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	01/30/2026

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

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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 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 and interview it was determined the facility failed to ensure an ice machine had the required air gap for 1 of 2 facility ice machines reviewed for kitchen sanitation. This placed residents at risk for cross contamination and foodborne illness. Findings include: On 1/28/26 at 10:04 AM, Staff 8 (Maintenance Director) was observed cleaning the ice machine in the janitor closet on the North Hall. Staff 8 stated he did not know what an airgap was or if the ice machine had an airgap (space between a water pipe sink or drain that prevents dirty water from flowing back into the clean water supply). Staff 8 confirmed the drainpipe was located below the sink basin and stated he did not believe this presented a problem in the event of the sink backflow. On 1/28/26 at 11:54 AM Staff 1 (Administrator) reviewed the ice machine and drain and stated it would be repaired. On 1/28/26 at 10:34 AM the ice machine in the janitor closet on the North Hall was observed. The ice machine drained into a sink on the floor with the top of the sink extending above the bottom of the drain, resulting in no air gap between the drain and the sink. The sink on the floor had trash in it, appeared dirty, and had reddish discoloration where the ice machine dripped into the sink. Staff 8 (Maintenance Director) confirmed the ice machine drain placement but did not feel it was an issue. On 1/28/26 at 11:54 AM Staff 1 (Administrator) reviewed the ice machine and drain and stated it would be repaired.

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 and interview it was determined the facility failed to properly sanitize and store resident care equipment for 1 of 3 halls reviewed for infection control. This placed residents at risk for exposure to blood borne pathogens and cross contamination. Findings include:1. On 1/28/26 at 11:19 AM Staff 6 (LPN) was on the central hall checking CBGs (blood sugar measurement) and moved to the south hall. Staff 6 had one glucometer on top of the medication cart with no cleaning supplies in sight. Staff 6 stated he cleaned the glucometer with an alcohol pad and opened the drawer and pointed to small alcohol prep pads. At this time another staff provided Staff 6 with the purple top Super Sani-Cloth Wipes. On 1/28/26 at 11:43 AM Staff 6 stated prior to moving to the south hall he checked one CBG with the glucometer and cleaned it with an alcohol prep pad. On 1/28/26 at 12:46 PM Staff 2 (DNS) stated the staff were to use the purple top wipes, Super Sani-Cloth Wipes, when cleaning the glucometer and the alcohol prep pads were not an appropriate cleaning product. 2. On 1/27/26 at 3:00 PM a gray plastic bedpan was observed lying on the floor, beneath the sink of the restroom shared between Rooms 15-16. The bedpan was sitting directly on the floor and was uncovered. This restroom was shared by two rooms with total capacity of four residents. On 1/28/26 at 9:19 AM a gray plastic bedpan was observed lying on the floor beneath the sink, uncovered and lying partially on top of a clear plastic bag. Part of the bedpan directly touched the floor of the restroom shared between Rooms 15-16. Staff 23 (CNA) indicated on 1/28/26 at 10:07 AM bedpans were labeled with resident names and stored in plastic bags in the restroom when not being used. Staff 2 (DNS) stated on 1/28/26 at 10:45 AM the expectation for bedpans was for them to be labeled by staff, cleaned after use, and stored in a closed plastic bag in the restroom when not in use. On 1/30/26 at 10:35 AM two gray bedpans were observed lying stacked one atop the other in the shared restroom between Rooms 15-16. The bottom bedpan was partially within a clear plastic bag but not enclosed. The top bedpan had no bag around it. Staff 2 observed the bedpans in the shared restroom between Rooms 15-16 at 10:36 AM and confirmed this was not the proper process for storage of bedpans when they were not in use.