STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385188	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Health and Rehabilitation	1525 Monmouth Street Independence, OR 97351

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review it was determined the facility failed to maintain essential kitchen equipment for 1 of 1 kitchen reviewed for kitchen services. This placed residents at risk for food borne illnesses. Findings include:The 12/5/07 manufacturer specifications for the Ecolab Model ES-2000 indicated the dishwasher required a minimum wash and rinse temperature of 120 degrees Fahrenheit and a recommended temperature of 140 degrees Fahrenheit.On 5/7/26 at 12:17 PM, an observation of the facility kitchen revealed the dishwasher temperature gauge was hazed and unreadable. Staff 16 (Registered Dietician) acknowledged the gauge was unreadable. She stated Dietary Manager was on vacation. She was unsure of the dishwasher's status and requested maintenance assistance.A review of the May 2026 dishwasher log did not include temperature monitoring.On 5/7/26 at 12:24 PM, Staff 15 (Maintenance Supervisor) acknowledged the temperature gauge was unreadable and needed to be replaced. Staff 15 stated the dishwasher temperature was tested with a thermometer on a regular basis but could not provide a temperature record.On 5/7/26 at 12:32 PM, observed Staff 15 use a temperature probe to test the water in the dishwasher and the temperature read 134 degrees Fahrenheit.On 5/7/26 at 12:44 PM, Staff 14 (Dietary Aide) stated she monitored the chemical levels of the dishwasher every morning and between meals but did not monitor the dishwasher temperature. On 5/7/26 at 1:32 PM, Staff 1 (Administrator) stated the facility did not have a temperature record log for the dishwasher and stated the temperature of the dishwasher was to be checked daily.

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 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 store food in a sanitary manner for 1 of 1 kitchen reviewed for food safety. This placed residents at risk for foodborne illnesses. Findings include:On 5/4/26 at 9:34 AM, a brief kitchen tour was completed and revealed the following:-An opened bag of cereal in dry storage was unlabeled and undated.-An opened container of ranch dressing in the refrigerator was undated.-An open bag containing eight boiled eggs in the refrigerator was unlabeled and undated.-An open block of cheese in the refrigerator was loosely wrapped and undated.On 5/4/26 at 9:36 AM, Staff 13 (Cook) stated staff were to date food products when opened and add a use-by date. Staff 13 confirmed the open items were undated and stated she would discard them.On 5/7/26 at 11:38 AM, Staff 16 (Registered Dietician) stated staff were to date any food product immediately when opened and discard any items found without dates.

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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, interview and record review it was determined the facility failed to implement measures to prevent the spread of infection related to catheter positioning, hand hygiene, and Enhanced Barrier Precautions for 1 of 1 staff member (Staff 8) reviewed during a random observation and 3 of 11 sampled residents (#s 4, 8, and 29) reviewed for infection control. This placed residents at risk for infections. Findings include: 1. On 5/4/26 at 1:32 PM, Resident 4's catheter was observed to be attached to her/his bed with part of the catheter resting on the floor. On 5/6/26 at 11:59 AM Resident 4 was observed with part of the catheter attached to the bed and part of it rested on the floor. On 5/6/26 at 9:00 AM Staff 21 (CNA) observed Resident 4's catheter and confirmed it rested on the floor. On 5/6/26 at 10:29 AM Staff 9 (CNA) observed Resident 4's catheter and confirmed it rested on the floor. Staff 9 stated a barrier between the catheter and the floor was required. Staff 9 raised Resident 4's bed slightly and placed a basin under the catheter. On 5/8/26 at 1:32 PM Staff 4 (LPN Infection Preventionist) stated resident catheter bags were not to rest on the floor. 