On 3/11/26 at 3:45 PM Staff 2 (DNS) acknowledged there were no documented pain interventions for Resident 86 from 3/8/26 through 3/11/26.