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	06/08/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview it was determined the facility failed to ensure a clean and homelike environment was provided for 1 of 2 shower rooms (West shower room) and 1 of 1 dining room reviewed for environment. This placed residents at risk for lack of homelike environment. Findings include:1. On 1/20/26, the State Survey agency received a complaint indicating there were environmental safety concerns, which included fallen tiles from the wall in the west shower room replaced with plastic cutting boards applied with foam glue. On 6/2/26 at 11:09 AM, four broken tiles measuring approximately five by six inches were observed in the west shower room. The joint where the wall and floor met contained a black substance, with the surrounding area appearing lighter. Additionally, on the opposite side of the wall, a metal shelving unit had a plant growing from the joint beneath its bottom shelf. On 6/2/26 at 11:14 AM, Staff 15 (RN) confirmed the cracked tiles and what appeared to be black mildew. Staff 15 got on the floor and pulled on the plant and confirmed it was growing from the outside. On 6/2/26 at 11:55 AM, Witness 11 (Complainant) confirmed the environmental concern with the west shower room. On 6/2/26 at 11:38 AM, Staff 1 (Administrator) confirmed the facility had been working on remodeling the room due to the concerns. 2. On 1/20/26, the State Survey agency received a complaint indicating there were environmental safety issues, which included a hole found in the dining room floor. An orange cone was placed over the damaged area after a staff incident, which was then later bolted to the floor. On 6/2/26 at 12:13 PM, a large orange cone approximately three feet high was observed in the main dining room between a table with residents and a counter. The cone was not removable. Four screws were observed bolting the cone to the floor. On 6/2/26 at 12:16 PM, Resident 19 stated she/he had been in the facility for about three and a half weeks and had bumped into the cone multiple times. Resident 19 stated the floor should be fixed and the cone removed. On 6/3/26 at 9:10 AM, a resident was observed with her/his walker bumping the cone while walking past it. The resident picked an item up from the counter and bumped the cone again when passing the same area. On 6/5/26 at 11:34 AM, Staff 32 (CNA) stated she had worked for the facility approximately five years. She stated there had been a large bubble on the floor which was peeling. A chair was over the damaged area, then a wet floor sign, and the orange cone had been present for approximately two years. On 6/8/26 at 8:48 AM, Staff 35 (Housekeeping Supervisor) stated the orange cone in the dining room had been there for approximately two years. On 6/8/26 at 10:25 AM, Staff 1 (Administrator) confirmed the dining room should not have a large cone in the room.

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
	385197	A. Building B. Wing	06/08/2026

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, it was determined the facility failed to ensure annual performance reviews for CNA staff were completed for 3 of 3 sampled CNA staff (#s 30, 31, and 32) reviewed for competent staff. This placed residents at risk for receiving care from staff who may have unidentified performance concerns. Findings include:A review of personnel profile records revealed the following.-Staff 30 (CNA) (hired on 7/23/18): No performance review provided.-Staff 31 (CNA) (hired on 9/15/23): No performance review provided.-Staff 32 (CNA) (hired on 12/7/20): No performance review provided. On 6/5/26 at 11:34 AM, Staff 32 stated she had worked at the facility approximately five years and she did not think she ever completed a performance review since she was hired. On 6/8/26 at 10:23 AM, Staff 1 (Administrator) confirmed annual performances reviews should be completed.