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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Helens Post Acute	75 Shore Drive Saint Helens, OR 97051

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide a comfortable and homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for an unsatisfying experience and living in an unkept environment. Findings include:Resident 41 was admitted to the facility in 2025 with a diagnoses including anxiety.A 1/28/26 Quarterly MDS assessed Resident 41 as cognitively intact.On 4/19/26 at 10:26 AM room [ROOM NUMBER]'s floor appeared unwashed and dark spots around the toilet and throughout the bathroom.On 4/19/26 at 10:49 AM Resident 41 stated her/his room was not cleaned regularly and had not been cleaned since Friday (4/17/26) because the facility was often short staffed.On 4/19/26 at 10:53 AM Staff 19 (Director of Housekeeping) was the only housekeeping staff observed to work in the facility. Staff 19 confirmed he was the only person working in housekeeping when the survey team entered on 4/19/26.On 4/19/26 at 10:59 AM the shared bathroom for room [ROOM NUMBER] was observed with dark stains in the toilet bowl.On 4/19/26 at 12:03 PM room [ROOM NUMBER] was observed with a dirty floor, debris spread throughout on the floor, dark stains in the toilet bowl and the bathroom smelled of urine.On 4/24/26 at 9:00 AM Staff 19 and Staff 20 (Regional Director of Housekeeping) walked throughout the facility with the surveyor. Staff 19 acknowledged he had scrubbed the resident's toilet bowls on 4/21/26 due to the dark stains. Staff 19 stated due to the older building some stains would not come off several surfaces. Staff 19 and Staff 20 confirmed the following observations:-room [ROOM NUMBER] shared bathroom with dark substance on the toilet seat, handle and tank.-room [ROOM NUMBER] floor baseboards were unclean.-The resident shower rooms on 3 of 3 halls appeared unclean and unkept by items left in the room.On 7/26/23 at 1:12 PM Staff 1 (Administrator) walked through the facility with surveyor. Staff 1 acknowledged he expected the residents' rooms and areas to be clean.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to monitor and assess resident skin conditions, administer psychotropic medications and insulin timely for 3 of 5 residents (#s 49, 82 and 94) reviewed for skin conditions, pain and insulin. This placed residents at risk for worsening skin conditions, increased anxiety and complications related to uncontrolled blood sugars. Findings include:1. Resident 49 was admitted to the facility in 9/2025 with diagnoses including diabetes. A 1/9/26 United Wound Healing Note revealed the following:-Resident 49 admitted to the facility with wounds of the bilateral lower extremities and right foot.-Interventions included offloading, repositioning and wound dressings, and the resident's tolerance of the treatment was reported to be good.-All wounds had healed, and treatment recommendations included to monitor for reopening of old wounds and for the presence of new wounds. Resident 49's 4/4/26 Quarterly MDS revealed the resident was severely cognitively impaired, experienced episodes of disorganized thinking (fragmented, illogical or disjointed thoughts often manifesting as incoherence or rapid shifting between unrelated topics) and did not have any ulcers, wounds or skin problems. Resident 49's 4/15/26 Potential for Impaired Skin Integrity and Diabetes Care Plans revealed the following:-Check skin when assisting with ADLs.-Ensure socks/hosiery were clean and absorbent every day.-Avoid constrictive shoes.-Carefully dry between toes but do not apply lotion between toes.-The resident refuses to take off her/his boots. Encourage the resident to remove them at night when in bed.-Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Report any of the above to the provider.-Monitor/document/report to the provider as needed any signs and symptoms of infection.-Refer to foot care nurse/podiatrist. Resident 49's 4/2026 Physician Orders directed the following:-A nurse was to perform a diabetic foot check every week and notify the provider if a skin issue was noted.-A weekly head-to-toe skin inspection was to be completed by the nurse. The resident care manager was to be notified of any new skin issue and if the resident would benefit from a podiatry consult. Any refusals were to be documented in the electronic record. A review of Resident 49's 4/2026 TAR revealed the following:-Staff 17 (LPN) completed the residents' weekly diabetic foot check on 4/6/26 and 4/13/26 and no skin issues were noted.