

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2025
NAME OF PROVIDER OR SUPPLIER Saint Helens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Shore Drive Saint Helens, OR 97051	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by Resident 3 for 1 of 5 (#2) sampled residents for abuse. This failure to prevent abuse resulted with Resident 2 experiencing severe pain. Findings include: The facility's abuse policy titled Prevention and Reporting; Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, last update 8/2022, revealed residents has the right to be free from abuse. The policy defined physical abuse as a willful infliction of injury which resulted in physical harm, pain or mental anguish. Willful was defines as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident 2 admitted to the facility in 1/2025 with diagnoses including neuromuscular dysfunction of the bladder and kidney disease. Resident 3 admitted to the facility in 3/11/25 with diagnoses including dementia with agitation and cognitive communication deficit. On 4/5/25 at 7:45 PM a Physical Aggression Received incident report was initiated by Staff 14 (Former LPN) between Resident 3 and Resident 2 which occurred at 7:00 PM. The report revealed Staff 14 was notified Resident 3 pulled on Resident 2's indwelling catheter (tube inserted into bladder through the urethra to allow urine to drain and held in place by tubing called a balloon) while Resident 2 was sleeping in her/his bed. A CNA heard Resident 2 yelling, entered the room and observed Resident 3 holding onto Resident 2's catheter urine collection bag. Resident 3 was noted to be confused and told the CNA she/he thought Resident 2 was going to pull on it' when asked why she/he did it. Staff 14 responded to the room and assessed Resident 2 who was in tears. Resident 2's 4/19/25 and 7/20/225 Quarterly MDS's assessed her/him as cognitively intact and had an indwelling catheter. On 10/14/25 at 1:43 PM Resident 2 recalled the 4/5/25 incident with Resident 3. Resident 2 stated her/his roommate, Resident 3 experienced confusion most of the time. Resident 2 stated on 4/5/25 she/he was sleeping and woke to Resident 3 pulling on her/his catheter tubing. Resident 2 then grabbed the tubing from being pulled out of the tubing entry cite. Resident 2 stated it felt like a game of tug-a-war with Resident 3 pulling on the tubing. Resident 2 stated Resident 3 was confused and when she/he asked Resident 3 what they were doing, she/he said they thought she/he was going to pull on it (catheter tubing). The surveyor observed Resident 2 demonstrate where the catheter tubing broke off when Resident 3 pulled it. Resident 2 stated the catheter tubing did not come all the way out because she/he grabbed it. Resident 2 stated it was painful and it hurt for several days following the incident. On 10/15/25 at 3:34 PM Staff 7 (CNA) stated they recalled the 4/5/25 incident when Resident 3 pulled and broke Resident 2's catheter tubing off. They recalled Resident 2 was definitely in pain for several days after. They recalled Resident 3 was confused. On 10/15/25 at 3:34 PM Staff 11 (CNA) stated they recalled the 4/5/25 incident when Resident 3 pulled and broke Resident 2's catheter tubing off. Staff 11 stated they overheard Resident 2 yelling and went into the room. Staff 11 saw Resident 2 holding her/his groin area and Resident 3 was holding Resident 2's catheter drainage bag. The catheter bag was torn off from Resident 2 and in Resident 3's hand. Staff 11 stated Resident 3 experienced confusion. On 10/15/25 at 4:41 PM Staff 13 (CNA) stated they recalled the 4/5/25 incident when Resident 3 pulled and broke Resident 2's catheter tubing off. Staff 13 stated they sat with Resident 2 for a long time after the incident, until the resident received her/his next scheduled pain medication, held her/his hand and provided an ice pack while Resident 2 cried hard. Staff 13 stated they cried with Resident 2 because it was so painful for the resident. Staff 14, who was the charge nurse that initiated the Physical Aggression Received incident report and responded to the 4/5/25 incident was unavailable for an interview. On 10/17/25 at 12:05 PM Staff 1 (Administrator) stated he expected all residents to be free from abuse while in the facility. Staff 1 acknowledged the 4/5/25 incident between Resident 2 and Resident 3.</p>		