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure residents who wished to self-administer medications were assessed for 1 of 2 sampled resident (#21) reviewed for ADLs. This placed residents at risk for unsafe self-administration of medications. Findings include: Resident 21 admitted to the facility in 1/2026 with a diagnosis of diabetes. On 1/26/26 at 11:04 AM Resident 21 was observed to have a box of Senokot (a laxative) on her/his overbed table, no staff were in the room, and Resident 21 stated she/he was told by a medical provider to take Senokot (a laxative) a couple times a day. A review of Resident 21's medical record revealed no order for self-administration of Senokot and no assessment for self-administration of Senokot. On 1/29/26 at 11:15 AM Staff 5 (LPN) reviewed Resident 21's medical record and stated there was no approval for her/him to keep medication at the bedside. Staff 5 went to Resident 21's room and confirmed there was Senokot on the overbed table and removed it from the room. Resident 21 told Staff 5 she/he had taken some of the Senokot during her/his stay in the facility. On 1/30/26 at 10:15 Staff 2 (DNS) stated residents who wished to have medication at bedside were to have an assessment completed, a physician order for self-administration, have a care plan in place, and the medication was to be stored in a lock box in the resident room.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to comprehensively complete a baseline care plan within 48 hours of a resident's admission for 3 of 3 sampled residents (#s 76 and 78) reviewed for care plans. This placed residents at risk for unmet needs. Findings include:1. Resident 76 was admitted to the facility on [DATE] with diagnoses including diabetes and subarachnoid hemorrhage (bleeding in the brain). A 1/27/26 record review revealed no evidence of a baseline care plan. On 1/27/26 at 1:18 PM, Staff 25 (CNA) stated resident care needs are in the care plan and Staff 25 stated Resident 76 did not have a care plan. On 1/27/26 at 1:21 PM, Staff 3 (LPN Resident Care Manager) stated Resident 76 admitted on [DATE] and acknowledged Resident 76 did not have a care plan. On 1/27/26 at 2:19 PM, Staff 2 (DNS) started it was the expectation for staff to formulate a baseline care plan for new residents at admission. 2. Resident 77 was admitted to the facility on [DATE] with diagnoses including Stage 4 pressure ulcer on the sacral region (full-thickness skin and tissue loss on the lower back), and osteomyelitis (bone infection). On 1/27/26 at 12:59 PM, Staff 10 (CNA) was asked how she learned residents' care needs. Staff 10 stated she read the resident's Kardex. Staff 10 was asked to review the Kardex and confirmed no Kardex existed. Staff 10 further stated oh she/he did not have one because she/he was a new resident. On 1/27/26 at 1:07 PM, Staff 11 (Agency CNA) stated sometimes residents did not have a Kardex and staff would have to ask the charge nurse about the resident's care needs. Staff 11 was asked to review Resident 77's Kardex and confirmed it only contained information related to catheter care. The 1/26/26 Baseline Care Plan Person-Centered Care Plan revealed Resident 77 had a Stage 4 pressure ulcer on her/his sacral region, required wound vac treatment (medical device that applies negative pressure to a wound bed), antibiotics, and had a lot of pain. Resident 77 was dependent on staff. No documentation was found in the clinical record to indicate Resident 77 had a baseline care plan addressing the Stage 4 pressure ulcer, including treatment, pain management, intravenous (IV) antibiotics, or any other identified needs. On 1/27/26 2:27 PM, Staff 12 (Regional Nurse) confirmed Resident 77's baseline care plan was not completed timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review it was determined the facility failed to implement comprehensive care plans for 3 of 7 sampled residents (#'s 3, 9 and 32) reviewed for unnecessary medications, diarrhea, and hospice. This placed residents at increased risk for unmet needs. Findings include: 1. Resident 3 admitted to the facility in 12/2025 with diagnoses including dysphonia (difficulty speaking) and depression. The 12/5/25 Hospital Discharge Summary revealed Resident 3 had a PHQ-9 (patient health Questionnaire) score of 21 which indicated severe depression. The 12/8/25 admission MDS indicated Resident 3 was cogitatively intact, had no mood disorders, and she/he received scheduled antidepressant and antipsychotic medications. The 12/8/25 Psychosocial Well-Being CAA indicated Resident 3 had little interest and/or pleasure in doing