

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Independence Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Monmouth Street Independence, OR 97351	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure staff provided care and services according to professional standards for 1 of 3 sampled residents (#4) reviewed for medication administration. This placed residents at risk for unsafe medication administration. Findings include: OAR [PHONE NUMBER] Scope of Practice Standards for All Licensed Nurses(1) Standards related to the licensee's responsibility for safe nursing practice. The licensee shall: (a) Practice within the laws and rules governing the practice of nursing at the level the nurse is licensed. OAR [PHONE NUMBER] Scope of Practice Standards for Registered Nurses(1) The Board recognizes that the scope of practice for the registered nurse encompasses a variety of roles, including, but not limited to: (a) Provision of client care; (2) Standards related to the RN's responsibility for ethical practice, accountability for services provided, and competency. The RN shall: (b) Be knowledgeable of the professional nursing practice and performance standards and adhere to those standards; (c) Be knowledgeable of the Oregon statutes and regulations governing RN practice and practice within those legal boundaries. Resident 4 was admitted to the facility in 10/2025 with diagnoses including osteoarthritis, mild cognitive impairment, and anxiety disorder. Resident 4's 11/9/25 Care Plan included the following interventions: -ADL self-care performance deficit related to dementia. -Resident experienced pain. -Monitor and document for side effects of pain medication. -Provide non-pharmacological pain interventions, including offering heat or cold packs and repositioning. Resident 4's 11/2025 Physician Orders included: -Tramadol HCl (an opioid pain medication) 50 mg by mouth every 12 hours as needed for pain. -Acetaminophen 325 mg by mouth every 4 hours as needed for pain. -Ice or heat application for 20 minutes every hour as needed for pain. -Morphine sulfate (an opioid pain medication) oral concentrate 0.25 mL by mouth every hour as needed for pain. A 5/21/26 Quarterly MDS assessment indicated Resident 4 had a BIMS score of 11, indicating moderate cognitive impairment. A FRI dated 5/28/26 documented Staff 15 (former RN) administered edible marijuana to Resident 4, which was not ordered by the resident's physician. On 7/29/26 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated Staff 14 (LPN) reported she witnessed Staff 15 providing Resident 4 with edible marijuana. Staff 15 was immediately placed on administrative leave during the investigation. Staff 15 was later terminated and reported to the OSBN. Staff 15 was interviewed and stated she had provided Resident 4 with edible marijuana and had not provided it to other residents. The facility identified no other residents received marijuana substances from Staff 15 and education was provided to all staff regarding professional standards. Attempts were made to interview Staff 15 on 7/30/26 at 8:58 AM and 7/31/26 at 9:42 AM, but were unsuccessful. On 7/30/26 at 9:05 AM, Staff 14 stated she was receiving orientation from Staff 15 on the date of the incident. While in Resident 4's room, Staff 14 observed Staff 15 cut up what appeared to be candy. When Staff 14 questioned Staff 15, Staff 15 stated the candy was edible marijuana gummies and (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged she was providing them to Resident 4. Staff 15 then placed the pieces of the gummies within Resident 4's reach. Staff 14 stated she was confused by Staff 15's actions, believed they were inappropriate, and reported the incident to facility management the following day. The deficient practice was identified as Past Noncompliance based on the following: On 5/28/26, the deficient practice was identified by the facility and was corrected when the facility completed an investigation and determined Staff 15 provided a controlled substance to Resident 4. The Plan of Correction included: -Staff 15 was terminated from employment. -Resident 4 was assessed for adverse reactions to marijuana substance and put on alert monitoring for psychosocial harm. -Facility led investigation to ensure no other residents had been provided with marijuana substances. -Facility wide re-education was provided regarding professional standards, abuse prevention, and following physician orders. Refer to F684		

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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 ensure a controlled substance was not administered without a physician's order for 1 of 3 sampled residents (#4) reviewed for medication administration. This placed residents at risk of receiving medications without a physician's order and experiencing adverse side effects. Findings include: Resident 4 was admitted to the facility in 10/2025 with diagnoses including atrial fibrillation, osteoarthritis, and anxiety disorder. Resident 4's care plan, initiated 11/9/25, included the following interventions:-ADL self-care performance deficit related to dementia.-Resident experienced pain.-Monitor and document for side effects of pain medication.-Provide non-pharmacological pain interventions, including offering heat or cold packs and repositioning. Resident 4's 11/2025 Physician Orders included:-Tramadol HCl (an opioid pain medication) 50 mg by mouth every 12 hours as needed for pain.-Acetaminophen 325 mg by mouth every 4 hours as needed for pain.-Ice or heat application for 20 minutes every hour as needed for pain.-Morphine sulfate (an opioid pain medication) oral concentrate 0.25 ml by mouth every hour as needed for pain. A 5/21/26 Quarterly MDS assessment indicated Resident 4 had a BIMS score of 11, indicating moderate cognitive impairment. A FRI dated 5/28/26 documented Staff 15 (former RN) administered edible marijuana to Resident 4, which was not ordered by the resident's physician. Resident 4's 5/29/26 Nursing Progress Notes documented the following:-At 12:47 AM, Resident 4 was placed on alert for psychosocial harm related to allegations of abuse. The resident slept intermittently throughout the shift with no complaints.-At 11:57 AM, Resident 4's representative was notified a nurse had given the resident marijuana edibles and possible alcohol, and the resident was being monitored for adverse effects. The representative expressed appreciation for the notification.-At 4:39 PM, Resident 4 remained on alert for psychosocial harm related to the allegations. The resident was up in a wheelchair for part of the day socializing with other residents. No concerns related to the allegation were noted, and staff continued monitoring. On 7/29/26 at 11:37 AM, Staff 9 (Social Services Director) stated she was not present when the incident occurred; however, she visited with Resident 4 in the days following the incident and observed no apparent side effects. On 7/29/26 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (Director of Nursing Services) stated Staff 14 (LPN) reported witnessing Staff 15 provide Resident 4 with edible marijuana. They interviewed Staff 15, who admitted providing Resident 4 with marijuana edibles. Staff 15 was immediately placed on administrative leave while the facility conducted an investigation. Following the investigation, Staff 15's employment was terminated, and a report was made to the Oregon State Board of Nursing. Their investigation did not identify evidence Staff 15 had provided marijuana or any other non-prescribed substances to additional residents. The facility also provided education to staff regarding professional standards, abuse prevention, and following physician orders. Staff 1 and Staff 2 acknowledged the facility was ultimately responsible for resident safety and acknowledged any staff providing residents with substances not ordered by a physician was unacceptable. Attempts were made to interview Staff 15 on 7/30/26 at 8:58 AM 7/31/26 at 9:42 AM, but were unsuccessful. On 7/30/26 at 9:05 AM, Staff 14 stated Staff 15 was providing her with orientation training on the date of the incident. Staff 14 stated when she entered Resident 4's room she observed Staff 15 cutting what appeared to be candy into smaller pieces. When Staff 14 questioned Staff 15, Staff 15 stated the candy was edible marijuana gummies and acknowledged providing them to Resident 4. Staff 14 observed Staff 15 place the pieces of the gummies within Resident 4's reach. Staff 14 stated she believed Staff 15's actions were inappropriate and reported the incident to facility management the following day. The deficient practice was identified as Past Noncompliance based on the following: (continued on next page)		

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