

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385224	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Windsor Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **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 necessary behavioral health services for 1 of 1 sampled resident (#32) reviewed for behavior. This failure resulted in Resident 32 continuing to experience untreated mental health symptoms, including expressing statements of wanting to die and socially isolating her/himself. Findings include: Resident 32 admitted to the facility in 4/2026 with diagnoses including anxiety disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, major depressive disorder, and bipolar disorder. A 4/30/26 admission MDS revealed Resident 32 had a score of 19 on the Patient Health Questionnaire-9 (an assessment of depression symptoms), which indicated she/he had moderately severe depression symptoms. Resident 32 indicated she/he had thoughts of being better off dead or hurting her/himself 12 to 14 days out of 14 days; felt down, depressed or hopeless 12 to 14 days out of 14 days; and stated she/he often felt lonely or isolated from those around her/him. A 5/1/26 Care Conference evaluation revealed Resident 32 requested to be seen by a mental health provider. A 5/5/26 Progress Note revealed a mental health provider attempted to see Resident 32, but she/he was at an appointment. A review of the medical record revealed no other communication, visit, or referral to a mental health provider. A 5/8/26 Social [NAME] admission and History evaluation indicated Resident 32 was very emotional and could benefit from additional mental health support. On 7/7/26 at 3:55 PM Staff 39 (CMA) stated when Resident 32 first admitted to the facility she/he made statements about wanting to die. On 7/8/28 at 10:11 AM Resident 32 was observed in her/his room, was tearful and yelling out. On 7/8/26 at 10:21 AM Resident 32 was in her/his wheelchair, was tearful and crying. Resident 32 stated when she/he admitted to the facility her/his mood was very poor and the facility did not do anything to help. On 7/8/26 at 1:37 PM Staff 6 (SSD) stated she did not recall if a referral for mental health was requested for Resident 32 but thought maybe she/he declined mental health treatment. Staff 6 stated Resident 32 had behaviors related to smoking, became agitated, and changed her/his emotions quickly. Staff 6 stated Resident 32 elected to temporarily go on hospice as a response to a depressive episode. On 7/8/26 at 2:02 PM Staff 28 (LPN Resident Care Manager) stated Resident 32 was generally unhappy but stated that was normal for Resident 32's diagnoses. Staff 28 stated Resident 32 briefly went on hospice as a response to not being able to smoke and a family conflict. Staff 28 stated she thought mental health support was offered and denied by Resident 32. On 7/13/26 at 1:09 PM Staff 1 (Administrator) stated if Resident 32 requested mental health support a mental health professional should have been contacted.		

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to staff a registered nurse for eight consecutive hours per day, seven days per week, for 18 out of 34 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: A review of the Direct Care Staff Daily Reports dated 6/3/26 through 7/6/26 revealed there were 18 days without 8 consecutive hours of registered nurse coverage on any shift in a 24 hour period on the following dates: 6/3/26, 6/4/26, 6/8/26, 6/9/26, 6/10/26, 6/15/26, 6/16/26, 6/17/26, 6/18/26, 6/22/26, 6/23/26, 6/24/26, 6/25/26, 6/29/26, 6/30/26, 7/1/26, 7/2/26, and 7/6/26. On 7/7/26 at 5:19 PM, Staff 18 (LPN) stated Staff 2 (DNS) did not work the floor. On 7/8/26 at 10:43 AM, Staff 2 confirmed she was not scheduled to work the floor on days when there were no RNs scheduled. Staff 2 stated she was only available three hours daily to complete resident assessments as an RN due to DNS obligations. Staff 2 acknowledged the requirements for RN coverage in the facility were not met. On 7/8/26 at 12:33 PM, Staff 36 (Regional Director of Clinical Operations) acknowledged the facility did not meet the staffing requirement for RNs.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review it was determined the facility failed to provide personalized individual and independent activities for 3 of 3 sampled residents (#s 7, 9, and 33) reviewed for activities. This placed residents at risk for unmet physical, mental, and psychosocial needs. Findings include: 1. Resident 7 was admitted to the facility in 2021 with diagnoses including seizures and history of TIA (mini stroke). An 8/5/25 Activity Evaluation indicated Resident 7 preferred independent and one-to-one activities. The 2/6/26 Quarterly MDS revealed Resident 7 indicated it was very important to do her/his favorite activities. Resident 7's 6/1/26 Revised Care Plan identified she/he enjoyed listening to music and watching TV or movies, had impaired psychosocial well-being, and was visually impaired. The 7/2026 Activity Calendar revealed planned sessions of one-to-one visits every Wednesday at 4 PM. No documentation was found in Resident 7's electronic health record that indicated the resident was offered or participated in independent or one-to-one activity opportunities. Observations of Resident 7 were made at various times of day from 7/6/26 through 7/9/26. Resident 7 spent all her/his time in bed and alone, except when receiving care. Occasionally Resident 