things. Resident 3 reported over the last year she/he had significant health issues and was currently needing a trach to support breathing. Resident 3 was at risk for psychosocial issues secondary to a lack of interest in participating in favorite activities. No additional documentation was provided. A 12/9/25 at 5:10 PM Physician Note revealed Resident 3 reported feeling emotional but did not want to make any psychotropic changes. The 12/9/25 Interdisciplinary Conference Note revealed Resident 3 felt uncomfortable around others. Staff were to encourage activity participation. Residents 3's Care Plan did not include resident-centered interventions related to depression, anxietyor mood. On 1/30/26 at 11:28 AM, Staff 4 (LPN/Resident Care Manager) confirmed Resident 3's care plan was not comprehensive. On 1/30/26 at 12:35 PM, Staff 13 (Social Service Director) stated she was not aware Resident 3 was taking antipsychotic mediations and confirmed the resident's care plan was not comprehensive. 2. Resident 9 was admitted to the facility in 6/2025 with diagnoses including hypertension (high blood pressure) and chronic obstructive pulmonary disease (a progressive, long-term lung disease that makes it hard to breathe by damaging the airways and air sacs). A review of Resident 9's medical record revealed she/he was admitted to hospice in 6/2025. A review of Resident 9's 6/27/25 care plan revealed no evidence of a hospice care plan. On 1/29/26 at 3:19 PM, Staff 3 (LPN Resident Care Manager) stated Resident 9 had been on hospice since 6/2025. Staff 3 acknowledged Resident 9 did not have a hospice care plan and stated it was expected for residents to have hospice included in their comprehensive care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 32 was admitted to the facility in 8/2023 with diagnoses including retention of urine (inability to completely empty the bladder) and protein malnutrition. The 7/12/24 Care Plan indicated Resident 32 was at risk for bowel incontinence related to reduced mobility. The 10/11/25 Care Plan indicated Resident 32 was at risk for skin impairment related to mixed incontinence and occasional diarrhea. The 11/11/25 Quarterly MDS revealed Resident 32 had moderate cognitive impairment and was always continent of bowel. The Physician Follow up notes from 12/4/25, 12/11/25, 12/18/25, 1/1/26, and 1/6/26 indicated Resident 32 had a history of chronic diarrhea. The Bowel Task from 12/29/25 through 1/27/26 indicated Resident 32 had 19 episodes of loose diarrhea. On 1/26/26 at 1:01 PM, Resident 32 reported experiencing frequent diarrhea for the past the year. Resident 32 stated she/he was taking medications for this condition, which provided some relief. Resident 32 stated a couple months ago she/he asked to see a gastroenterologist to help better understand the underlying cause of her/his chronic diarrhea. On 1/28/26 at 9:36 AM, Staff 15 (CMA) stated Resident 32 experienced both diarrhea and constipation for at least the past six months. Staff 15 stated recent adjustments to her/his bowel medications appeared to be more effective for the past few months. On 1/28/26 at 9:46 AM, Staff 16 (CNA) stated resident 32 was prone to diarrhea and may have multiple episodes in a day, sometimes up to four. Staff reported resident 32 consistently notified them of bowel issues and requested anti-diarrheal medication as needed. On 1/28/2026 10:15 AM Resident 32 was observed lying in bed, wearing a shirt and gray brief, in the fetal position. The brief contained a stool stain approximately 3 inches long and .5 inches wide, appearing to be diarrhea. The resident's wheelchair was covered with disposable chucks. During observation, resident 32 did not respond to verbal stimuli. On 1/28/26 at 10:16 AM, Resident 32's roommate stated over the past six months Resident 32 frequently complained about her/his diarrhea, and she/he spent a significant amount of time in the bathroom because she/he had frequent diarrhea, sometimes up to five times per day. On 1/28/26 at 10:19 AM, Staff 14 (CNA) stated last night, he found Resident 32 sleeping on the toilet where she/he had been for approximately 30 to 45 minutes. Staff 14 reported Resident 32 had experienced multiple episodes of diarrhea. Staff 14 further stated over the past four to five weeks Resident 32 had regular episodes of diarrhea. On 1/30/26 at 11:40 AM, Staff 4 (LPN/RCM) stated she was aware Resident 32 had chronic diarrhea and her/his care plan was not comprehensive. On 1/30/26 at 2:51 PM, Staff 2 (DNS) confirmed Resident 32 had a history of diarrhea and expected her/his care plan to be comprehensive.