STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385224	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Health and Rehabilitation	820 Cottage Street NE Salem, OR 97301

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to protect the resident's right to be free from neglect by staff for 1 of 3 sampled residents (#103) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include:Resident 103 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) with acute exacerbation and respiratory failure. The resident was on hospice services.Resident 103's Physician Order dated 11/4/25 included to administer morphine sulfate 0.25 ml by mouth every hour as needed for shortness of breath and/or moderate to severe pain.On 11/5/25 at 4:57 AM, Resident 103's Progress Note indicated the resident had a period of COPD exacerbation, was groaning, had difficulty breathing and was complaining of being thirsty.On 11/5/25 at 6:29 PM, Resident 103's Progress Note indicated the resident was having difficulty swallowing and all tablet medication would be held. The resident was distressed, had rapid breathing and was very anxious.Resident 103's 11/2025 MAR noted the resident received a dose of her/his morphine medication on 11/6/25 at 8:38 PM. No further doses of the medication were administered on 11/6/25.On 12/12/25, the State Survey Agency received a call from Witness 1 (Former Staff), which indicated on 11/6/25, Staff 7 (LPN) was assigned to Resident 103's care and had refused to administer the resident's ordered pain medication even when staff members were reporting the resident was exhibiting screaming, shortness of breath, and very anxious behaviors. Staff 8 (LPN) tried to educate Staff 7 that the medication was to assist the resident to be comfortable and to not have pain or distress, but Staff 7 refused to medicate the resident and refused to give Staff 8 the medication cart keys so she could medicate the resident per the resident's physician orders. On 2/20/26 at 12:29 PM, Staff 1 (Administrator) stated Staff 7 reported she did not give the resident the morphine medication because it could depress the resident's breathing. On 2/23/26 at 2:42 PM, Staff 8 (LPN) stated she worked the evening of 11/6/25 and remembered Resident 103 screaming and observed the resident exhibiting signs of terminal agitation such as pulling off her/his clothes, screaming, crying, and shortness of breath. Staff 8 spoke to Staff 7 who stated she had given the resident Tylenol earlier. Staff 8 stated Staff 7 would not listen to her. Staff 8 stated she called the on-call manager but did not get an answer.On 2/23/26 at 1:35 PM, Staff 13 (CNA) stated Resident 103 was on hospice and Staff 7 was the resident's nurse and refused to give the resident her/his ordered morphine. Staff stated Resident 103 had a very bad night and was screaming, anxious, uncomfortable and painful the whole shift. Staff remembered Staff 8 told Staff 7 to call hospice or the doctor, but Staff 7 ignored her. Staff 13 stated she felt Staff 7 was neglecting the resident.On 2/23/26 at 3:44 PM, Staff 14 (CNA) stated she went to help with Resident 103 who was painful and disoriented. She asked Staff 7 for pain medication for the resident, but Staff 7 told her no. Staff 14 stated she went to Staff 8 for help, who spoke to Staff 7, but was told to mind her own business. Staff 14 stated she was so upset because the resident was in pain and that was what hospice was for.On (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/24/26 at 10:43 AM, Staff 9 (LPN) stated the incident with Resident 103 was awful. The resident was screaming. Staff 9 stated Staff 8 had informed her the resident was screaming, and that Staff 7 would not give the resident her/his morphine medication. Staff 9 stated she came in early to provide comfort or medications. She held the resident's hand, repositioned her/him, and rubbed her/his head. When she asked Staff 7 why the resident was not medicated, she stated the resident did not need it. Staff 9 stated Staff 7 did not want to depress the resident's breathing, but she felt the medication would have helped with this.On 2/24/26 at 4:55 PM, Staff 7 (LPN) stated she did not remember if she gave the resident medication. Staff 7 stated she would have to get back with an answer after she checked the medical record because she thought she must have done something for the resident. Staff 7 did not make any further contact and did not provide any documentation or further