STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385197	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Post Acute	135 Maple Street Ashland, OR 97520

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review it was determined the facility failed to notify a resident's responsible party for 1 of 3 sampled residents (#1) reviewed for UTIs. This placed residents at risk for lack of representative involvement. Findings include: Resident 1 was admitted to the facility in 11/2024 with a diagnosis of UTI.a. Resident 1's Progress Notes revealed on 4/28/25 Resident 1 had a change in mental status, had abdominal pain, did not urinate, and was sent to the emergency department.Resident 1's clinical record had no evidence her/his representative was notified of her/his hospital transfer. On 10/22/25 at 10:54 AM Staff 2 (DNS) stated families were to be notified when residents were transferred to the hospital and Resident 1's family was not notified. b. Resident 1's Progress Notes revealed on 5/27/25 she/he reported abdominal pain but agreed to stay in the facility for lab tests. On 5/28/25 Resident 1 had continued abdominal pain and was transported to the hospital for evaluation and treatment. Resident 1's clinical record had no evidence her/his representative was notified of her/his hospital transfer. On 10/22/25 at 10:54 AM Staff 2 (DNS) stated families were to be notified when residents were transferred to the hospital and Resident 1's family was not notified.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 ensure a safe discharge for 2 of 3 sampled residents (#s2 and 6) reviewed for discharge. This placed residents at risk for unmet post-discharge care needs. Findings include: 1.Resident 2 was admitted to the facility in 3/2025 with a diagnosis of cellulitis (bacterial skin infection) of the legs.Resident 2's 6/4/25 Conference Notes revealed she/he was medically stable and reported she/he wanted to go home soon. Resident 2 reported she/he could pay for caregivers and had a friend who could also help.Resident 2's 6/18/25 PT Discharge Summary indicated discharge recommendations were for Resident 2 to have 24-hour care and home health services. The summary indicated Resident 2 was discharged home with support from others. Resident 2's 6/18/25 Discharge summary revealed she/he was discharged home with home health. The discharge summary did not indicate Witness 2 (Friend) was notified of the discharge or if Resident 2 was provided resources for in-home caregivers. On 10/21/25 at 9:20 AM Witness 2 stated the facility did not call him prior to Resident 2's discharge. Witness 2 stated when Resident 2 opened her/his door she/he saw rats. Luckily Resident 2's neighbor was home and allowed Resident 2 to spend the night until she/he was transported to the hospital for additional discharge planning. Witness 2 stated Resident 2's neighbor called him to let him know Resident 2 was discharged from the facility. Witness 2 stated when he went to Resident 2's home he also discovered she/he did not have running water because the pump to the well broke. Witness 2 stated if the facility called prior to Resident 2's discharge he could have verified the condition of Resident 2's home and notified the facility. On 10/21/25 at 11:20 AM Staff 4 (Social Service Assistant) stated Resident 2 reported she/he had a friend who could help at home. Staff 4 stated she did not confirm with Witness 2 to ensure he was available to assist. On 10/21/25 at 12:07 PM Staff 5 (Social Services) stated Resident 2 did not want to pay for care givers despite recommendations from PT. Staff 5 stated she did not recall if the facility reviewed the risks of Resident 2 discharging without caregivers. On 10/21/25 at 2:13 PM Staff 3 (Director of Rehabilitation) stated the facility recommended Resident 2 be discharged to an alternative living situation, but she/he wanted to go home. Resident 2 was cognitively impaired but was able to make her/his own decisions. Resident 2 was able to get dressed after being set up, needed assistance with meal preparation, and daily caregiving. Staff 3 stated Witness 2 did not come into the facility for training or to participate in the discharge planning. On 10/22/25 at 11:14 AM Staff 12 (DNS) stated Resident 2 was not provided information about the risks of going home without 24-hour caregivers, was not provided a list of resources in her/his area, and staff did not contact Witness 2 to verify he could assist Resident 2 after discharge. 2. Resident 6 was admitted to the facility in 9/2025 with a diagnosis of a fracture. Resident 6's discharge MDS revealed she/he was cognitively intact. Resident 6's 10/9/25 Discharge Summary revealed discharge instructions included post-discharge appointments. A post-operative appointment was scheduled for 10/7/25. On 10/20/25 at 3:59 PM Witness 1 (Family) stated family was not present when the facility reviewed the discharge paperwork with Resident 6. Witness 1 stated they missed an appointment because it was not listed on the discharge paperwork. On 10/21/25 at 11:08 AM Staff 6 (LPN Resident Care Manager) stated Resident 6 went to an orthopedic appointment on 10/7/25, the same day the discharge instructions and appointments were printed. The new appointment from the 10/7/25 orthopedic appointment did not get transcribed onto the discharge instruction sheet. On 10/22/25 at 11:13 AM Staff 2 (DNS) stated staff need to ensure the most current information including appointments were on the discharge instruction sheet.