7 had her/his TV on but was most often observed sleeping or lying in bed with the light off. On 7/6/26 at 1:32 PM Resident 7 stated she/he was bedbound and visually impaired. Resident 7 indicated no one in the facility offered her/him any activities to do in her/his room. On 7/8/26 at 4:04 PM Resident 7 indicated activity staff never offered the opportunity to participate in the planned one-to-one visits. On 7/9/26 at 9:49 AM Staff 15 (Activities Director) acknowledged the facility did not have a meaningful activity program for residents unable to attend group activities. Staff 15 was unable to identify a personalized independent or one-to-one activity program for Resident 7. On 7/9/26 at 10:33 AM Staff 1 (Administrator) acknowledged residents unable to attend group activities needed individualized and meaningful activity opportunities. 2. Resident 9 was admitted to the facility in 4/2026 with diagnoses including generalized anxiety disorder and adult failure to thrive. A 4/23/26 Care Conference note indicated Resident 9 was unable to get up from bed, and preferred independent activities and one-to-one visits. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5/23/26 Revised Care Plan revealed Resident 9 preferred self-directed or independent activities in her/his room. The care plan indicated Resident 9 identified an interest in arts and crafts, reading, religious studies, watching TV and sports, and electronic use. The 7/2026 Activity Calendar revealed planned sessions of one-to-one visits every Wednesday at 4 PM. No documentation was found in Resident 9's electronic health record that indicated the resident was offered or participated in independent or one-to-one activity opportunities. On 7/6/26 at 10:53 AM Resident 9 stated she/he was frequently bored, and the only thing to do in her/his room was watch TV. Resident 9 stated she/he was interested in being offered independent activities, if the activity was something she/he was interested in. On 7/8/26 at 9:35 AM Resident 9 indicated activity staff never offered the opportunity to participate in the planned one-to-one visits. On 7/9/26 at 9:49 AM Staff 15 (Activities Director) acknowledged the facility did not have a meaningful activity program for residents unable to attend group activities. Staff 15 was unable to identify a personalized independent or one-to-one activity program that aligned with Resident 9's interests. On 7/9/26 at 10:33 AM Staff 1 (Administrator) acknowledged residents unable to attend group activities needed individualized and meaningful activity opportunities. 3. Resident 33 was admitted to the facility in 4/2026 with diagnoses including Chronic Obstructive Pulmonary Disease and hearing loss. A 4/30/26 Activities Evaluation indicated Resident 33 did not like to color, preferred independent activities, and liked bingo. The 5/1/26 admission MDS and related CAAs revealed Resident 33 had a BIMS score of 13 which indicated the resident was cognitively intact, the resident was at risk for impaired communication, and it was very important for the resident to be outside when the weather was good. Review of Resident 33's Activity Progress Notes revealed the resident was offered group activities but declined and participated in independent activities on multiple days during the following months:-5/2026: 12 days -6/2026: 20 days-7/2026: 2 days No additional activities were identified from 5/1/26 through 7/6/26. A 5/23/26 revised Care Plan indicated Resident 33 preferred self-directed activities which included arts and crafts, watching television, and listening to music. On 7/6/26 at 9:27 AM, Resident 33 stated no meaningful activities were offered. Resident 33 stated she/he was more active at home and did not spend much time watching television. A television displayed a cartoon program and Resident 33 intermittently dozed during the interview. No radio or activity supplies were observed in the resident's room. Resident 33 stated she/he did not like (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cartoons and fell asleep often because of the lack of activities. On 7/8/26 at 8:29 AM, Resident 33 stated her/his roommate was new to the facility and activities staff came to visit the roommate. Resident 33 stated they walk past my bed and don't even ask her/him about activities. Resident 33 had the television on and no activities supplies were in her/his room. On 7/8/26 11:31 AM, Staff 15 (Activities Director) stated she never thought to encourage staff to get Resident 33 up for activities. She was aware residents complained about the lack of weekend activities, and residents who often remained in bed were limited to coloring and one-on-one conversations. Staff 15 stated she lacked documentation of conversations with Resident 33 and needed to improve personalized activities options. Staff 33 stated she was unsure what meaningful activities were for Resident 33 and Staff 15 was behind in her responsibilities including revision of care plans. On 7/8/26 at 2:08 PM, Staff 20 (CNA) stated she worked with Resident 33 routinely and never saw activity staff visit the resident or provide one-on-one interaction. Staff 20 indicated Resident 33 often remained in bed. Family occasionally visited but less often recently. On 7/8/26 at 5:34 PM, Witness 4 (Family Member) indicated she was concerned about the lack of activities for Resident 33. Witness 4 stated Resident 33 liked to play bingo and go outside at home and would benefit with more interactions since the resident continued to remain in her/his room with little to do. On 7/9/26 at 10:33 AM, Staff 1 (Administrator) stated she expected an individualized and meaningful activity program for each resident, care plans should be updated to reflect the interests of each resident, and progress notes should be accurate and reflect conversations that were conducted.