-Staff 15 (LPN) completed the resident's weekly skin inspection on 4/14/26 and no skin issues were noted. A 4/15/26 Nursing Quarterly Evaluation completed by Staff 3 (LPN-Resident Care Manager) indicated Resident 49 did not have any skin integrity concerns. A review of Resident 49's clinical record indicated the resident had routine refusals of all aspects of care. On 4/20/26 at 1:14 PM, Resident 49 was observed in her/his room, sat in her/his wheelchair and wore pants, thick socks and heavy boots. Resident 49 stated she/he was not going to participate in activities on this day as she/he was having trouble with my socks. The resident pulled up her/his right pant leg and revealed a dark red sock covered in flaked skin, and the exposed part of her/his (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calf was bright red. The resident attempted to pull the right sock away from the skin but was only able to pull away the top part of the sock as the sock stuck to the resident's skin at her/his ankle. A large skin indent was observed where the top part of the sock had been, the skin that was visible underneath was bright red and appeared raw and exuded a malodorous odor. A dirty, blood-tinged bandage was observed underneath the resident's right sock and was stuck to the resident's skin. The resident, unprompted by the state surveyor, removed her/his boots at this time. The resident's socks appeared dirty and were covered in flaked skin. The resident was unable to answer any specific questions related to her/his skin as her/his speech was disorganized (incoherent, illogical or rambling speech) but stated her/his legs were getting more painful and she/he had been in pain for a couple of months because of her/his ankles. On 4/20/26 at 4:18 PM, Resident 49 was observed to ambulate down the hall towards the nurse's station. The resident wore dark red socks and did not wear any shoes or boots. Once at the nurse's station, Resident 49 lifted her/his right pant leg and asked Staff 30 (RN) for some help with this. Resident 49 returned to her/his room and Staff 30 remained at the nurse's station. On 4/21/26 at 11:26 AM, Staff 31 (LPN) stated some of the nurses at the facility do not complete resident skin checks, and they don't even offer. On 4/21/26 at 11:48 AM, Staff 12 (CNA) stated Resident 49 refused to shower, change clothes or remove her/his shoes. Staff 12 stated she had never visualized the resident's legs or feet. On 4/21/26 at 12:32 PM, Staff 15 stated she had never completed a head-to-toe skin inspection for Resident 49 and did not recall completing a skin assessment on 4/14/26. Staff 15 stated she thought she was able to visualize the resident's feet and legs on one occasion but it was not recent. Staff 15 stated she had not reported to the resident's provider her/his refusals of skin inspections. On 4/21/26 at 1:53 PM, Staff 44 (Physician Assistant-Certified) stated she was aware of Resident 49's daily refusals of care, but she would expect to be notified weekly of any refusals of skin inspections. Staff 44 stated she could not recall the last time she was notified Resident 49 refused a skin inspection. On 4/21/26 at 7:22 PM, Staff 17 stated she had never assessed Resident 49's feet. Staff 17 stated her documentation on the resident's TAR on 4/6/26 and 4/13/26 indicated she attempted to complete the resident's diabetic foot check, but the resident refused on both occasions. Staff 17 further stated she had notified the resident's resident care manager of her/his diabetic foot care refusals, but she had not notified the resident's provider. On 4/22/26 at 10:28 AM, Staff 3 stated she was unsure as to when to notify a resident's provider if a resident refused a skin inspection or a diabetic foot check. Staff 3 stated she observed Resident 49's feet on 4/21/26 after the resident had independently removed her/his boots but did not state the last time she had visualized the resident's feet prior to this opportunity. On 4/22/26 at 10:45 AM, Staff 2 (DNS) stated Resident 49's provider should have been notified each time the resident refused a skin inspection or diabetic foot care and confirmed the provider had not been notified. 2. Resident 82 was admitted to the facility in 1/2026 with diagnoses including diabetes requiring hemodialysis (a medical procedure for advanced kidney failure that removes waste products, toxins (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and excessive fluids from the blood). Physician orders dated 2/20/26 and 3/19/26 indicated Resident 82 was prescribed the following diabetic medications: -Insulin aspart (fast-acting insulin) 2 units with meals, scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM. -Insulin aspart before meals and at bedtime according to the prescribed sliding scale (insulin doses adjusted based on pre-meal blood sugars designed to correct high blood sugars), scheduled to be administered at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM. A review of Resident 82's 4/1/26 through 4/20/26 DAR (Diabetic Administration Record) revealed the resident's insulin was not administered