explanation for this incident.On 2/24/26 at 12:15 PM, Witness 2 (Hospice Agency Care Manager) stated their notes indicated hospice staff were frustrated with medication administration not being done as ordered at the facility. She also stated the morphine would be appropriate for shortness of breath. If the resident was breathing too hard or too quickly it could slow the breathing down and greatly benefit the resident which was why the medication was ordered. On 2/25/26 at 8:59 AM, Staff 4 (LPN/Unit Manager) indicated she remembered an issue with the resident not receiving pain medications. Staff 7 refused to give morphine when the resident was short of breath, and it would depress the resident's breathing. Staff 4 stated Staff 8 had informed her Resident 103 had been crying out, and Staff 7 refused to give the medication. Staff 4 stated the medication was for pain and shortness of breath, but Staff 7 walked away from her and would not discuss the issue.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on interviews and record review it was determined the facility failed to ensure the resident was free from involuntary seclusion by staff for 1 of 3 sampled residents (# 104) reviewed for involuntary seclusion. This placed residents at risk for mistreatment. Findings include:Resident 104 was admitted to the facility in 2025 with diagnoses including hip fracture and dementia. Resident 104's 12/2025 Care Plan did not include interventions to keep the resident at the nurse's station all night to prevent falling. On 12/12/25, the State Survey Agency received a call from Witness 1 (Former Staff). Witness 1 stated on 12/6/25 she was notified that Staff 6 (LPN) forced Resident 104 to stay up in her/his wheelchair most of the night on 12/5/25. The resident was kept at the nurse's station up until around 2:00-2:30 AM when staff provided the resident with incontinence care. Staff refused to get the resident back out of bed because Resident 104 made multiple requests to go to bed and the resident did not usually stay up at night. Staff 6 got Resident 104 back up and took the resident back to the nurse's station and kept the resident there until 5:00 AM. Staff 6 stated she did not want to deal with having to write any potential incident reports if the resident fell. On 2/20/26 at 10:41 AM, Staff 1 (DNS) stated she was not the DNS at the time of this incident, and stated staff could have a resident at the nurse's station to monitor her/him but not for the entire night and not for staff's convenience. On 2/20/26 at 12:29 PM, Staff 1 (Administrator) stated Staff 6 was on her probationary period. There was a notification in her in-box about Staff 6 keeping Resident 104 up all night. When she asked Staff 6 about it, Staff 6 stated she did not remember doing so. Staff 1 stated she told Staff 6 when a resident wants to go to bed, you put them to bed, and it is not okay to keep a resident up for your convenience. Staff 6 denied it. Staff 1 stated she listened to Staff 6's side of the story but felt Staff 6 did not understand she had done something wrong. On 2/20/26 at 1:26 PM, Staff 16 (CNA) stated she observed Resident 104 sitting up by the nurse's station on the south hall. At approximately, 7:00 PM on evening shift, staff assisted the resident with incontinent care, but Staff 6 intervened and stated the resident was not going to bed and told staff they were to get the resident back up. Staff 16 asked Resident 104 what she/he wanted to do, and the resident stated she/he wanted to stay in bed. Staff did not get the resident up. Staff 6 called facility management and was told if the resident wanted to go to bed, then put the resident to bed. Staff 16 stated on 12/5/25, Resident 104 was kept up until 2:00 or 3:00 AM and then back up until 5:00 AM and she felt that was abusive. On 2/20/26 at 1:38 PM, Staff 15 (CNA) stated she was assigned to Resident 104 during the evening shift (2:00 PM to 10:00 PM), and last rounds were between 9:00 and 9:30 PM. Staff 15 stated when she walked by Resident 104 her/his coffee cup was being kept refilled all the time and it was not normal to serve coffee to the resident at night. Staff 6 had the resident next to her at the nurse's station with a table and coffee cup. Staff 15 stated she told Staff 6 she was going to lie the resident down and Staff 6 told her no, that she wanted to keep the resident up by the nurse's station because the resident had been falling, and she did not want to deal with