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review it was determined the facility failed to have adequate staff available to meet the needs of residents in a timely manner for 1 of 2 halls (South Hall) reviewed for sufficient staffing. This placed residents at risk for unmet needs. Findings include: 1. Resident 2 admitted to the facility in 6/2026 with diagnoses including diabetes, dysphasia (difficulty swallowing) and pressure ulcer. Resident 2 resided on the South Hall. An undated Meal Delivery Times document indicated breakfast was delivered to the South Hall at 7:30 AM and at 7:45 AM to the dining room. An undated Residents that Smoke document indicated the approximate supervised smoking schedule was from 6:30 AM to 7:00 AM, 10:00 AM to 10:30 AM and 1:00 PM to 1:30 PM on day shifts. The 6/18/26 admission MDS revealed Resident 2 had a BIMS score of 5 which indicated the resident was severely cognitively impaired. A 6/25/26 revised Care Plan revealed Resident 2 required two staff to assist with transfers, one staff to assist with dressing, and the resident was to dine in the dining room with close supervision due to risk of aspiration (the accidental breathing in of foreign objects, such as food, into the lungs). On 7/7/26 at 5:19 PM, Staff 18 (LPN) stated nursing staff routinely followed up on nursing tasks not completed by the previous shift. Staff 18 stated resident admissions often required unplanned time to complete required nursing tasks. Staff 18 stated Staff 2 (DNS) was often not present on the nursing unit, and competing nursing responsibilities delayed nurses from providing timely assistance to CNAs with resident care requests. On 7/8/26 at 8:21 AM, Staff 20 (CNA) stated she returned from the supervision of smoke breaks after being away from resident care for 40 minutes and was assigned to assist Resident 2. Staff 20 stated she was not able to timely attend to the needs of Resident 2 to ensure his/her brief was changed and she/he was up for breakfast. On 7/8/26 at 8:22 AM, Resident 2 was observed in bed with her/his call light on and the resident was in her/his gown. On 7/8/26 at 8:36 AM, Staff 20 answered the call light for Resident 2 and stated the resident's morning routine required a lot of time with staff and included: two staff to assist her/him into her/his wheelchair, one staff to supervise her/his eating, and both a nurse and CNA to change her/his wound dressing and brief change. Staff 20 stated it took additional time and staff coordination to address Resident 2's morning care which was difficult. On 7/8/26 at 8:41 AM, Staff 18 provided wound care for Resident 2. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/26 at 10:43 AM, Staff 2 (DNS) stated the nursing management team and many nurses were new to the facility. Staff 2 stated nursing staff often had more than two admissions which impacted their workload and residents were waiting for 30 minutes for care. On 7/8/26 at 4:55 PM, Staff 25 (CNA) stated care was often delayed for Resident 2 who required the assistance of two staff. Staff 25 stated the staff assigned to monitor smoke breaks often had to extend the allotted time due to residents' behaviors. Staff 25 stated Resident 2 complained of leg pain when she/he was left in bed for extended periods of time. Staff 25 stated extended smoke breaks at 1:00 PM frequently interfered with the timely care of residents before change of shift at 2:00 PM. On 7/10/26 at 11:37 AM, Staff 7 (Resident Care Manager-LPN) stated she was new to the facility, and the facility needed a culture change to ensure staff were available to assist with resident care. Staff 7 stated she needed to be on the floor to know how the building operated. On 7/10/26 at 12:20 PM, Resident 2 confirmed she/he experienced increase pain when she/he was in bed for extended periods of time. On 7/13/26 at 9:34 AM, Staff 1 (Administrator) stated the facility budget for staffing was limited and not based on resident acuity, CNAs were scheduled to maintain minimum staffing ratios with some additional shifts for resident showers, and management was expected to assist with call lights. Staff 1 acknowledged care lights were not addressed timely. 2. Resident 40 was admitted to the facility in 12/2025 with diagnoses including left and right below the knee amputation. Resident 40 resided in the South Hall. A 3/17/26 revised Care Plan revealed Resident 40 required set-up assistance for toileting and dressing and the resident used prosthetic legs for safety. A 4/21/26 BIMS assessment revealed Resident 40 had a score of 15 which indicated the resident was cognitively intact. On 7/6/26 at 12:58 PM and 7/10/26 at 1:56 PM, Staff 19 (CNA) stated staff breaks, meetings and resident smoke breaks often occurred at the same time which impacted timely resident care. Staff 19 stated there was not sufficient staff to address resident care needs, and the expectation was to answer call lights within seven to ten minutes. On 7/7/26 at 4:47 PM, Staff 4 (LPN) stated the current staffing levels did not meet the behavioral issues of current