STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chehalem Post Acute	1900 E. Fulton Street Newberg, OR 97132

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and record review it was determined the facility failed to provide written advance notice to a resident/responsible party prior to room changes for 2 of 3 sampled residents (#s 11 and 12) reviewed for resident rights. This placed residents at risk for potential adjustment difficulties and delayed family communication related to changes in room location. Findings include:The facility's Room/Roommate and Change Notification Policy, dated 8/1/24, indicated residents had the right to receive a written notice, including the reason for the change, before a resident's room or roommate was changed. 1. Resident 12 was admitted to the facility in 7/2025 with diagnoses including quadriplegia (paralysis affecting all four limbs of the body) and aphasia (a language disorder resulting from brain damage affecting speaking or comprehension). Resident 12's admission Profile/Face Sheet revealed Witness 2 (Family Member) was the responsible party. Progress notes from 7/2025 through 9/2025 revealed no documentation or written notification of Resident 12's room change had been provided to Witness 2. The clinical record revealed Resident 12 moved rooms on 8/21/25. On 1/12/26 at 11:15 AM Witness 2 stated she was not provided written notification of Resident 12's room change before Resident 12 was moved on 8/21/25. On 1/12/26 at 2:25 PM Staff 2 (DNS), and on 1/13/26 at 11:11 AM Staff 1 (Administrator) confirmed Witness 2 did not receive a written notification for the room change on 8/21/25. Staff 2 stated room change notification was completed by social services; however, Staff 20 (Social Service Director) did not work during the time of the room change. Staff 2 stated she expected all residents to receive written notification when there is a room change. 2. Resident 11 was admitted to the facility in 2/2025 with diagnoses including dementia and cognitive communication deficits (impaired cognition making conversation hard to follow, thoughts disorganized and word-finding difficulties). Resident 11's admission Profile revealed Resident 11 was her/his own responsible party. Resident 11's Census indicated Resident 11 changed rooms on the following dates: (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/20/25, 12/22/25, 12/30/25 and 1/3/26. On 1/12/26 at 2:18 PM and 1/14/26 at 9:22 AM, Resident 11's communication was unintelligible, and responses were unreliable when asked yes/no questions related to her/his room changes. No documentation was found in Resident 11's clinical record regarding written notification for room changes on 12/20/25, 12/22/25, 12/30/25 and 1/3/26. On 1/13/26 at 12:18 PM and 1/14/26 at 9:46 AM, Staff 1 (Administrator) reported a resident or resident's responsible party should receive a written notification of room change prior to the resident being moved. Staff 1 confirmed no written notification was provided to Resident 11 for room changes which occurred on 12/20/25, 12/22/25, 12/30/25 and 1/3/26.

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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 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. Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received showers for 2 of 3 sampled residents (#12 and 16) reviewed for ADLs. This placed residents at risk for a lack of personal hygiene and loss of dignity. Findings include:The facility's Activities of Daily Living Policy dated 3/2018 indicated residents who were unable to carry out activities of daily living independently would receive services necessary to maintain good grooming and personal hygiene. 1. Resident 12 was admitted to the facility in 7/2025 with diagnoses of quadriplegia (paralysis affecting all four limbs of the body) and aphasia (a language disorder resulting from brain damage affecting speaking or comprehension). Resident 12's 7/23/25 admission MDS indicated the resident had a severe cognition deficit and was dependent with bathing/showering. The Care plan dated 7/24/25 revealed Resident 12 was dependent on staff for her/his ADL care needs and required one-person total assistance for showering. The care plan did not include frequency of showering. A review of Resident 12's 11/1/25 through 11/30/25 bathing task logs indicated the resident received showers on Wednesdays and Saturdays and revealed the following: -11/2025 the resident had 10 opportunities for showers. -11/1/25, 11/19/25, 11/26/25, and 11/29/25 a shower was provided. -11/5/25 and 11/12/25 Resident 12 received two bed baths. -11/8/25, 11/15/25, and 11/22/25 were Saturdays, and no shower was provided. -11/24/25 Resident 12 refused. -No evidence was found in the clinical record the resident was provided a make-up shower on 11/8/25, 11/15/25, 11/22/25, and 11/24/25. A Grievance Form dated 11/17/25 indicated Witness 2 (Family Member) was concerned Resident 12 was not receiving adequate showers. Witness 2 reported the resident had a strong body odor and greasy hair and face. Witness 2 requested Resident 12 receive shower three times per week instead of twice weekly. The request was not implemented until 11/24/25, seven days later. On 1/12/26 at 11:15 AM, Witness 2 stated Resident 12 was not showered at the frequency needed and, as a result, Resident 12 smelled badly. Witness 2 stated she reported the issue to Staff 16 (Assistant DNS/Former LPN Resident Care Manager) and informed her, she didn't want Resident 12 to have bed baths only showers as the bed baths were insufficient. Observation from 1/12/26 through 1/15/26 from 9:16 AM to 3:37 PM, revealed Resident 12 was either in bed or seated in her/his Geri Chair (a specialized seating solution designed for individuals with mobility challenges), was