timely on the following days: -Insulin aspart on 4/2/26 was administered at 7:17 PM and should have been administered at 5:00 PM, 4/3/26 was administered at 6:13 PM and should have been administered at 5:00 PM and 4/7/26 was administered at 2:05 PM and should have been administered at 12:00 PM. -Sliding scale Insulin aspart on 4/3/26 was administered at 10:24 PM, 4/8/26 was administered at 9:36 PM, 4/13/26 was administered at 9:01 PM and 4/19/26 was administered 9:41 PM. These doses should have been administered at 8:00 PM. No evidence was found in Resident 82's clinical record as to why her/his insulin was administered late on the above dates. On 4/19/26 at 10:51 AM and 4/21/26 at 11:25 AM, Resident 82 stated, on many occasions, her/his insulin was not being administered timely. Resident 82 stated she/he was a brittle diabetic (a diabetic that experiences frequent and severe swings in blood sugars) and required hemodialysis so receiving her/his insulin timely to keep her/his blood sugars controlled was very important. Resident 82 stated it was frustrating to receive her/his insulin late and late administration mostly occurred with her/his bedtime insulin. On 4/22/26 at 11:38 AM, Staff 14 (RN) stated Resident 82's blood sugars go low really fast. Staff 14 stated Resident 82 reported to him that her/his nighttime insulin was administered late, at times. Staff 14 stated the night shift nurse (6:00 PM to 6:00 AM) was responsible for administering medications and insulin to residents so they could get busy and might not be able to administer insulin on time. 4/23/26 at 11:54 AM, Staff 3 (LPN-Resident Care Manager) stated when nurses administered insulin late, they were required to write a progress note explaining the reasoning for the late insulin administration. She reported the nighttime nurse could get busy and backed up with medication and insulin administration, resulting in insulin not being administered timely. Staff 3 reviewed Resident 82's 4/2026 DAR and confirmed the resident's insulin was not administered timely on the dates identified. Staff 3 stated it was her expectation that insulin be administered according to the times established on the DAR unless a progress note was written to explain the rationale for late administration. Staff 3 acknowledged the dates identified did not have progress notes written, and Resident 82's insulin was not timely administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 94 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (a narrowing of spaces within the spine leading to pain), anxiety disorder, panic disorder, and opioid dependence. Resident 94's 2/28/26 admission MDS indicated the resident was cognitively intact. Resident 94's 2/24/26 admission orders included the following:- Lorazepam (a medication used to treat anxiety) 1 mg oral tablet, take 1.5 tablets by mouth two times a day (morning and lunch), and 1 tablet every evening as needed. Resident 94's 2/2026 MAR indicated the following medications were ordered on 2/24/26 at 10:26 AM:1. Lorazepam 1 mg oral tablet - give 1.5 tablets by mouth two times a day related to generalized anxiety disorder.-Scheduled administration times: 8:00 AM and 12:30 PM.-Not administered at either 8:00 AM or 12:30 PM on 2/25/26. 2. Lorazepam 1 mg oral tablet - give 1 tablet by mouth in the evening as needed related to generalized anxiety disorder.-Administered on 2/25/26 at 7:33 AM (not in the evening as ordered). On 4/21/26 at 1:01 PM Staff 33 (LPN) stated they did not recall Resident 94, the admission, or any issues related to the delivery of lorazepam. Staff 33 was unable to provide additional information regarding whether the lorazepam prescription was sent to the pharmacy, or why their was a delay in delivery. No documentation by Staff 33 was identified in the medical record to clarify the events surrounding the lorazepam prescription and its delivery. On 4/21/26 at 6:26 PM Witness 7 (Complainant) stated Resident 94 was admitted to the facility around noon on 2/24/26. Witness 7 stated the admitting nurse advised Resident 94's lorazepam would be delivered to the facility within a few hours of admission. Witness 7 stated at approximately 2:30 AM on 2/25/26 Resident 94 called them upset indicating she/he needed lorazepam, and it was not available. Witness 7 stated they contacted the facility, advised the nurse the resident needed lorazepam and were told the prescription for lorazepam had not been sent to the pharmacy. On 4/27/26 at 12:49 PM Staff 36 (CNA) stated Resident 94 was agitated the night of admission to the facility and the resident requested anti-anxiety medication several times which they reported to the nurse. Staff 36 stated Resident 94 was in distress because her/his lorazepam was not available and upon admission she/he was told it would be. Staff 36 stated the resident also