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to provide bathing for 2 of 2 sampled residents (#s 20 and 21) reviewed for ADLs. This placed residents at risk for unmet care needs. Findings include: 1. Resident 20 was admitted to the facility on 1/2025 with diagnoses including chronic pain syndrome. The 1/29/25 admission MDS revealed Resident 20 had a BIMS score of 9 indicating moderate cognitive impairment and was dependent for bathing. On 1/26/26 at 1:21 PM Resident 20 stated feeling she/he did not get as clean as she/he would like due to staff rushing through showers and not cleaning her/his genitals thoroughly. The resident stated she/he needed help bathing due to pain. The 1/2026 shower schedule specified Resident 20's bathing days were Sundays and Wednesdays. Saturdays were the make-up bathing day for any residents who missed a scheduled shower during the week. The bathing task was reviewed for 12/31/25 through 1/28/26. Resident 20 declined bathing Wednesday 1/7/26 and 1/21/26 with no documented follow up attempts. There was no documented bathing on Sunday 1/4/26 or Sunday 1/11/26. No make-up bathing was documented for any Saturday during 1/2026. Resident 20's 1/2026 progress notes revealed no documented attempts at make-up bathing on Saturdays, or a reason bathing was not completed 1/4/26 and 1/11/26. On 1/28/26 at 9:35 AM Resident 20 was observed in bed with greasy hair. The resident was unable to recall her/his bathing schedule. On 1/28/26 at 1:36 PM Staff 24 (CNA) said the bathing schedule was inconsistent due to agency staff in the building, showers did not always get done or rescheduled. Staff 24 said when a resident refused their scheduled bathing time, the expectation was to try again at another time or have a different staff offer. On 1/29/26 at 9:50 AM Staff 22 (CNA) reported residents had two scheduled days per week for bathing. If a resident declined a shower on their scheduled day, the expectation was for staff to offer a make-up shower on Saturdays. On 1/29/26 at 11:17 AM Staff 4 (LPN Resident Care Manager) reported facility staff were available at any time to provide bathing services. She said there was no formal process for adding a resident to the Saturday make-up schedule, but the expectation was for staff to follow through on re-scheduling missed showers. 2. Resident 21 was admitted to the facility on [DATE] with a diagnosis of diabetes. A 1/26/26 admission MDS revealed Resident 21 had a BIMS of 13, which indicated she/he was cognitively intact, and required assistance with bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive care plan revised 1/19/26 revealed Resident 21 required extensive assistance with bathing. A 1/21/26 facility shower schedule revealed Resident 21 was to be bathed during the day on Mondays and Thursdays. A review of Resident 21's Bathing Tasks revealed she/he was bathed on 1/22/26. The scheduled shower days of 1/19/26 and 1/26/26 were documented as no (not scheduled for this shift) and no additional showers were documented as completed. On 1/26/26 at 11:03 AM Resident 21 was observed in bed in a hospital gown and her/his hair appeared unwashed and uncombed. Resident 21 stated she/he was bathed only one time since admission on [DATE]. Resident 21 stated she/he asked about being bathed, but the staff did not do it. On 1/26/26 at 9:20 AM Resident 21 was observed in a hospital gown and her/his hair appeared unwashed. Resident 21 stated she/he was not yet bathed that week. On 1/28/26 at 2:40 PM Staff 9 (CNA) stated on days when the designated shower aid was moved to CNA she would focus on basic care and may miss completing bathing for the residents. On 1/29/26 at 9:50 AM Staff 7 (CNA) stated on days when there was less staff, she would not always assist residents with bathing. On 1/29/26 at 2:25 PM Staff 3 (LPN Resident Care Manager) stated staff were expected to offer bathing as scheduled and if missed during the week, bathing was to be offered on Saturdays.