2. A 4/2024 CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms document indicated Enhanced Barrier Precautions (EBP) was recommended when high-contact care was provided to residents with indwelling medical devices (tubes inserted into the body). On 5/6/26 at 9:24 AM, Staff 12 (CNA) was observed to assist Resident 8 into her/his bathroom. Resident 8 was observed to have an indwelling catheter. Staff 12 donned gloves, assisted Resident 8, doffed the gloves, and exited the room. Staff 12 did not don a gown while providing care to Resident 8. On 5/6/26 at 9:30 AM, Staff 12 stated he escorted Resident 8 to the bathroom and emptied her/his catheter bag. Staff 12 stated he wore gloves while he provided the care and a gown was not needed for that activity. On 5/8/26 at 11:35 AM, Staff 2 (DNS) and Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) stated staff were to follow Enhance Barrier Precautions when providing high-contact care for Resident 8. Staff 3 stated high-contact care included any contact with Resident 8's catheter or catheter bag. 3. On 5/7/26 at 7:55 AM, Staff 8 (LPN) was observed at the medication cart on the west hallway, Staff 8 dropped a cotton ball on the floor, disposed of it in a garbage can, and then placed the lid on top of the insulin pen without completing hand hygiene. On 5/7/26 at 7:77 AM Staff 2 (DND) stated nursing staff were expected to complete hand hygiene prior to returning items to the medication cart. 4. A 4/2024 CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent the Spread of Multi-drug-resistant Organisms indicated, Enhanced Barrier Precautions (EBP) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was recommended when high-contact care was provided to residents with indwelling medical devices (tubes inserted into the body). On 5/4/26 at 1:20 PM Resident 29 was observed in her/his room with a PICC (long flexible tube inserted into the upper arm and advanced until the tip rests just above the heart) line on her/his right arm. On 5/4/26 at 1:29 PM Resident 29 stated staff did not wear PPE when they administered IV medications or provided PICC care. On 5/7/26 at 8:35 AM Staff 4 (IP/LPN) was observed disconnecting Resident 29's IV medication from her/his PICC line and began to complete a flush protocol (the insertion of saline fluid to prevent blockages) to the resident's PICC line without donning a gown. On 5/7/26 at 8:43 AM, Staff 4 stated she did not need to don a gown for Resident 29's flush protocol and staff were not required to follow EBP when they provided high-contact care to the resident because she/he did not have open wounds. On 5/11/26 at 12:50 PM, Staff 2 (DNS) stated she expected residents with PICC lines to be placed on EBP in the facility. Staff 2 stated nursing staff were expected to don a gown and gloves when high contact care was provided to Resident 29, which included interventions for her/his PICC/

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 of 5 sampled residents (#s 4, 6, and 14) reviewed for immunizations. This placed residents at risk for influenza and pneumonia. Findings include: 1 Resident 4 was admitted to the facility in 2024 with diagnoses included multiple sclerosis (an autoimmune disease which affects the central nervous system). A review of Resident 4's immunization record revealed no documentation she/he was offered or received an influenza vaccine in 2025.On 5/8/26 at 3:13 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) stated she reviewed Resident 4's documentation and confirmed there was no evidence Resident 4 was offered or received an influenza vaccine.2. Resident 6 admitted to the facility in 2025 with diagnoses including osteomyelitis (bone infection). A review of Resident 6's immunization record revealed she/he received a PCV 13 in 2017.A review of the CDC Pneumococcal Vaccine Recommendations revealed Resident 6 required another dose of a pneumococcal vaccine to be current.A review of Resident 6's medical record revealed a 11/4/25 Multi-Vaccine Consent Form signed by Resident 6 but was incomplete and pneumococcal vaccines were neither accepted nor declined. On 5/8/26 at 3:13 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) confirmed Resident 6 did not receive an updated Pneumococcal vaccine and the consent form was not completed thoroughly.3. Resident 14 admitted to the facility in 2025 with diagnoses including kidney failure.A review of Resident 14's immunization record revealed no documentation she/he received a influenza immunization in 2025.A 12/18/25 Multi-Vaccine Consent Form signed by Resident 14 revealed she/he consented to receive an influenza immunization. On 5/8/26 at 2:03 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) reviewed Resident 14's medical record and confirmed she/he did not receive an influenza immunization.