not interviewable, and had oily facial skin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/26 at 12:36 PM, Staff 13 (CNA) stated the resident was to receive showers twice weekly in 11/2025. Staff 13 stated she provided two bed baths in 11/2025 because Resident 12 occasionally experienced pain. Staff 13 stated if Resident 12 missed a shower, it should be made up the next day unless the resident refused. Staff 13 further stated if Resident 12 refused a shower, a bed bath should be offered, and if the resident refused the bed bath, the nurse would be notified. On 1/13/26 at 1:04 PM, Staff 14 (CNA) stated Resident 12 was scheduled to be showered twice weekly and was dependent on staff for showering and did not often refuse showering. Staff 14 stated the usual process for providing Resident 12 a shower is to have her/him transferred into a shower bed, then assisting her/him with washing her/his hair and body. On 1/13/26 at 2:55 PM Staff 8 (CNA) stated she worked with Resident 12, and showering was important because the resident sweated a lot, could have smelly hair, and oily skin. On 1/13/26 at 1:13 PM, Staff 10 (LPN) stated if Resident 12 refused bathing/showering, the CNA would notify the nurse, and the nurse would approach Resident 12. If Resident 12 continued to refuse, she/he was offered a bed bath, and Resident 12 was to be offered a shower the next day. Staff 10 reported if Resident 12's shower was missed, it should be made up later in the same day or the next day. Staff 10 indicated showers were not being completed for Resident 12 in 11/2025 because the facility utilized agency staff often on Saturdays. On 1/14/26 at 2:38 PM Staff 19 () stated she was Resident 12's Resident Care Manager in 11/2025 and was contacted by Witness 2 about Resident 12 not receiving bed baths and increasing the number of showers needed from two times a week to three times a week. Staff 19 indicated she updated Resident 12's care plan to showers only on 11/17/25 and the number of showers a week to three times a week was not implemented until 11/24/25. On 1/13/26 at 3:01 PM and 1/14/26 at 2:45 PM, Staff 2 (DNS) stated she was aware Resident 12 did not receive her/his scheduled showers in 11/2025. Staff 2 stated Resident 12 was scheduled to be showered twice weekly in 11/2025. Staff 2 stated she expected residents to receive at least two showers each week or more if necessary. Staff 2 reported the facility was using a large number of agency CNAs and getting showers completed was an issue with agency staff. 2. Resident 16 was admitted to the facility in 9/2025 with diagnoses including diabetes and metabolic encephalopathy (brain dysfunction caused from an underlying cause such as diabetes or infection). Resident 16's 9/14/25 Care Plan indicated the resident was incontinent of stool, preferred showers and was totally dependent on staff to provide bathing twice a week or as necessary. Resident 16's 9/19/25 admission MDS indicated the resident had moderate cognitive impairment, required substantial to maximal assistance by staff for bathing and did not refuse care. The 12/2025 Shower Schedule indicated Resident 16 was scheduled for showers on Wednesday and Saturday evening shifts. Resident 16's 12/12/25 through 1/12/26 bathing task logs indicated the resident received a shower on 12/21/25. A review of Resident 16's progress notes from 12/13/25 through 1/14/26 revealed no evidence the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was provided with additional showering opportunities if showering was refused, or the resident's shower was not provided. On 1/13/26 at 9:15 AM and 1/14/26 at 9:11 AM, Resident 16 was in bed, her/his hair was greasy, and the resident was in a gown. Resident 16 stated she/he was not showered regularly and estimated her/his most recent shower was approximately one month ago. Resident 16 stated, in the past, she/he showered every day because showering was her/his giddy-up and go. Resident 16 stated her/his hair was greasy and dirty and had not been washed in a while. Resident 16 stated staff did not offer her/him a shower in a long time, and she/he rarely refused to shower. Resident 16 reported she/he was surprised no one told her/him they stink since it had been so long since she/he showered. On 1/13/26 at 9:48 AM, Staff 5 (CNA) stated Resident 16 was incontinent of bowel and bladder and frequently soiled herself/himself. Staff 5 reported the facility frequently utilized agency CNA staff who often documented refused for showers without offering the resident an opportunity to shower. Staff 5 stated Resident 16 rarely refused showers. Staff 5 reviewed Resident 16's bathing task logs and stated all refusal documentation was by agency staff. On 1/13/26 at 2:31 PM, Staff 8 (CNA) stated Resident 16 was a heavy wetter and often had explosive diarrhea. Staff 8 stated residents were not getting showered like they are supposed to be because staff did not have time to get all residents' showered, especially on Saturdays when the staff were primarily agency CNAs. Staff 8 stated Resident 16 was scheduled for evening showers but sometimes it was too busy, or a second person could not be found to help, since Resident 16 required two staff and a mechanical lift transfer to provide a shower. Staff 8 stated Resident 16 did not always receive her/his showers as scheduled. On 1/13/26 at 3:01 PM, Staff 2 (DNS) stated she expected residents to receive at least two showers each week or more if necessary. Staff 2 reported the facility was using a large number of agency CNAs and getting showers completed was an issue with agency staff. On 1/13/26 at 3:05 PM, Staff 4 (Regional Assistant Director of Clinical Services) reviewed Resident 16's bathing task logs and confirmed the resident's last shower was provided on 12/21/25 and that was not acceptable.