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	03/17/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure the call light was accessible for 1 of 3 sampled residents (#10) reviewed for accommodation of needs. This placed residents at risk for the inability to call for assistance. Findings include:Resident 10 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (chronic condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs and other body parts) and weakness.A review of Resident 10's 2/27/26 admission MDS revealed she/he was cognitively intact.A 2/26/26 Facility Reported Incident (FRI) reported Resident 10 received a bed bathe on 2/23/26 on the evening and the call light was not accessible to the resident until the next morning. Resident 10 reported no one checked in on her/him throughout the night and the resident needed to use the toilet.On 3/17/26 at 10:08 AM Staff 6 (CNA) stated she checked on Resident 10 on 2/24/26 at approximately 7:40 AM and her/his call light button was clipped to the top corner of the mattress and untucked under the pillow. Staff 6 stated Resident 10 was very upset because the call light was not accessible and had an episode of fecal incontinence in bed because she/he was unable to call for assistance throughout the night.On 3/17/26 at 10:13 AM Staff 7 (LPN) stated Staff 6 had informed Resident 10 was very upset after having an episode of fecal incontinence during the night because the resident's call light was not accessible. On 3/17/26 at 12:40 PM Staff 1 (Administrator) acknowledged Resident 10 did not have the call light accessible and experienced an episode of fecal incontinence. Staff 1 stated she expected staff to check on residents at least every two hours during the shift.

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
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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide pain medication as ordered for 1 of 3 sampled residents (#7) reviewed for pain management. This placed residents at risk for worsening discomfort. Findings include:Resident 7 admitted to the facility in 10/2025 with diagnoses including right tibia and fibula fracture with an external fixator (device to stabilize fracture from the outside using pins, clamps and rods) and diabetes.The 10/23/25 physician order indicated Resident 7 was to receive oxycodone 5 MG every four hours as needed for pain.On 10/27/25 a public complaint was received by the State Agency which alleged the facility ran out of Resident 7's pain medication on 10/25/25 and Resident 7 had requested pain medication prior to a physical therapy session on 10/27/25.The 10/29/25 admission MDS Pain CAA revealed to administer pain interventions per provider orders.A review of the 10/2025 TAR revealed Resident 7 reported a pain level of nine on 10/27/25 at 6:00 AM.A review of the 10/2025 MAR revealed Resident 7 did not receive oxycodone 5 MG on 10/27/25.A review of the facility Controlled Substance Book Number 5 revealed Resident 7's last administered dose of oxycodone 5 MG was on 10/25/25 at 7:35 PM and the quantity of tablets remaining were zero.A 10/27/25 at 8:44 AM Progress Note by Staff 24 (LPN) revealed Resident 7 complained of pain, requested oxycodone 5 MG and the facility was out of the medication. The progress note further revealed Staff 24 contacted the pharmacy to re-order oxycodone 5 MG and requested a pull code from the Cubex (automated medication dispensing system for single item requests) to administer Resident 7 pain medication. The pharmacy denied the request for the Cubex as the remaining oxycodone 5 MG from the original script was already packaged for delivery to the facility and was to be delivered around noon on 10/27/25. The pharmacy stated a new prescription from the provider was needed for further refills.A 10/27/25 at 8:46 AM Progress Note by Staff 24 revealed a voicemail was left for the on-call provider related to the request for a new oxycodone 5 MG prescription.A 10/27/25 at 10:55 AM Progress Note by Staff 24 revealed the on-call provider faxed a new prescription for oxycodone 5 MG to the pharmacy that would arrive that evening and three additional tablets of oxycodone 5 MG would be delivered to the facility that afternoon along with approval to pull from the Cubex if needed.A review of Resident 7's progress notes and medical record revealed no documentation of the date and time the pharmacy delivered the oxycodone 5 MG to the facility, and no additional pain-management interventions were implemented for the resident on 10/27/25 after the reported pain level of nine at 6:00 AM. On 3/16/26 at 3:04 PM Staff 24 stated she recalled on 10/27/25 it was difficult to obtain pain medication from the pharmacy for Resident 7 but did not recall if the resident was offered other pain interventions while waiting for the pharmacy's delivery. On 3/17/26 at 10:09 AM Witness 9 (Pharmacy Technician) stated Resident 7's oxycodone 5 MG prescription with a quantity of four tablets was delivered to the facility on [DATE] at 3:55 PM. On 3/17/26 at 1:51 PM Staff 2 (DNS) stated she was in a different management role at the time and did not recall the details. Staff 2 confirmed Resident 7's oxycodone 5 MG supply was depleted on 10/25/25 and the facility did not re-order Resident 7's pain medication timely.