called Witness 7 twice and reported she/he needed her medication and had not received it. On 4/22/26 at 5:24 PM Staff 37 (RN) stated the night of Resident 94's admission they received a call from Witness 7 requesting lorazepam for the resident and upon assessment the resident appeared agitated. Staff 37 stated Resident 94 had admitted to the facility earlier that day with orders for lorazepam 1mg tablet, but the prescription had not been sent to the pharmacy and the resident's medication was not available for administration. Staff 37 contacted the on-call provider and requested a prescription. Staff 37 then requested a pull-code (a code for secure access) from the pharmacy to access the facility's backup supply of lorazepam and was denied because the resident's order was for lorazepam 1mg tablets, whereas the available dose was for 0.5mg tablets. Staff 37 stated they were unable to administer Resident 94 her/his lorazepam. On 4/24/26 at 10:35 AM Staff 3 (LPN-Resident Care Manager) and Staff 4 (RNCM) stated the resident was admitted to the facility from home without a hard copy of the prescription for lorazepam. Staff 4 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated in such cases the admitting nurse should have requested a STAT (immediate) prescription from the on-call provider for Resident 94's lorazepam for delivery as soon as possible and ideally within four hours. Staff 3 and Staff 4 stated there should have been diligent follow-up by the floor nurse and documentation reflecting the cause of any delay and the status of the prescription delivery, especially given Resident 94's diagnoses. Staff 3 acknowledged there was no record of follow-up on the lorazepam prescription in Resident 94's medical record. Staff 3 acknowledged Resident 94 did not receive her/his requested dose of lorazepam the night of admission and did not receive her/his scheduled doses as ordered the following day.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review it was determine the facility failed to ensure residents received appropriate pain management for 1 of 2 sampled residents (#94) reviewed for pain. This placed residents at risk for increased pain. Findings include:Resident 94 was admitted to the facility in 2/2026 with diagnoses including spinal stenosis (a narrowing of spaces within the spine leading to pain), dorsalgia (back pain), anxiety disorder, panic disorder, and opioid dependence. Resident 94's 2/28/26 admission MDS indicated the resident was cognitively intact. Resident 94's 2/24/26 admission orders included the following:Hydrocodone-acetaminophen (an opioid pain reliever) 10 mg - 325 mg oral tablet, give 1 tabs every four hours as needed for pain.Resident 94's 2/2026 MAR indicated the following medication was ordered on 2/24/26 at 10:26 AM:- Hydrocodone-acetaminophen 10 mg - 325 mg oral tablet, give 1 tablet every four hours as needed for pain.- Hydrocodone-acetaminophen 10 mg - 325 mg oral tablet was first administered to the resident on 2/25/36 at 4:25 AM.On 4/21/26 at 1:01 PM Staff 33 (LPN) stated they did not recall Resident 94, the admission, or any issues related to the delivery of hydrocodone-acetaminophen. Staff 33 was unable to provide additional information regarding whether the hydrocodone-acetaminophen prescription was sent to the pharmacy, or why there was a delay in delivery. No documentation by Staff 33 was identified in the medical record to clarify the events surrounding the hydrocodone-acetaminophen prescription and its delivery.On 4/21/26 at 6:26 PM Witness 7 (Complainant) stated Resident 94 was admitted to the facility around noon on 2/24/26. Witness 7 stated the admitting nurse advised Resident 94's hydrocodone-acetaminophen would be delivered to the facility within a few hours of admission. Witness 7 stated at approximately 2:30 AM on 2/25/26 Resident 94 called them in distress indicating she/he was in pain and needed hydrocodone-acetaminophen, and it was not available. Witness 7 stated they contacted the facility, advised the nurse the resident needed pain medication and were told the hydrocodone-acetaminophen prescription had not been sent to the pharmacy. On 4/27/26 at 12:49 PM Staff 36 (CNA) stated Resident 94 was in pain on 2/25/26 and was agitated the night of admission to the facility and the resident requested pain medication several times which they reported to the nurse. Staff 36 stated Resident 94 was upset because her/his hydrocodone-acetaminophen was not available when she/he was told it would be at the time of admission. Staff 36 stated the resident also called Witness 7 twice and reported she/he was in pain and needed her pain medication and had not received it. Staff 36 stated they were unsure what time Resident 94 began requesting pain medication but believed it was early in their shift, which began at 10:00 PM.On 4/22/26 at 5:24 