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 offer a COVID-19 vaccine for 3 of 5 sampled residents (#s 4, 6, and 14) reviewed for immunizations. This placed residents at risk for COVID-19. Findings include: 1. Resident 4 was admitted to the facility in 2024 with diagnoses included multiple sclerosis (an autoimmune disease which affects the central nervous system). A review of Resident 4's immunization record revealed no documentation she/he was offered or received a COVID-19 vaccine in 2025.On 5/8/26 at 3:13 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) stated she reviewed Resident 4's documentation and confirmed there was no evidence Resident 4 was offered or received a COVID-19 vaccine.2. Resident 6 admitted to the facility in 2025 with diagnoses including osteomyelitis (bone infection). A review of Resident 6's immunization record revealed she/he did not have documentation of a COVID-19 vaccine in 2025.A review of Resident 6's medical record revealed a 11/4/25 Multi-Vaccine Consent Form signed by Resident 6, and the COVID-19 vaccine was neither accepted nor declined. On 5/8/26 at 3:13 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) confirmed Resident 6 did not receive an updated COVID-19 vaccine and the consent form was not completed.3. Resident 14 admitted to the facility in 2025 with diagnoses including kidney failure.A review of Resident 14's immunization record revealed no documentation she/he received a COVID-19 immunization in 2025.A 12/18/25 Multi-Vaccine Consent Form signed by Resident 14 revealed she/he consented to receive a COVID-19 immunization. On 5/8/26 at 2:03 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) reviewed Resident 14's medical record and confirmed she/he did not receive a COVID-19 immunization.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to ensure residents were informed of the risks and benefits of psychotropic medications for 2 of 5 sampled residents (#s 4 and 43) reviewed for unnecessary medications. This placed residents at risk for uninformed about their medications. Findings include: 1. Resident 4 admitted to the facility in 2024 with diagnoses including depression. Resident 4's physician orders revealed a 1/6/26 order for citalopram (an antidepressant). A review of Resident 4's medical record revealed no indication she/he was informed in advance of the risks and benefits of citalopram. On 5/11/26 at 1:19 PM Staff 2 (DNS) confirmed Resident 4 was not informed of the risks and benefits of citalopram. 2. Resident 43 was admitted to the facility in 5/2026 with diagnoses including esophageal obstruction (narrowed esophagus). Resident 43's 5/2/26 Physician Orders indicated the resident was prescribed clonazepam (antianxiety medication) for anxiety. Review of Resident 43's medical record revealed no indication the resident was informed in advance of the risks and benefits of clonazepam. On 5/8/26 at 11:35 AM, Staff 2 (DNS) acknowledged Resident 43 was not informed of the risks and benefits for the use of clonazepam.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review it was determined the facility failed to ensure residents had unsoiled clean linens for 1 of 3 linen closets reviewed for environment. This placed residents at risk for a lack of a homelike environment. Findings include:On 5/6/26 at 10:26 AM the left lower corner of the east hall linen closet was observed to have multiple black spots. On 5/6/26 at 11:10 AM Staff 11 (CNA) stated there was a mold odor in the east linen closet at times. Staff 11 opened the east linen closed and confirmed there appeared to be mold in the lower left corner of the closet with multiple blankets touching the black spots on the wall. Staff 11 removed the blankets and sent them to laundry. On 5/6/26 at 12:03 PM Staff 15 (Maintenance Supervisor) stated he was unaware of any concerns with mold in the east linen closet. Staff 15 looked in the linen closed and confirmed there was mold in the lower left corner.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to complete a Significant Change MDS within the required timeframe for 1 of 1 sampled resident (#6) reviewed for hospice. This placed residents at risk for unassessed hospice needs. Findings include: Resident 6 admitted to the facility in 11/2025 with diagnoses including osteomyelitis (an infection in the bone). A 4/21/26 Progress Note revealed Resident 6 admitted to hospice services on 4/21/26. A Significant Change MDS assessment dated [DATE] was completed on 5/7/26, 17 days after Resident 6 admitted to hospice. On 5/8/26 at 10:55 AM Staff 18 (MDS Coordinator) reviewed Resident 6's Significant Change MDS and confirmed it was not completed within 14 days after Resident 6 was admitted to hospice.