residents. Staff 4 stated staff were in a hurry and did not address all the resident needs when they entered resident rooms. Staff 4 stated some residents suffered because of the lack of thorough care. On 7/8/26 at 10:43 AM, Staff 2 (DNS) stated the nursing management team was new to the facility. Staff 2 acknowledged residents waited 30 minutes for care. On 7/12/26 at 6:15 PM, Staff 10 (CNA) stated call lights were difficult to answer timely without a (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consistent shower aide, and the wait times exceeded 30 minutes. On 7/13/26 at 9:00 AM, Resident 40 stated she/he turned on her/his call light at 5:20 AM which was not answered until 6:10 AM. Resident 40 stated she/he did not receive the required assistance with dressing and toileting which prevented the resident from being ready for the day. Resident 40 stated Staff 14 (CNA) was unavailable due to the care of other residents and her morning meeting. On 7/13/26 at 9:12 AM, Staff 14 stated she started her shift after the morning meeting and addressed the needs of another resident who was yelling before answering Resident 40's call light. Staff 14 stated she was unaware Resident 40's call light was on for more than 45 minutes and care often took 30 minutes for some residents. Staff 14 stated nurses were not always available to assist. On 7/13/26 at 9:34 AM, Staff 1 (Administrator) stated she attempted to have consistent and additional staff above the CNA minimums but had to work within a budget. Staff 1 stated she expected call lights to be answered as soon as possible and acknowledged call lights were not answered timely. 3. Resident 4 was admitted to the facility in 1/2026 with diagnoses including chronic pain and muscle weakness. Resident 4's Care Plan revealed she/he needed the assistance of two staff to transfer via a mechanical lift (a device used to transfer a person with limited mobility). The Care Plan also indicated the resident had right shoulder pain and muscle weakness, and pain was a trigger for impaired psychosocial well-being. On 7/13/26 at 9:15 AM Staff 14 (CNA) was observed trying to find a second CNA to assist with transferring Resident 4 out of bed. Staff 14 stated the other two CNAs for the hall were busy assisting a different resident who also needed two people for transfers. Staff 14 notified Resident 4 that she was unable to transfer her/him out of bed and would return. When Staff 14 left, Resident 4 yelled, Don't leave me laying like this, and said she/he was uncomfortable in bed. From 9:17 AM to 9:43 AM Staff 14 answered call lights on her own, and no other CNAs were available to assist her with Resident 4. During that time Resident 4 continued to express displeasure at being left in bed and indicated pain and discomfort. At 9:46 AM Staff 14 and a second CNA entered Resident 4's room to transfer her/him out of bed. On 7/13/26 at 11:05 AM Resident 4 stated there was a long wait time to get out of bed that morning, and her/his shoulder bothered her/him while waiting. On 7/13/26 at 2:53 PM Staff 1 (Administrator) stated the facility staffed CNAs based on the required minimum, not based on resident acuity. On 7/13/26 at 2:57 PM the posted Direct Care Staff Daily Report revealed seven total CNAs for day shift, which was consistent with the state required minimum number of CNAs for the shift.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. Based on interview and record review it was determined the facility failed to assist residents in obtaining dental services for 3 of 3 sampled residents (#s 7, 10, and 43) reviewed for dental services. This placed residents at risk for unmet dental needs. Findings include: 1. Resident 7 was admitted to the facility in 2021 with diagnoses including seizures and history of TIA (mini stroke). On 7/6/26 at 1:43 PM Resident 7 stated her/his teeth were disintegrating. Resident 7 pulled back her/his lips to show her/his teeth, and the resident was observed to have several teeth missing on the top and bottom. Resident 7 stated she/he was supposed to have a dental appointment earlier in the year, but the visit did not occur and was not rescheduled. No documentation related to dental services was found in Resident 7's electronic health record. On 7/9/26 at 10:58 AM Staff 6 (Social Services Director) acknowledged Resident 7 had a dental appointment scheduled for 2/17/26, but it was cancelled for an unknown reason. Staff 6 further acknowledged the cancelled dental appointment was not rescheduled and follow up with the resident was not completed. 2. Resident 10 was admitted to the facility in 10/2024 with diagnoses including dysphagia (difficulty swallowing) and trigeminal neuralgia (a rare chronic nerve condition that causes sudden, severe, electric-shock-like facial pain). On 7/6/26 at 10:56 AM, Resident 10 stated her/his upper dentures were broken and she/he needed to see the dentist. On 7/9/26, at 10:30 AM, Staff 6 (SSD) stated Resident 10 saw the dentist on 1/21/26 but she was unable to locate the progress notes for the 1/21/26 dental appointment. Staff 6 stated it was her responsibility to make dental appointments for residents when requested, but she had no process to assess the need for dental appointments. On 7/10/26 at 10:10 AM, Staff 27 (CMA) stated about a month ago Resident 10 reported to her that her/his dentures were broken. Staff 27 stated she informed the charge nurse but could not remember which charge nurse. On 7/13/26 at 3:43 PM, Staff 2 (DNS) stated Staff 6 was responsible for making dental appointments for residents when requested. Staff 6 stated it was the expectation was for residents to be assessed for the need for dental visit quarterly, during the care conference. 