PM Staff 37 (RN) stated the night of Resident 94's admission they received a call from Witness 7 requesting pain medication for the resident reporting she/he had called them from her/his room upset and in pain. Staff 37 stated Resident 94 had admitted to the facility earlier that day with orders for hydrocodone-acetaminophen for pain control, but the prescription had not been sent to the pharmacy, and therefore resident's pain medication was not available for administration. Staff 37 requested a prescription from the on-call provider and a pull-code (a code for secure access) from the pharmacy to access the facility's backup supply of hydrocodone-acetaminophen. Staff 37 administered Resident 94 her/his first dose of hydrocodone-acetaminophen on 2/25/26 at 2:25 AM.On 4/24/26 at 10:35 AM Staff 3 (LPN-Resident Care Manager) and Staff 4 (RNCM) stated the resident was admitted to the facility from home without a hard copy of the hydrocodone-acetaminophen prescription. Staff 4 stated in such cases the admitting nurse should have requested a STAT (immediate) prescription from the on-call provider for Resident 94's hydrocodone-acetaminophen for delivery as soon as possible and ideally within four hours. Staff 3 and Staff 4 stated there should have been diligent follow-up by the floor nurse and documentation reflecting the cause of any delay and the status of the prescription delivery, especially given Resident 94's diagnoses. Staff 3 acknowledged there was no record of follow-up on the hydrocodone-acetaminophen prescription in Resident 94's medical record and the medication was not readily available to the resident upon request.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide therapy services as ordered for 4 of 4 sampled residents (#s 8, 50, 82 and 95) reviewed for rehabilitation services. This placed residents at risk for a decline in functional abilities and diminished quality of life. Findings include: Resident 95 was admitted to the facility on [DATE] with a diagnoses including a stroke and a history of falls. The 1/8/26 physician orders prescribed Resident 95 to receive Physical therapy, Occupational therapy and Speech therapy evaluations and treatments as indicated from assessments and evaluations. On 1/9/26 Resident 95 was assessed by Physical therapy to receive therapy five times per week for the certification period of 1/9/26 through 3/9/26. Record review of the Physical therapy records revealed Resident 95 was provided with therapy only four times per week in the following weeks:-2/2/26, 2/3/26, 2/4/26, 2/5/26;-2/9/26, 2/10/26, 2/11/26, 2/12/26;-2/24/26, 2/25/26, 2/26/26 and 2/27/26. On 1/14/26 Resident 95 was assessed for Speech therapy services and not recommended for therapy services at this time. On 1/19/26 Resident 95 was assessed by Speech therapy to require therapy two times per week for the next 60 days. No documentation was provided that indicated Resident 95 was treated by Speech therapy after 1/19/26. Resident 95 was evaluated for Occupational therapy on 2/23/26, 42 days after admission. Record review of the Occupational therapy records revealed Resident 95 was evaluated to need Occupational therapy for five days per week for 60 days. Resident 95 only received Occupational therapy on the following dates: -2/23/26 to 2/27/26 (assessment plus four days);-3/2/26, 3/3/26, 3/4/26 and 3/6/26 (four days);-3/9/26. Resident 95 discharged from the facility on 3/18/26. On 4/24/26 Staff 1 (Administrator) Staff 1 verified Resident 95's therapy services on his computer. Staff 1 confirmed Resident 95 was not provided with therapy services as prescribed. Staff 1 stated he expected Resident 95's Occupational and Speech therapy assessments to be completed in a timely manner and therapy evaluations should have been completed within 48 hours of her/his admission. Staff 1 expected all therapy services provided to residents as often as determined by therapist assessments and signed by the physician. 2. Resident 82 was admitted to the facility in 1/2026, was transferred to the hospital on 2/9/26 and readmitted to the facility on [DATE] with diagnoses including diabetes and mild protein-calorie malnutrition, a form of malnutrition arising from a deficiency of protein, calories and fats necessary to meet bodily needs. