STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385222	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Helens Post Acute	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview the facility failed to report an allegation of abuse and neglect within the required time frame to the State Agency for 2 of 2 sampled residents (#4 and #7) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include1. Resident 7 was admitted to the facility in 2/2013 with diagnoses including anoxic brain injury (a critical condition that resulted in a lack of oxygen to the brain). Resident 7's 1/12/25 Care Plan indicated the resident had a history of impaired cognitive function with poor impulse control, difficulty in expressing general awareness, decision making, self-expression and mental status. Resident 7's 3/31/25 MDS identified resident with a BIMS score of 0 out 0 which indicated severe cognitive impairment. A 10/23/25 Facility Investigation Report indicated Resident 7 had swelling and bruising on her/his right knee on 10/11/25. An x-ray was ordered on 10/13/25, which identified Resident 7 had a right knee fracture. The facility concluded that the injuries were likely a result of a self-initiated injury from kicking the footboard of the bed. On 3/3/26 at 11:31 AM, Staff 26 (RN) stated she was informed by staff that Resident 7 had noted swelling of the knee. Upon examination of Resident 7, Staff 26 noted significant bruising and swelling around the resident's right knee. Staff 26 stated she ordered an x-ray which revealed the resident had suffered a fracture of the right knee. Staff 26 stated the resident did not know how she/he injured herself/himself and stated she didn't believe Resident 7's injury was self-inflicted. On 3/3/26 at 12:24 PM, Staff 2 (DNS) stated staff initially became aware of Resident 7's swelling of the knee on 10/11/25, but administration did not report it until 10/13/25. Staff 2 stated staff initially became aware of Resident 7's swelling of the knee on 10/11/25. Staff 2 stated she was aware of the incident but had not reported it to the State Agency as staff failed to report this incident to management. On 3/4/26 at 4:49 PM, Staff 11 (LPN) confirmed she was initially made aware of the residents suspected injury on 10/11/25 and did not report it to the facility's administration. Staff 11 stated that she did not report the incident due the assumption the facility was already aware. On 3/9/26 at 12:29 PM, Staff 1 (Administrator) confirmed the facility did not report the incident within the required time. 2. Resident 4 was re-admitted to the facility in 2023 with diagnoses including dementia. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/6/25 Annual MDS revealed Resident 4 had a BIMS of 11 (moderately impaired) and was dependent on toileting and personal hygiene. A 3/17/25 Facility Reported Incident revealed on 3/15/25, Staff 6 (CNA) allegedly failed to complete incontinence care for Resident 4 throughout her eight-hour shift. On 3/5/26 at 8:10AM, Staff 2 (DON) confirmed the facility reported the 3/15/25 neglect allegation on 3/17/25 but should have reported the allegation within two hours to the State Agency. On 3/5/26 at 2:12PM, Staff 1 (Administrator) confirmed the facility did not report the 3/15/25 neglect allegation within the required time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to have evidence a thorough investigation was completed to prevent potential abuse for 1 of 2 sampled residents (#7). This placed residents at risk for abuse. Findings include: Resident 7 was admitted to the facility in 2/2013 with diagnoses including anoxic brain injury (a critical condition that resulted in a lack of oxygen to the brain).Resident 7's 1/12/25 Care Plan revealed the resident had a history of impaired cognitive function with poor impulse control, difficulty in expressing general awareness, decision making, self-expression and mental status. Resident 7's 3/31/25 MDS identified resident with a BIMS score of 0 out 0 which indicated severe cognitive impairment.A 10/23/25 Facility Investigation Report indicated on Resident 7 had swelling and bruising on her/his right knee on 10/11/25. An x-ray was ordered on 10/13/25, which identified Resident 7 had a right knee fracture. The facility concluded that the injuries were likely a result of a self-initiated injury from kicking the footboard of the bed. On 3/3/26 at 11:31 AM, Staff 26 (RN) stated she was informed by care staff that Resident 7 had noted swelling of the knee. Upon examination of Resident 7, Staff 26 noted significant bruising and swelling around the resident's right knee. Staff 26 stated she ordered an x-ray which revealed the resident had suffered a fracture of the right knee. Staff 26 stated the resident did not know how she/he injured herself/himself and stated she didn't believe Resident 7's injury was self-inflicted.On 3/3/26 at 12:24 PM, Staff 2 (DNS) stated staff initially became aware of Resident 7's swelling of the knee on 10/11/25. Staff stated upon her examination she noted no bruising was identified and Resident 7's injury was likely self-inflicted due to her/his poor impulse control. There was no documented evidence the facility thoroughly investigated an injury of unknown source which resulted in a fractured right knee.On 3/9/26 at 12:29 PM, Staff 1 (Administrator) confirmed the facility did not thoroughly investigate Resident 7's injury of unknown source.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to follow physician's orders for medication administration for 1 of 3 sampled residents (#1) reviewed for quality of care. This placed residents at risk for unmet medication needs. Findings include:Resident 1 was admitted to the facility in 12/2024 with diagnoses including polyneuropathy (widespread malfunction of multiple peripheral nerves throughout the body), inflammatory spondylosis-cervical region (chronic, inflammatory, and degenerative disorders affecting the neck vertebrae) and hypothyroidism (abnormally low activity of the thyroid gland). Resident 1's Physician Order dated 1/4/2025 directed that Resident 1 receive Thyroid Oral 90 mg daily by mouth for treatment of hypothyroidism. Resident 1's 1/2025 MAR indicated Thyroid Oral 90 mg was not administered on 1/19/25, 1/20/25, 1/22/25, 1/23/25, and 1/24/25, with instructions to see nurses notes. Resident 1's Nursing Progress notes dated 1/19/25 and 1/20/25 indicated the Thyroid Oral 90 mg medication was on order. Resident 1's Nursing Progress notes dated 1/22/25 and 1/23/25 indicated the resident's Thyroid medication was unavailable. Resident 1's Nursing Progress note dated 1/24/25 indicated the facility contacted the pharmacy, and the pharmacy reported the medication was on backˆorder. A later progress note on 1/24/25 indicated the medication was expected to be delivered that night. Review of Resident 1's clinical record indicated there was no documentation that the facility notified Resident 1's provider of the missed doses of Thyroid medication or attempted to obtain the medication from an alternative source. On 3/9/26 11:28 AM, Staff 12 (LPN) stated that if a resident was out of a medication, she would call the pharmacy to see when it was scheduled to be delivered. If the medication was on back-order, she would notify the RCM or DNS, and she or they would reach out to the provider for a possible substitute. On 3/10/26 at 10:45 AM, Staff 1 (Administrator) and Staff 2 (DNS) stated they were not working at the facility when Resident 1 was at the facility but expected the provider to be notified of the medication being unavailable and of the resident's missed doses.