3. Resident 43 was admitted to the facility in 1/2025 with diagnoses including hemiplegia (partial paralysis) of right dominant side following a stroke. On 7/6/26 at 11:13 AM, Resident 43 was observed to have missing teeth and tooth decay. Resident 43 (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she/he needed to go to the dentist, but she could not transfer to a chair alone, so she/he was unable to be seen by a dentist. A 9/29/25 progress note indicated Resident 43 requested to see a dentist. A 10/21/25 progress note indicated Resident 43 had a dental appointment on 10/9/25, but Resident 23 was unable to be seen due to inability to transfer to the dental chair. On 7/9/26 at 10:30 AM, Staff 6 (SSD) stated 43 had a telehealth dental appointment on 2/6/26 but she was unable to locate any notes from that visit. Staff 6 stated it was her responsibility to make dental appointments for residents when requested, but she stated she had no process to assess the need for dental appointments. On 7/13/26 at 3:43 PM, Staff 2 (DNS) stated Staff 6 was responsible for making dental appointments for residents when requested. Staff 6 stated it was the expectation was for residents to be assessed for the need for dental visit quarterly, during the care conference.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review the facility failed to ensure residents were fully informed and understood the binding arbitration agreement for 3 of 3 sampled residents (#s 2, 33, and 53) reviewed for arbitration. This placed residents at risk for being uninformed regarding their legal rights. Findings include: 1. Resident 2 was admitted to the facility in 6/2026 with diagnoses including adjustment disorder and paranoid schizophrenia (mental illness). A 6/15/26 BIMS assessment revealed Resident 2 had a score of 5 which indicated the resident was severely cognitively impaired. A State Arbitration Agreement dated 6/15/26 revealed Resident 2 signed the document. Review of Resident 2's clinical record revealed the resident had a durable Power of Attorney (person appointed to make financial decisions) who was not family. During interviews on 7/8/26 at 1:35 PM and 7/13/26 at 12:50 PM, Staff 30 (Admissions) stated she had family present when Resident 2 signed the Arbitration Agreement and was unaware on 6/15/26 the resident had a POA when the resident signed the document. Staff 30 stated she was unaware residents had 30 days to rescind the agreement and no follow-up conversation occurred. Staff 30 stated the electronic admission documents forced the acceptance or declination of the Arbitration Agreement in order to complete Resident 2's admission to the facility. On 7/13/26 at 3:41 PM, Staff 1 (Administrator) acknowledged the facility needed a different process to ensure the resident or representative understood the Arbitration Agreement. Staff 1 stated staff were expected to have a follow up conversation with residents about the Arbitration Agreement within 30 days of the resident signing the form. 2. Resident 33 was admitted to the facility in 4/2026 with diagnoses including Chronic Obstructive Pulmonary Disease and symptoms and signs involving cognitive function and awareness. The 5/1/26 admission MDS revealed Resident 33 had a BIMS score of 13 which indicated the resident was cognitively intact. A State Arbitration Agreement dated 4/26/26 revealed Resident 33 signed the document. Review of Resident 33's clinical record revealed Witness 4 (Family Member) was the resident's medical and financial Power of Attorney. On 7/8/26 at 8:29 AM, Resident 33 stated she/he was not at her/his best during the admission process and was alone because Witness 4 was traveling. Resident 33 stated she/he did not recall information or education regarding an Arbitration Agreement. During interviews on 7/8/26 at 1:35 PM and 7/13/26 at 12:50 PM, Staff 30 (Admissions) stated it was difficult to ascertain the cognition of a resident during admission. Staff 30 stated she believed Resident 33 was able to understand and sign the Arbitration Agreement. Staff 30 stated she was unaware residents had 30 days to rescind the agreement and no follow-up conversation occurred. Staff 30 stated the electronic admission documents forced the acceptance or declination of the Arbitration Agreement in order to complete Resident 33's admission to the facility. On 7/8/26 at 5:34 PM, Witness 4 stated she arrived a few days after Resident 33 admitted to the facility and would not have allowed Resident 33 to sign the Arbitration Agreement. Witness 4 stated she was unaware the Arbitration Agreement was signed by Resident 33 until today. On 7/13/26 at 3:41 PM, Staff 1 (Administrator) acknowledged the facility needed a different process to ensure the resident or representative understood the Arbitration Agreement. Staff 1 stated staff were expected to have a follow up conversation with residents about the Arbitration Agreement within 30 days of the resident signing the form. 3. Resident 53 was admitted to the facility in 5/2026 with diagnoses including anxiety and depression. A 5/5/26 BIMS assessment revealed Resident 53 had a score of 13 which indicated the resident was cognitively intact. A State Arbitration