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 82's 2/13/26 Hospital Discharge and Transfer Orders indicated the resident was prescribed a mechanical soft diet (foods that were chopped, ground, mashed or pureed). Resident 82 was to be evaluated and treated by a SLP. Resident 82's SLP records indicated the resident was not assessed by a SLP until 3/2/26, 17 days after her/his readmission. The resident received mechanical soft diet textures until the SLP assessment was completed. On 4/19/26 at 10:50 AM, Resident 82 stated it took a month to get off puree foods. Resident 82 reported she/he was told the facility needed to hire more SLP staff in order to assess her/him and determine if her/his diet could be changed. On 4/22/26 at 12:16 PM, Staff 9 (Regional Director of Rehabilitation) reviewed Resident 82's SLP documentation and confirmed the resident was not assessed until 3/2/26. Staff 9 was unsure why Resident 82 was not assessed by SLP prior to 3/2/26. On 4/22/26 at 1:00 PM and 4/24/26 at 1:46 PM, Staff 1 (Administrator) acknowledged on 2/13/26 Resident 82 was readmitted to the facility with SLP evaluation and treatment orders and confirmed the resident was not assessed until 3/2/26. Staff 1 stated he expected Resident 82's SLP assessment to be completed in a timely manner and the SLP evaluation should have been completed within 48 hours of her/his readmission. 3. Resident 8 was admitted to the facility in 2/2026 with diagnoses including muscle weakness. Resident 8's 2/12/26 Physician Orders directed the resident to be evaluated and treated by OT (Occupational Therapy). Resident 8's 2/17/26 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty, and she/he had not received any therapy services in the previous seven days. A 4/20/26 OT Evaluation & Plan of Treatment Form revealed Resident 8 received an initial evaluation by OT on 4/20/26. On 4/19/26 at 1:36 PM, Resident 8 was observed in her/his room and sat in her/his wheelchair. Resident 8 stated she/he did not receive any OT and was interested in participating in any therapy that could help her/him to get out of here. On 4/27/26 between 9:29 AM to 10:10 AM, Staff 27 (CNA), Staff 30 (RN), Staff 34 (Agency CNA) and Staff 35 (CNA) stated they had never observed Resident 8 work with therapy since the resident's admission to the facility. On 4/27/26 at 10:36 AM, Staff 8 (Rehabilitation Director) stated therapy evaluations were typically completed the day of or day after an order for therapy was received. Staff 8 stated Resident 8 had an order for an OT evaluation and treatment from 2/12/26 but the evaluation was not completed until 4/20/26 as he had experienced difficulty maintaining Certified Occupational Therapy Assistants. Staff 8 acknowledged Resident 8's therapy evaluation was not timely. 4. Resident 50 was re-admitted to the facility in 10/2025 with diagnoses including anoxic brain injury (continued on next page)

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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Helens Post Acute	75 Shore Drive Saint Helens, OR 97051

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(damage to the brain due to a lack of oxygen) and right femur fracture (thighbone fracture). Resident 50's 11/12/25 Orthopedic After Visit Summary included an order for PT (Physical Therapy). A review of the resident's clinical record revealed no evidence the PT order was acknowledged, clarified, or given to the therapy department. On 4/23/26 at 3:24 PM Staff 4 (RNCM) stated the order must have been missed. She confirmed the therapy department was not informed of the order, the therapy order was not clarified, and the resident did not receive therapy services.

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	04/27/2026

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review it was determined the facility failed to provide an effective pest control program for 1 of 1 facility reviewed for environment. This placed residents at risk for exposure to household pest and increased health risks. Findings include: On 4/22/26 at 9:19 AM Witness 9 (Agency Pest Control) was observed in the facility to place traps for roaches around the facility. AT 9:24 AM Witness 9 stated he came to the facility one time per month per the contract. Witness 9 stated he had not observed evidence of rodents in the facility but observed evidence of roaches for months.Review of the Pest Control Log on 4/22/26 at 1:10 PM revealed sightings of roaches had been reported from 10/2025 to 4/2026.On 4/22/26 at 1:52 PM Witness 9 stated the facility really needed services for two applications per month for pest control to eradicate the roaches.On 4/22/26 at 1:54 PM Staff 1 (Administrator) Staff 1 acknowledged concerns with roaches throughout the facility. Staff 1 stated he had asked Witness 9 to provide more service during his past and recent visits one time per month to control pests, especially roaches. On 4/23/26 at 12:11 PM and 4:45 PM Staff 43 (CNA) and Staff 44 (CNA) both reported sightings of roaches in the facility. Staff 43 and Staff 44 stated sightings were not always written or reported in the Pest Control Log.On 4/24/26 at 8:13 AM Staff 27 (CNA) stated she had observed roaches in the facility and was unaware of a Pest Control Log to report sightings of pests.On 4/27/26 at 9:38 AM Staff 1 confirmed the ongoing issue of roaches, and he expected the facility to be pest free.