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined the facility failed to obtain physician orders for tracheostomy care in a timely manner for 1 of 2 sampled residents (# 3) reviewed for respiratory services. This placed residents at risk for respiratory complications. Findings include:The Facility's 8/1/24 Tracheostomy Care Policy and Procedure Revealed staff were to verify physician orders. Resident 3 admitted to the facility on [DATE] with diagnoses including dysphonia (difficulty speaking), dysphagia (difficulty swallowing) and Barrett's esophagus without dysplasia (lining of the food pipe has changed due to acid reflux). The 12/5/25 Hospital Discharge Orders indicated tracheostomy (small opening in the neck that helps a person breathe) care as directed. No additional tracheostomy specific care instructions were included in the discharge documentation. The 12/5/25 Nursing Admission/readmission Evaluation Assessment revealed Resident 3 required tracheostomy care. A 12/8/25 at 11:45 AM, Nurse's Note revealed Resident 3 did not have tracheostomy care orders in place. The resident's tracheostomy cannula appeared to be dislodged from the opening in the neck, and the resident was sent to the hospital for evaluation and placement of the tracheostomy tube. Review of Resident 3's clinical record revealed staff did not obtain orders for tracheostomy care upon her/his admission to the facility on [DATE] or before the resident returned from the hospital on [DATE]. On 1/26/26 at 2:43 PM, Resident 3 was observed lying in bed. Gauze at the tracheostomy site was noted to be slightly saturated. Resident 3 reported she/he requested staff assistance for tracheostomy care, including gauze changes and suctioning, and stated response times from staff were often prolonged. On 1/29/26 at 2:14 PM, Staff 27 (Admission/Marketing/LPN) reviewed Resident 3's 12/5/25 Hospital Discharge Orders and confirmed the tracheostomy orders were unclear and lacked detailed instructions. Staff 27 stated nursing staff were expected to follow up to clarify tracheostomy orders in a timely manner. On 1/30/26 at 3:43 PM, Staff 2 (DNS) stated staff were expected to follow up with tracheostomy orders. Staff 2 reviewed Resident 3's health record and acknowledged tracheostomy care orders were not obtained until three days after the resident was admitted .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review it was determined the facility failed to ensure staff completed competencies prior to caring for a resident with a tracheostomy for 1 of 1 sampled resident (#3) reviewed for respiratory care. This placed residents at risk for respiratory complications. Findings include: The 2025 Facility Assessment identified the Competencies and skills required for staff. The facility implemented an orientation program for new hires that included completion of a competency checklist. Staff competencies are evaluated annually, continuously monitored, and supplemented with additional training as necessary. Resident 3 admitted to the facility on [DATE] with diagnoses including dysphonia (difficulty speaking), dysphagia (difficulty swallowing) and Barrett's esophagus without dysplasia (lining of the food pipe has changed due to acid reflux). The 12/5/25 Hospital Discharge Orders revealed tracheostomy care as directed. No additional tracheostomy specific care instructions were included in the discharge documentation.The 12/5/25 Nursing Admission/readmission Evaluation Assessment revealed Resident 3 required tracheostomy care (surgical opening created in the trachea (windpipe) through the neck to provide an airway and/or allow removal of secretions from the lungs. On 1/26/26 at 2:43 PM, Resident 3 reported she/he requested assistance for tracheostomy suctioning multiple times and experienced extended wait times before care was provided.On 1/29/26 at 12:38 PM, Staff 26 (Agency LPN) stated not all nurses were trained to provide tracheostomy care. Staff 26 stated she provided instructions to some nurses regarding tracheostomy care. Staff 26 stated Resident 3 was dependent on staff tracheostomy care needs and experienced anxiety related to difficulty breathing. Staff 26 stated she overheard an agency nurse state in the presence of the resident, that she did not know how to provide tracheostomy care. On 1/29/26 at 7:13 PM, Witness 1 reported overhearing a nurse tell another nurse that she did not know how to provide tracheostomy care for Resident 3. Witness 1 also stated she had to provide suctioning on multiple occasions due to delays in staff response, and she believed staff