her/his falls. Staff 15 stated she and another staff changed the resident but then got the resident back up because Staff 6 had insisted. Staff 15 stated the issue was being reported to a manager at the time by other staff. On 2/23/2026 at 3:01 PM, Staff 8 (LPN) stated Resident 104 had multiple falls at the facility and was not care-planned to stay up all night at the nurse's station to prevent falls. Staff 8 stated on 11/5/25 Staff 6 was upset because the resident kept falling on her shift, so she wanted to keep the resident up at the nurse's station. Staff 8 stated she tried to educate Staff 6 that this was abuse but Staff 6 did not listen. On 11/5/25 Resident 104 was up in her/his wheelchair in the hallway. The resident told Staff 8 she/he was tired, so she asked staff to put the resident to (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. Staff 6 overheard what was discussed and stated the resident was not going to bed, the resident was sleeping right here at the nurse's station and walked away. Staff 8 heard Staff 6 tell staff to get the resident out of bed and into her/his wheelchair because she was not doing another incident report. The resident was taken back to the nurse's station. Around 2:30 AM, Staff 14 (CNA) told Staff 8 she was taking the resident to bed because the resident wanted to lie down. Staff 8 said she again told Staff 6 she could not force the resident to sleep in her/his chair because it was abuse. At 5:00 AM Staff 6 finally allowed the resident to be put to bed. On the second night Staff 6 attempted to keep the resident up and at the nurse's station, got Resident 104 a blanket and tucked it around her/him in the wheelchair and placed the resident at the nurse's station. Staff 8 stated Resident 104 stated she/he was tired and wanted to go to bed. Staff 8 stated she overheard Staff 6 tell the resident she/he was going to sleep here and not fall. On 2/23/26 at 3:44 PM, Staff 14 (CNA) stated Resident 104 was asking to go to bed and Staff 6 did not want the resident to go to bed because she did not want to write any reports about the resident falling. Staff 14 stated around 2:00 to 2:30AM, she finally told Staff 6 she was taking the resident to bed and did not care if she got written up. On 2/26/26 4:15 PM, Staff 6 (LPN) stated Resident 104 liked to get out of bed, and she/he fell a lot. Staff 6 stated she did keep the resident up all night at the nurse's station. Staff stated on 12/5/25 the resident was restless and decided to keep the resident up in her/his wheelchair. Staff stated she got the resident a pillow, tucked a blanket snugly around the resident, leaned her/his chair back, and put coffee and magazines on a nearby table. The resident was awake a long time and around 1:00 AM the resident was sleepy, and had staff put her/him to bed. Staff stated on 12/6/25, she did the same thing. Staff 6 stated staff she was being abusive to the resident and all the aides were mad about it. Staff 6 called the on-call nurse and told her the resident had dementia and could not say what she/he wanted, but the resident did say she/he wanted to lay down. Staff stated she was told by facility management to lie the resident down.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure allegations of abuse or neglect were reported timely for 2 of 3 sampled residents (#s 103 and 104) reviewed for abuse reporting. This placed residents at risk for continued abuse and neglect. Findings include:1. Resident 103 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) with acute exacerbation and respiratory failure.Resident 103's Physician Order dated 11/4/25 included to administer morphine sulfate 0.25 ml dose by mouth every hour as needed for shortness of breath and/or moderate to severe pain.On 12/12/25, the State Survey Agency received a public complaint by Witness 1 (Former Staff), which reported on 11/6/25 Staff 7 (LPN) was assigned to Resident 103's care and had refused to administer the resident's ordered pain medication even when staff members were reporting the resident was exhibiting screaming, shortness of breath, and very anxious behaviors. Witness 1 stated she was not told about the incident when it occurred, so she was not able to report the incident. Witness 1 stated Staff 1 (Administrator) was aware of the incident and talked to Staff 7, but was unaware if a Facility Reported Incident (FRI) was reported to the State Survey Agency. On 2/24/26 at 2:43 PM, Staff 1 (Administrator) acknowledged there was no FRI submitted to the State Survey Agency. On 2/25/26 at 8:59 AM, Staff 4 (LPN/Unit Manager) stated she was aware of an incident involving Staff 7 refusing to give Resident 103 her/his pain medication, morphine, despite being told the resident was distressed by other staff members. Staff 4 acknowledged no FRI was reported to the State Survey Agency. 