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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 personal care for 1 of 4 sampled residents (#34) reviewed for ADLs. This placed residents at risk for not receiving grooming. Findings include:Resident 34 was admitted to the facility on [DATE] with diagnoses including schizophrenia and major depressive disorder. The 4/22/26 admission MDS indicated Resident 34 had a BIMS score of 14, which indicated the resident was cognitively intact, and required staff assistance with personal care, which included shaving.On 5/4/26 at 11:27 AM Resident 34 was observed in her/his room with facial hair that was long and thick. Resident 34 stated she/he preferred short facial hair, but staff did not offer to trim or shave her/his facial hair since admission into the facility.On 5/6/26 at 1:56 PM Staff 10 (CNA) stated she worked with Resident 34 on 5/5/26 but did not offer to shave or trim the resident's facial hair. On 5/6/26 at 2:16 PM Staff 6 (CNA) stated she provided care to Resident 34 during her shift but did not offer to shave or trim the resident's facial hair. Staff 6 stated residents were provided assistance to shave or trim facial hair on scheduled bathing days.On 5/7/26 at 10:08 AM Staff 17 (CNA) stated residents bathed two times a week in the facility and she offered to shave or trim residents' facial hair on their scheduled bathing days. Staff 17 confirmed she offered and assisted Resident 34 with bathing since her/his admission but did not offer to shave or trim the resident's facial hair. On 5/7/26 at 10:30 AM Staff 8 (LPN) stated Resident 34 was timid and reluctant to communicate her/his needs to staff. Staff 8 stated she was unaware of Resident 34's facial hair or personal care preferences.On 5/11/26 at 12:08 PM Staff 3 (Assistant Director of Nurses/LPN Resident Care Manager) stated she expected staff to offer to shave or trim residents' facial hair as needed based on their preference or on their scheduled bathing days. Staff 3 stated Resident 34 was in the facility a sufficient length of time for her/his facial hair preferences to be known and accommodated by staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide PRN bowel medication for 1 of 5 sampled residents (#34) reviewed for unnecessary medications. This placed residents at risk for unmet bowel care needs. Findings include:The facility's Bowel Protocol policy dated 5/2025 stated if a resident does not have a bowel movement for three days, the nurse administers the physician ordered bowel program.Resident 34 admitted to the facility on [DATE] with diagnoses including chronic idiopathic constipation. A review of Resident 34's Physician Orders dated 4/17/26 included sennoside 8.6 mg and polyethylene glycol 3350 powder, for constipation on a PRN basis. The Physician Orders also indicated the resident was to receive Milk of Magnesia for constipation on a PRN basis after three days of no bowel movement.A review of Resident 34's bowel record indicated the resident had no bowel movement from 4/21/26 to 4/24/26 (four days). A review of Resident 34's 4/2026 MAR revealed no indication the resident received or refused PRN medications for constipation from 4/21/26 to 4/24/26. On 5/11/26 at 10:29 AM Staff 7 (LPN) stated Resident 34 went three days without a bowel movement in 5/2026 but she was unaware if the resident went three or more days without a bowel movement in 4/2026. On 5/11/26 at 12:18 PM Staff 3 (Assistant Director of Nursing/LPN Resident Care Manager) confirmed the resident went four days without a bowel movement from 4/21/26 to 4/24/26 and did not receive PRN constipation medications. Staff 3 stated nursing staff were expected to offer and administer Resident 34 one of her/his three ordered PRN constipation medications on 4/24/26.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviewed it was determined the facility failed to implement wound care interventions as ordered for 1 of 1 sampled resident (#40) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: Resident 40 was admitted to the facility in 3/2026 with diagnoses including leg amputation and pressure ulcers.A 3/27/26 physician order indicated staff were to perform wound care to the pressure ulcers on Resident 40's back every day shift.Progress Notes on 4/6/26 and 4/10/26 indicated wound care was not completed, and staff passed the treatment on to the next shift.On 4/22/26, a complaint was received which indicated Resident 40 was admitted to the facility on [DATE] with multiple unstageable pressure ulcers to her/his back. Witness 3 (Complainant) indicated staff did not always provide wound care, the wounds worsened, and the resident was sent to the hospital.On 5/7/26 at 11:28 AM, Staff 19 (CMA) stated Resident 40 had a bariatric bed and mattress, but she/he liked to stay on her/his back and did not get out of bed as often as she/he should have.On 5/7/26 at 11:53 AM, Staff 3 (Assistant Director of Nursing / Licensed Practical Nurse Resident Care Manager) stated Resident 40 was given a bariatric bed upon admission due to her/his weight and not being able to fit in a standard bed. Staff 3 stated she ordered an air mattress which came four days later. Staff 3 stated she spoke with Resident 40 multiple times regarding repositioning off her/his back and getting out of bed more, but the resident did not always comply.On 5/11/26 at 9:57 AM, Staff 7 (LPN) and Staff 18 (MDS Coordinator) stated Resident 40 was to have dressing changes to her/his back daily but on 4/6/26 and 4/10/26 the dressings were not changed. Staff 7 stated the dressing changes were supposed to be passed on to the next shift, but they were not completed on the next shift either.