Agreement dated 5/6/26 revealed Resident 53 signed the document. During interviews on 7/8/26 at 1:35 PM and 7/13/26 at 12:50 PM, Staff 30 (Admissions) stated it was (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	difficult to ascertain the cognition of a resident during admission. Staff 30 stated she believed Resident 53 was able to understand and sign the Arbitration Agreement. Staff 30 stated she was unaware residents had 30 days to rescind the agreement and no follow-up conversation occurred. Staff 30 stated the electronic admission documents forced the acceptance or declination of the Arbitration Agreement in order to complete Resident 53's admission to the facility. On 7/8/26 at 5:12 PM, Resident 53 stated she/he did not recall signing the Arbitration Agreement and would not have signed it based on the current education provided. Resident 53 stated she/he hoped the facility would ensure a resident was at their best when signing important documents during admission, and she/he was not at her/his best at that time. On 7/13/26 at 3:41 PM, Staff 1 (Administrator) acknowledged the facility needed a different process to ensure the resident or representative understood the Arbitration Agreement. Staff 1 stated staff were expected to have a follow up conversation with residents about the Arbitration Agreement within 30 days of the resident signing the form.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to follow Enhanced Barrier Precautions, failed to disinfect reusable resident equipment between residents, and failed to ensure staff implemented proper hand hygiene while assisting residents for 1 of 1 facility reviewed for infection control. This placed residents at risk for exposure to infections and illness from cross contamination. Findings include: The facility's 8/2025 Handwashing/Hand Hygiene policy indicated hand hygiene is performed as soon as feasible after hands become contaminated, such as after contact with mucous membranes and/or body fluids or excretions, and after handling/transporting soiled linen. The facility's 3/2025 Standard Precautions policy indicated reusable resident-care equipment is not used for the care of another resident until it has been appropriately cleaned. 1. On 7/7/26 at 1:51 PM Staff 16 (CNA) and Staff 18 (CNA) were observed to exit room [ROOM NUMBER] with a mechanical lift (a device used to transfer a person with limited mobility) and place it in the hallway. Staff did not clean the lift before leaving the areas. On 7/7/26 at 1:56 PM Staff 12 (CNA) was observed near the lift. Staff 12 stated if a lift was in the hallway, she assumed it was clean and ready to use. On 7/7/26 at 2:06 PM Staff 16 stated she did not clean the lift after it was used in room [ROOM NUMBER] and did not know if Staff 18 cleaned it. On 7/7/26 at 2:09 PM Staff 18 stated she did not clean the lift after it was used with the resident in room [ROOM NUMBER]. On 7/13/26 at 12:05 PM Staff 3 (Infection Preventionist) stated lifts were to be cleaned after each use. 2. On 7/9/26 at 10:40 AM Staff 9 (CNA) was observed exiting room [ROOM NUMBER] holding a bag of soiled linens in each hand. Staff 9 walked down the hall, placed the bags in the soiled utility closet, then proceeded to walk through the facility, stopping at the nurses station and therapy room. On 7/9/26 at 10:47 AM Staff 9 acknowledged hand hygiene was not completed after she dropped off the bags to the soiled linen closet. On 7/9/26 at 2:14 PM Staff 3 (Infection Preventionist) stated hand hygiene was to be completed immediately after disposing of dirty linens. 3. On 7/10/26 at 3:32 PM Staff 13 (CNA) was observed coughing into his hands and blowing his nose as he approached Resident 8 near the nurses station. Staff 13 put his hands on the resident's wheelchair handles, transported the resident into her/his room, and closed the door. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/26 at 3:42 PM Staff 13 acknowledged hand hygiene was not performed between coughing into his hands and blowing his nose and touching Resident 8's wheelchair. On 7/13/26 at 12:05 PM Staff 3 (Infection Preventionist) stated staff were to perform hand hygiene immediately after contact with bodily fluids. 4. On 7/10/26 at 3:48 PM Staff 7 (Resident Care Manager LPN) and Staff 17 (CNA) were observed to take a mechanical lift (a device used to transfer a person with limited mobility) into room [ROOM NUMBER] to transfer the resident to bed. At 3:54 PM Staff 7 exited the room. At 4:02 PM Staff 17 exited the room and moved on to other tasks down the hall; the lift was observed inside room [ROOM NUMBER] near the door. On 7/10/26 at 4:11 PM Staff 17 stated the lift is used for any resident in the facility and acknowledged it was not cleaned after it was used with the resident in room [ROOM NUMBER]. On 7/13/26 at 12:05 PM Staff 3 (Infection Preventionist) stated lifts were to be cleaned after each use. 5. On 7/7/26 at 3:51 PM Staff 33 (CNA) and Staff 34 (CNA) entered Resident 32's room; an Enhanced Barrier Precautions (EBP) sign was observed on her/his door. Staff 33 and Staff 34 used a mechanical lift to assist Resident 32 into bed; neither staff donned a gown prior to providing care to Resident 32. On 7/7/26 at 3:59 PM Staff 34 acknowledged Resident 32 was on EBP, but since the staff only assisted her/him to bed they did not need to follow EBP for that task. On 7/7/26 at 4:07 PM Staff 33 stated Resident 32 was not on EBP, but if the resident was on EBP he would have followed the precautions for any activities where the resident was touched. Staff 33 stated he did not follow EBP when he assisted Resident 32 into bed. On 7/10/26 at 12:04 PM Staff 3 (LPN/IP) stated when staff assisted any resident on EBP into bed the staff were to wear gloves and a gown.