STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review it was determined the facility failed to ensure appropriate medication storage temperatures were logged and maintained for 2 of 2 medication rooms reviewed for medication storage. This placed residents at risk for reduced efficacy of medication. Findings include:1. On 3/25/26 at 8:24 AM the third floor medication refrigerator temperature logs were observed to be blank on the following dates: 3/1/26; 3/4/26; 3/7/26; 3/8/26; 3/13/26; 3/14/26; 3/15/26; 3/16/26; 3/17/26; 3/18/26; 3/19/26; 3/21/26; 3/22/26; 3/23/26 and 3/24/26. The medication refrigerator contained insulin and other medications. On 3/25/26 at 8:24 AM Staff 3 (LPN) acknowledged the temperature logs were blank on the identified dates and acknowledged the refrigerator contained insulin and other medications. On 3/25/26 at 9:04 AM Staff 2 (DNS) acknowledged the identified dates with blank temperature logs and provided no additional information.2. On 3/25/26 at 8:55 AM the second floor medication refrigerator temperature logs were observed to be blank on the following dates: 3/11/26; 3/12/26; 3/13/26; 3/18/26 and 3/19/26. The medication refrigerator contained insulin and flu vaccines.On 3/25/25 at 8:55 AM Staff 4 (LPN) acknowledged the temperature logs were blank on the identified dates and acknowledged the refrigerator contained insulin and flu vaccines.On 3/25/26 at 9:04 AM Staff 2 (DNS) acknowledged the identified dates with blank temperature logs and provided no additional information.

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
	385206	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review it was determined the facility failed to ensure residents the right to a dignified dining experience for 1 of 1 sampled resident (#32) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include:Resident 32 was admitted to the facility in 1/2026 with diagnoses including hospice care and Alzheimer's disease. The 1/28/26 Care Plan revealed Resident 32 needed limited to one-on-one assistance with all food and fluids, to assist as needed with meals, and required two-person assistance with mobility. The 2/3/26 admission MDS revealed Resident 32 was severely cognitively impaired and required substantial to maximum assistance with eating.On 3/23/26 at 12:00 PM Resident 32 was observed in a wheelchair in the dining room while staff served meals to other residents. At 12:31 PM Resident 32 received her/his meal and a CNA assisted with one bite. The CNA then walked away from the resident and did not return until 12:46 PM, 15 minutes later. During that time Resident 32 did not independently feed herself/himself and no other staff approached her/him to help with eating. On 3/25/26 at 8:08 AM Resident 32 was observed in a wheelchair in the dining room at a table alone. There were three other residents in the dining room sitting together and staff served their breakfasts. At 8:52 AM, 44 minutes later, Resident 32 was served breakfast and a CNA assisted her/him with eating. On 3/25/26 at 12:19 PM Resident 32 was observed in the dining room with a full beverage in front of her/him, but the resident did not independently pick up the cup to take sips. Resident 32 was observed continuously until 1:17 PM, 58 minutes later, and was not approached by any staff to assist her/him with the beverage or offer a meal. On 3/25/26 at 2:46 PM Staff 5 (CNA) reported dependent residents waited until all other residents were served their meals before staff were available to assist them with eating. On 3/26/26 at 9:07 AM Staff 6 (CNA) stated Resident 32 required full assistance from staff for eating and drinking. On 3/26/26 at 10:17 AM Staff 7 (RNCM) stated residents who were able to independently eat were served first, and residents dependent for eating had to wait to be served until a CNA was free to assist them. On 3/26/26 at 10:51 AM Staff 2 (DNS) acknowledged dependent residents having extended wait times in the dining room while other residents ate did not meet facility standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

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 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 inform residents and the resident's responsible party of the risks and benefits, and to ensure consent was obtained, for the use of psychotropic medications for 1 of 5 sampled residents (#4) reviewed for unnecessary medications. This placed residents at risk for lack of informed consent of psychotropic medications. Findings include:Resident 4 admitted to the facility in 2025 with diagnoses including mild episode of depressive disorder.A 12/13/25 physician order indicated the following medications to be administered to Resident 4:- Duloxetine (antidepressant) for depression and pain.A review of the clinical record revealed no indication the risks and benefits of the antidepressant medication were reviewed, or consent was obtained for the use of Duloxetine for Resident 4.On 3/25/26 at 1:54 PM Staff 1 (Administrator) stated he was unable to locate any information to indicate the risks and benefits were reviewed, or a consent was obtained for Resident 4's use of the antidepressant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

