STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385182	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creswell Post Acute	735 South 2nd Street Creswell, OR 97426

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 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 report timely to the State Survey Agency an allegation of injury of unknown source for 1 of 3 sampled residents (#18) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 18 was admitted to the facility in 6/2022 with diagnoses including behavioral disturbance and dementia. A facility incident report dated 1/15/25 indicated Resident 18 was found on 1/15/25 with a bruise to the left eye. Staff did not know how the injury occurred and the resident was unable to explain what happened. An Incident Investigation dated 1/15/25 indicated on 1/10/25, Staff 24 (CNA) observed a bruise to Resident 18's eye and reported the bruise to Staff 10 (LPN). On 12/11/25 at 9:45 AM, Staff 2 (DNS) confirmed the incident was not reported to the State Agency in a timely manner. The incident met the criteria for non-compliance as follows:1. The incident indicated non-compliance for F609 2. There was sufficient evidence the facility corrected the non-compliance and was in substantial compliance with F609 as evidenced by:-No deficient practice was found at F609 with additional sampled residents.-The facility identified the deficient practice and provided in-service training to nursing staff on reporting injuries of unknown origin.-Weekly audits were implemented for four weeks, followed by monthly audits for three months.

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 discharge plan for 1 of 3 residents (# 21) reviewed for discharged planning. This place residents at risk for not having a discharge plan. Findings include:A review of the resident 21's clinical record revealed no evidence of a discharge plan in the resident file. A notification on the Evaluations tab of the clinical record indicated the discharge plan was 16 days overdue. The resident's Care Plan dated 11/26/25 revealed the resident's discharge preferences were not addressed in the Care Plan. Care Conference Notes dated 12/3/25 revealed no documentation of the resident's discharge plan.On 12/11/25 at 1:58 PM, Staff 36 (Social Services Coordinator) stated she should have had the resident's discharge plan completed. On 12/11/25 at 2:00 PM, Staff 2 (DNS) stated she was not familiar with the discharge planning procedure, but it was the responsibility of Social Services to complete a discharge plan.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, it was determined the facility failed to complete timely MDS assessments for 2 of 7 sampled residents (#s 27 and 34) who were reviewed for catheter use and staffing. This placed residents at risk for unassessed needs. Findings include:1. Resident 27 was admitted to the facility in 11/2025 with diagnoses including fractured femur and osteoarthritis. On 12/8/25 a review of Resident 27's clinical record revealed the admission MDS assessment was marked in progress and overdue by 15 days. On 12/8/25 at 12:06 PM, Staff 11 (MDS Coordinator) confirmed she was behind on 11/2025's MDS reports. On 12/11/25 at 11:54 AM Staff 2 (DNS) confirmed MDS assessments should be completed timely. 2. Resident 34 was admitted to the facility in 11/2024 with diagnoses including pressure ulcer and chronic kidney disease. On 12/9/25 a review of Resident 34's clinical record revealed her/his annual MDS assessment was in progress and overdue by 15 days. On 12/11/25 at 11:54 AM Staff 2 (DNS) confirmed MDS assessments should be completed timely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to update the resident's care plan for 1 of 2 residents (#20) reviewed for abuse. This placed residents at risk for a lack of planned interventions. Findings include:Resident 20 was admitted to the facility 5/1/25 with diagnoses including dementia. A Facility Reported Incident (FRI) dated 5/22/25 revealed Resident 20's care plan was revised to keep the resident further than an arm's length away from other residents when she/he appeared agitated. A FRI dated 6/5/25 revealed Resident 20 was involved in physical aggression towards another resident. Resident 20's Care Plan revealed the intervention to keep the resident away from other residents when she/he appeared agitated was added to the Care Plan on 6/5/25. On 12/11/25 at 12:35 PM, Staff 2 (DNS) stated the resident's care plan should have been updated within five days of the 5/22/25 FRI and she had failed to update the resident's care plan timely.

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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 provide sufficient staffing to meet the needs of 2 of 4 residents (#17 and 33) during random observations. This placed residents at risk for unmet needs. Findings include:1. Resident 17 was admitted to the facility in 9/2025 with diagnoses including chronic kidney disease and epilepsy. An 8/20/25 admission MDS indicated Resident 17 had a BIMS score of 14 (cognitively intact). On 12/9/25 at 9:23 AM, the call light monitor was observed and revealed Resident 17's call light was activated at 8:47 AM and completed at 9:34 AM, a total wait time of 47 minutes. On 12/9/25 at 9:53 AM, Resident 17 stated call light wait times were sometimes long. On 12/9/25 at 1:12 PM, Staff 29 (CNA) stated during Resident 17's call light wait time, he was assisting another resident with incontinent care. Staff 29 stated the facility used to have devices to communicate with other staff, but they were no longer available. On 12/11/25 at 11:55 AM, Staff 2 (DNS) stated she expected resident's needs to be met and confirmed Resident 17's call light wait time was too long. 2. Resident 33 was admitted to the facility in 9/2025 with diagnoses including anxiety and chronic pain. A 9/29/25 admission MDS indicated Resident 33 had a BIMS score of 15 (cognitively intact). On 12/9/25 at 9:23 AM, an observation of the call light monitor revealed Resident 33's call light was activated at 8:53 AM and completed at 9:33 AM, a total wait time of 40 minutes. On 12/10/25 at 10:14 AM, Staff 34 (CNA) stated during Resident 33's call light time, she was assigned to work in the dining room. On 12/11/25 at 11:55 AM, Staff 2 (DNS) stated she expected resident's needs to be met and confirmed Resident 33's call light wait time was too long.