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on interview and record review it was determined the facility failed to assess for self-administration of medications for 1 of 4 sampled residents (#31) reviewed for choices. This placed residents at risk for delayed treatment for chest pain and shortness of breath. Findings include: Resident 31 was admitted to the facility in 6/2026 with diagnoses including asthma and angina pectoris (temporary chest pain, pressure, or discomfort that happens when your heart muscle isn't getting enough oxygen-rich blood). A review of physician orders revealed a 6/12/26 order for nitroglycerin (a medication used to treat chest pain) as needed for chest pain and a 6/12/26 order for albuterol inhaler (a fast-acting rescue medication that quickly relaxes tight muscles around the airways in your lungs) as needed for difficulty breathing or shortness of breath. On 7/6/26 at 2:11 PM, Resident 31 stated she/he requested to self-administer her/his nitroglycerin and albuterol but was informed that she/he could not self-administer while in the facility. Resident 31 expressed concern related to extended wait times for medications and stated she/he wanted to self-administer the nitro and albuterol because those were the two medications she/he needed immediately when having symptoms. A review of Resident 31's medical record revealed no evidence of a self-administration evaluation or self-administration orders. On 7/10/26 at 2:00 PM, Staff 28 (LPN Resident Care Manager) stated Resident 31 asked if she/he could self-administer her/his medications and Staff 28 informed Resident 31 she/he could not self-administer medications while in the facility. On 7/13/26 at 3:45 PM, Staff 2 (DNS) stated residents had the right to self-administer their medications if they were able to do it safely. Staff 2 stated if a resident requested self-administering their medications, staff were expected to assess the resident's ability to self-administer medication and if residents were assessed to be safe, staff were expected to request orders for self-administering medications.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review it was determined the facility failed to allow resident self-determination related to smoking for 2 of 4 sampled residents (#s 31 and 32) reviewed for choices. This placed residents at risk for diminished quality of life. Findings Include: A review of the Resident Smoking Safety Policy revealed no evidence relating to the number of cigarettes residents were allowed to smoke during their 20-minute smoking break. 1. Resident 31 was admitted to the facility in 6/2026 with diagnoses of cervical spondylosis with myelopathy (age related arthritis of the neck/spine). On 7/6/26 at 1:57 PM, Resident 31 stated she/he was allowed to smoke during the 20-minute smoke breaks, but she/he felt like the facility treated the residents who required supervision while smoking, like children by allowing them two cigarettes only during each smoking break. Resident 31 stated she/he wanted to be allowed to smoke as many cigarettes as she/he wanted during the 20-minute smoke break. On 7/9/26 at 10:09 AM, Staff 29 (CNA) was observed with the residents who required supervised smoking. Staff 29 stated she was trained that residents were only allowed to smoke two cigarettes during their 20-minute smoking break. On 7/9/26 at 10:49 AM, Staff 1 (Administrator) stated supervised smokers were allowed five smoking breaks daily, and during those breaks the supervised smokers were allowed two cigarettes each break per the smoking policy which the residents sign. On 7/13/26 at 4:19 PM, Staff 1 (Administrator) acknowledged the smoking policy, and the smoking schedule did not state the number of cigarettes a resident was allowed to smoke during their 20-minute smoking break. Staff 1 acknowledged residents who required supervised smoking were allowed to have as many cigarettes as they wanted during their 20-minute smoke break. 2. Resident 32 was admitted to the facility in 4/2026 with diagnoses including end stage renal disease and chronic pain. On 7/9/26 at 10:09 AM, Staff 29 (CNA) was observed with the residents who required supervised smoking. Staff 29 stated she was trained that residents were only allowed to smoke two cigarettes during their 20-minute smoking break. On 7/10/26 at 10:11 AM, Resident 32 was observed at the smoking break. Resident 32 stated the facility treats us like kids by only allowing two cigarettes during their 20-minute smoke break. On 7/9/26 at 10:49 AM, Staff 1 (Administrator) stated supervised smokers were allowed five smoking breaks daily, and during those breaks the supervised smokers were allowed two cigarettes each break per the smoking policy which residents sign. On 7/13/26 at 4:19 PM, Staff 1 (Administrator) acknowledged the smoking policy, and the smoking schedule did not state the number of cigarettes a resident was allowed to smoke during their 20-minute smoking break. Staff 1 acknowledged residents who required supervised smoking were allowed to have as many cigarettes as they wanted during their 20-minute smoke break.