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 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 provide hygiene and grooming care to 1 of 1 sampled resident (#32) reviewed for ADLs. This placed residents at risk for unmet hygiene and grooming needs. Findings include: Resident 32 was admitted to the facility in 1/2026 with diagnoses including hospice care and Alzheimer's disease. The 1/28/26 Care Plan revealed Resident 32 needed one-person assistance for hygiene and bathing. The 2/3/26 admission MDS for Resident 32 revealed she/he needed substantial to maximum assistance with hygiene tasks, was dependent for mobility, and received a BIMS score of 1 indicating severe cognitive impairment.The daily care documentation for 3/2026 revealed Resident received no bathing or nail care from 3/1/26 to 3/19/26. On 3/26/26 at 12:45 PM Witness 2 (Family Member) expressed concern for Resident 32's cleanliness and hygiene, as well as the length and cleanliness of her/his fingernails and toenails. Witness 2 removed the resident's blanket and socks and prompted her/him to open her/his mouth. There was white build-up around and between the resident's teeth. Resident 32 had a brown substance under all fingernails and her/his toenails extended past the toe tips. Witness 2 started to clean and clip the resident's toenails and was observed to remove a large amount of white build-up from around the left big toenail. Witness 2 indicated Resident 32's feet had a foul odor, which was also observed by the surveyor. On 3/26/26 at 1:29 PM Staff 6 (CNA) reported Resident 32 started receiving bathing through her/his hospice agency the previous week, but facility staff continued to be responsible for hygiene and grooming care. On 3/26/26 at 1:45 PM Staff 8 (CNA) stated she assisted Resident 32 that morning and acknowledged she did not wash the resident's hands or brush her/his teeth. Staff 8 stated she did not have time to complete all of Resident 32's hygiene care that morning.On 3/26/26 at 2:33 PM Witness 5 (Hospice Nurse) stated Resident 32 received bathing services through hospice but did not have nail care on her/his hospice care plan.On 3/27/26 at 8:54 AM Staff 9 (CNA) stated hygiene tasks were to be completed daily and as needed, and nail care typically occurred after showers and as needed. On 3/27/26 at 9:09 AM Witness 3 (Hospice Aide) reported Resident 32 received her/his first shower from hospice on Thursday 3/19/26 but she did not recall the condition of the resident's toenails at that visit. On 3/27/26 at 9:16 AM Staff 7 (RNCM) acknowledged all hygiene care was to be completed twice per day, and nail care was to be done weekly and as needed. Staff 7 was unable to identify a reason the facility did not provide bathing or nail care services from 3/1/26 to 3/19/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385206	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Home	5353 Columbus Street SE Albany, OR 97321

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review it was determined the facility failed to ensure residents received seizure medications for 1 of 1 sampled resident (#25) reviewed for medications. This placed residents at risk for seizures. Findings include:Resident 25 was admitted to the facility in 10/2025 with diagnoses including stroke and hemiplegia (paralysis affecting one side of the body). A 1/22/26 Physician Order revealed prescriptions for two anti-seizure medications: Briviact 50 mg given twice daily, and Clobazam 10 mg given at bedtime. The 2/2026 MAR revealed Resident 25 missed her/his dose of Clobazam on 2/3/26, 2/4/26, and 2/5/26, as well as a dose of Briviact on 2/5/26. Each missed dose was documented as med not available by Staff 10 (Certified Medication Assistant). On 3/26/26 at 3:10 PM Staff 10 (Certified Medication Assistant) acknowledged he was able to order medications but did not order Resident 25's anti-seizure medication when he saw it was out. Staff 10 stated nursing staff, not him, was responsible for contacting a physician regarding missed medications but was unable to recall if he informed nursing staff of the missed medications. On 3/26/26 at 3:26 PM Staff 11 (LPN) stated on 2/5/26 she was notified Resident 25 was out of Briviact and would not receive her/his second dose that day. Staff 11 further stated she was unaware of the three missed doses of Clobazam until 2/5/26. On 3/27/26 at 8:27 AM Witness 4 (Physician) stated Briviact and Clobazam were important medications for preventing Resident 25 from having seizures. Witness 4 reported missed doses of those medications could result in a grand mal seizure On 3/27/26 at 10:23 AM Staff 7 (RNCM) acknowledged Resident 25 missed anti-seizure medications on 2/3/26, 2/4/26, and 2/5/26. Staff 7 further acknowledged the missed medications increased Resident 25's risk for seizures.