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to ensure physician orders were followed to prevent accidental choking for 1 of 5 sampled resident (#43) reviewed for unnecessary medications. This placed residents at risk for adverse outcomes related to aspiration. Findings include:Resident 43 was admitted to the facility in 5/2026 with diagnoses including esophageal obstruction (narrowed esophagus).Resident 43's 5/1/26 Care Plan indicated she/he required enteral nutrition (tube feeding) related to esophageal obstruction and was to remain NPO (nothing by mouth).Resident 43's 5/1/26 Physician's Orders stated Resident 43 was NPO.On 5/7/26 at 1:34 PM, Witness 2 (Family Member) stated Resident 43 was served juice at breakfast and was now coughing.On 5/7/26 1:54 PM, Resident 8 was observed sitting upright in bed, coughing, and attempting to spit up phlegm.On 5/7/26 at 1:55 PM, Staff 8 (LPN) stated Resident 43 was served juice at breakfast by a CNA. Staff 8 stated Resident 43 consumed approximately half of a sip of juice before it was removed, Resident 43 was evaluated and the incident was reported to the administrator.A 5/7/26 Progress Note indicated Resident 43 consumed five milliliters of juice orally. Resident 43's lungs sounded free and clear of any liquid, the physician was notified, and Resident 43 was placed on alert.A 5/7/26 Incident Report revealed Resident 43 was provided juice by Staff 9 (CNA). Staff 9's written statement indicated she did not see Resident 43's tube feed and provided her/him with juice. Staff 9 wrote the juice was removed the minute she was told Resident 43 could not have it.On 5/8/26 at 10:39 AM, Staff 2 (DNS) stated Staff 9 (CNA) served Resident 43 orange juice while passing fluids prior to breakfast service. Staff 2 stated Resident 43's physician orders and care plan were not followed.On 5/8/26 at 12:44 PM and 5:29 PM, attempts to contact Staff 9 were unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385188	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Health and Rehabilitation	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 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 it was determined the facility failed to ensure a catheter bag was properly placed for 1 of 1 sampled residents (#8) reviewed for urinary catheters. This placed residents at risk of urinary tract infections. Findings include: Resident 8 was admitted in 2/2025 with diagnoses including pneumonia (lung infection).The 2/6/26 Annual MDS indicated Resident 8 was cognitively intact and an indwelling urinary catheter was in place.Resident 8's Care Plan, revised on 12/17/25, identified the presence of an indwelling urinary catheter. Care Plan Interventions included to change from a leg bag to drain bag for day and night use and encourage proper positioning of the catheter and drainage bag.Multiple observations on 5/4/26 through 5/6/26 between 9:00 AM to 4:00 PM revealed Resident 8 sat in a wheelchair with the catheter drainage bag placed on her/his wheelchair seat, above the bladder, between the resident's leg and the arm rest.On 5/6/26 at 9:03 AM Staff 10 (CNA) stated Resident 8 frequently placed the catheter bag above her/his bladder and staff were expected to remind her/him to reposition the bag below the bladder.On 5/6/26 at 9:30 AM Staff 12 (CNA) was observed assisting Resident 8 with care. Resident 8's catheter bag was positioned on the wheelchair, above the bladder, between her/his leg and the armrest. Staff 12 stated Resident 8 frequently placed the catheter bag in that location and he did not remind the resident to move it below his/her bladder.On 5/6/26 at 9:53 AM Resident 8's catheter bag was observed to be on the seat of the wheelchair, above the bladder, between her/his leg and the armrest. Staff 8 (LPN) stated Resident 8's catheter bag was not in the proper position and the proper placement required the bag to remain below the bladder. Staff 8 stated Resident 8 needed to wear a leg bag when out of bed and when she/he refused, staff were expected to remind Resident 8 to position the catheter drainage bag below her/his bladder on the outside of the wheelchair.On 5/8/26 at 11:35 AM Staff 2 (DNS) stated Resident 8's catheter bag was to remain below her/his bladder at all times and staff were expected to assist the resident with maintaining proper placement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385188	A. Building B. Wing	05/11/2026

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and record review it was determined the facility failed to post complete staffing information for 1 of 1 facility reviewed for required staff postings. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include:Observations of the Direct Care Staff Daily Reports posted at the facility entrance revealed the evening shift section was left blank on the following dates and times:-5/4/2026 at 2:52 PM-5/5/26 at 3:58 PM-5/6/26 at 3:45 PMOn 5/6/26 at 3:48 PM Staff 8 (LPN) stated the charge nurse was responsible to complete and post the Direct Care Staff Daily Reports at the start of each shift. Staff 8 stated the evening shift started at 2:00 PM and confirmed she did not complete the 5/6/26 evening shift section of the Direct Care Staff Daily Report. On 5/11/26 at 12:46 PM Staff 2 (DNS) stated she was aware of prior incidents when the evening shift section of the Direct Care Staff Daily Reports was not completed and posted timely. Staff 2 stated she expected the charge nurse to complete and post the evening shift section of the Direct Care Staff Daily Reports within the first hour of the shift and acknowledged it was not completed as required from 5/4/26 to 5/6/26.