2. Resident 104 was admitted to the facility in 2025 with diagnoses including hip fracture and dementia.On 12/12/25, the State Survey Agency received a public complaint by Witness 1 (Former Staff), which reported she was notified that Staff 6 (LPN) forced Resident 104 to stay up in her/his wheelchair most of night on 12/5/25. Resident 104 was kept at the nurse's station, continuously given coffee, because Staff 6 did not want to deal with the resident falling and any potential incident reports. Witness 1 stated she notified the Administrator of the incident and was told not to submit a FRI to the State Agency because they took care of it in-house. On 2/20/26 at 10:41 AM, Staff 2 (DNS) stated there should have been an investigation done for this incident. Staff 2 stated that nursing staff could have a resident at the nurse's station for monitoring, but not for the entire night and not for staff convenience.On 2/24/26 at 2:43, PM Staff 1 (Administrator) acknowledged there was no FRI submitted to the State Survey Agency.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to thoroughly investigate allegations of potential abuse and neglect for 2 of 3 sampled residents (#103 and 104) reviewed for abuse investigations. This placed residents at risk for continued abuse and neglect. Findings include:1. Resident 103 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) with acute exacerbation and respiratory failure.On 12/12/25, the State Survey Agency received a public complaint by Witness 1 (Former Staff), which reported on 11/6/25 Staff 7 (LPN) was assigned to Resident 103's care and had refused to administer the resident's ordered pain medication even when staff members were reporting the resident was exhibiting screaming, shortness of breath, and very anxious behaviors. Witness 1 stated she was not told about the incident when it occurred, so she was not able to investigate the incident. Witness 1 stated Staff 1 (Administrator) was aware of the incident and talked to Staff 7, but was unaware if there was an investigation completed. On 2/20/26 at 12:29 PM, Staff 1 (Administrator) Staff 1 acknowledged no investigation was completed and stated she felt the incident was handled by the facility. Staff 1 was unable to provide any documentation to show an investigation was done and how abuse/neglect was ruled out. On 2/24/26 at 4:55 PM, Staff 7 (LPN) stated she did not remember if she gave the resident medication. Staff 7 stated she would have to get back with an answer after she checked the medical record because she thought she must have done something for the resident. Staff 7 did not have any further contact and did not provide any documentation or further explanation for the incident.On 2/25/26 at 8:59 AM, Staff 4 (LPN/Unit Manager) stated she was aware of an incident involving Staff 7 refusing to give Resident 103 her/his pain medication, morphine, despite being told the resident was distressed by other staff members. Staff 4 acknowledged there was no investigation completed. 2. Resident 104 was admitted to the facility in 2025 with diagnoses including hip fracture and dementia.On 12/12/25, the State Survey Agency received a public complaint by Witness 1 (Former Staff), which reported she was notified that Staff 6 (LPN) forced Resident 104 to stay up in her/his wheelchair most of the on 12/5/25. Resident 104 was kept at the nurse's station, continuously given coffee, because Staff 6 did not want to deal with the resident falling and any potential incident reports. Witness 1 stated she notified the Administrator of the incident. On 2/20/26 at 10:41 AM, Staff 2 (DNS) stated there should have been an investigation done for this incident. Staff 2 stated that nursing staff could have a resident at the nurse's station for monitoring, but not for the entire night and not for staff convenience.On 2/20/26 at 12:29 PM, Staff 1 (Administrator) Staff 1 acknowledged no investigation was completed and stated she felt the incident was handled by the facility. Staff 1 was unable to provide any documentation to show an investigation was done and how abuse/neglect was ruled out.