were not competent to provide tracheostomy care.On 1/30/26 at 1:07 PM, Staff 6 (LPN) stated Resident 3 was admitted to the facility with tracheostomy care needs and reported he did not know how to provide tracheostomy care and had not received prior training from the facility. Staff 6 stated he requested assistance from another nurse during an attempt to change the resident's tracheostomy tube, Staff 6 reported the incorrect tube size was used, and the tracheostomy tube was inadvertently removed. Staff 6 further stated staff were unsure where the resident's tracheostomy supplies were located and the resident was sent to the hospital.On 1/30/26 at 3:43 PM, Staff 2 (DNS) stated the facility expected nursing staff to be competent prior to providing tracheostomy care. Staff 2 further stated if staff had appropriate tracheostomy supplies and training, some of the resident's hospitalizations could have potentially been avoided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review it was determined the facility failed to acquire medications resulting in missed doses for 1 of 1 sampled resident (#56) reviewed for pharmacy services. This placed residents at risk for missed medications. Resident 56 was admitted to the facility 1/2026 with diagnoses including a skin infection and wounds.On 1/26/26 at 10:40 AM Resident 56 reported missed medication doses due to the facility not ordering medications before they ran out.On 1/6/26 Resident 56 was prescribed oral antibiotic Rifaximin 550 mg tablets with one tablet given two times a day.The 1/2026 Medication Administration Record revealed missed doses of Rifaximin on 1/8/26, 1/9/26, 1/15/26, 1/16/26, and 1/25/26. Progress notes indicated the Rifaximin was on order 1/8/26, 1/9/26, 1/15/26, 1/16/26, and 1/25/26. There was no documentation indicating follow up with the pharmacy to check the medication's order status.On 1/29/26 at 10:40 AM Staff 21 (CMA) stated it was the responsibility of staff administering medications to put in an order prior to medications running out. On 1/29/26 at 11:38 AM Staff 2 (DNS) reported Rifaximin was not a medication kept on hand in the facility and required ordering. Staff 2 said the expectation was for staff to follow up with the pharmacy to see if a medication on hand in the facility was an acceptable substitute or if the pharmacy could satellite the medication to the facility, which typically had a four-hour turnaround time. She said communication with the pharmacy should have been documented.

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	01/30/2026

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review it was determined the facility failed to provide influenza and pneumococcal vaccines for 1 of 5 sampled residents (#6) reviewed for immunizations. This placed residents at risk for influenza and pneumonia. Findings include: Resident 6 admitted to the facility in 9/2022 with a diagnosis of diabetes. An 8/19/25 Informed Consent revealed Resident 6 consented to receive a pneumonia vaccine.A review of Resident 6's medical record revealed no indication she/he was offered a current influenza vaccine. A review of Resident 6's immunization record revealed no evidence Resident 6 received a pneumonia vaccine or an influenza vaccine. On 1/30/26 at 1:59 PM Staff 2 (DNS) stated the facility offered influenza vaccines in 9/2025 and 10/2025 and it should have been offered to Resident 6. Staff 2 stated the pneumonia vaccine should have been administered to Resident 6 at the same time as the influenza vaccine, and she/he did not receive the vaccines.

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	01/30/2026

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Creswell Post Acute	735 South 2nd Street Creswell, OR 97426

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined the facility failed to provide a COVID-19 vaccine for 1 of 5 sampled residents (#13) reviewed for immunizations. This placed residents at risk for COVID-19. Findings include: Resident 13 admitted to the facility in 2018 with a diagnosis of respiratory failure.A 11/6/25 Informed Consent revealed Resident 13 consented to receive a COVID-19 vaccine.A review of Resident 13's immunization record revealed she/he did not receive a COVID-19 vaccine.On 1/30/26 at 1:59 PM Staff 2 (DNS) confirmed Resident 13 did not receive the COVID-19 vaccine during the facility's 11/2025 COVID-19 clinic.