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation and interview the facility failed to ensure residents could meet in private for 1 of 1 resident council meeting reviewed for resident rights. This placed residents at risk for diminished quality of life. Findings include: On 7/8/26 at 11:00 AM, Resident Council took place in the dining room with this surveyor and four residents, including Resident 43 and Resident 15. During the Resident Council meeting, which lasted approximately 30 minutes, staff entered the dining room without knocking four different times. On 7/9/26 at 9:33 AM, Resident 15 stated during their monthly Resident Council staff interrupted often. On 7/9/26 at 10:07 AM, Resident 43 stated during their monthly Resident Council Meeting, staff interrupted the meeting multiple times. Resident 43 stated when staff interrupted the meeting, she/he lost her/his train of thought. On 7/9/26 at 10:13 AM, Staff 15 (Activity Director) stated staff were expected to allow the residents to have a private Resident Council meeting. Staff 15 state she was aware staff interrupted the staff have interrupted the Resident Council Meeting, but it was improving and during the June 2026 Resident Council Meeting, staff only interrupted once. On 7/13/26 at 4:20 PM, Staff 1 (Administrator) stated residents had the right to meet privately and staff were expected to not interrupt during Resident Council meetings.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure non-psychotropic PRN medication was administered prior to psychotropic medication as ordered for 1 of 5 sampled residents (#8) reviewed for medications. This placed residents at risk for adverse side effects of psychotropic medication. Findings include: Resident 8 was admitted to the facility in 1/2024 with diagnoses including anxiety disorder and heart failure. The 10/16/25 Significant Change MDS and related CAAs revealed Resident 8 elected hospice services on 10/12/25 due to a decline in health and heart failure. Resident 8 received psychotropic medications to address her/his hallucinations and anxiety. A 3/16/26 signed hospice physician order indicated Resident 8 was to receive lorazepam (antianxiety medication) every four hours as needed and to use albuterol (fast acting medication for shortness of breath) first. The 6/2026 and 7/2026 TARs revealed Resident 8's albuterol was not administered prior to the resident's lorazepam on 6/4/26, 6/16/26, 6/20/26, and 7/1/26. On 7/8/26 at 1:56 PM, Staff 25 (CNA) stated it was not unusual for Resident 8 to have hallucinations which triggered her/his anxiety. On 7/10/26 at 11:12 AM, Staff 27 (CMA) stated she relied on nurses to conduct assessments prior to PRN medication administration. Staff 27 confirmed she gave Resident 8 lorazepam on 6/20/26 and stated she was not instructed by Staff 18 to provide the resident's albuterol first. On 7/10/26 at 9:00 AM, Staff 2 (DNS) stated the 3/16/26 order for lorazepam was unclear. Staff 2 stated nursing staff were to follow physician orders as written and to contact the physician for clarification. On 7/10/26 at 9:45 AM, Witness 1 (Hospice Director of Nursing) stated hospice preferred the least restrictive interventions for Resident 8. Witness 1 stated albuterol was intended to address the main symptom of the resident's anxiety which was shortness of breath.		

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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 safely store narcotics for 1 of 1 sampled resident (#70) reviewed for safe medication storage. This placed residents at risk for misappropriation of their narcotic. Findings include: Resident 70 was admitted to the facility in 3/2026 with diagnoses including a fractured left femur (thigh bone) and a fractured left humerus (upper arm bone) On 7/10/26 at 10:15 AM Witness 5 (Complainant) stated two months ago Resident 70 was moved from the North Hall to the South Hall and there was a card of oxycodone (narcotic pain medication) missing. Witness 5 stated the card was located a few days later behind a picture frame in the North Hall. On 7/10/26 at 3:34 PM, Staff 4 (LPN) stated a couple of months ago she was counting medications with the night shift nurse and discovered Resident 70 was a card of oxycodone. Staff 4 stated the nurse manager was immediately notified. A 4/27/26 investigation indicated a card of Resident 70's oxycodone was missing on 4/25/26 and was found a few days later behind the back of a picture frame. The investigation indicated a diversion audit was to be completed by the pharmacy on 5/5/26 and education was to be provided to nurses and CMAs after completion of audit of the narcotic book. The 4/27/26 investigation stated misappropriation of Resident 10's oxycodone was identified. On 7/13/26 at 11:44 AM, Staff 2 (DNS) stated staff discovered Resident 70 was missing card of oxycodone during count on 4/27/26 and during the investigation it was discovered the card was missing since 4/25/26. Staff 2 stated the missing oxycodone card was found on 4/30/26 behind the picture frame. Staff 2 stated no further investigation was completed to determine how Resident 70's card of oxycodone ended up behind a picture frame in the facility's hallway and police were not notified of the misappropriation of Resident 10's oxycodone.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review it was determined the facility failed to ensure a safe discharge for 1 of 2 sample residents (#60) reviewed for discharge planning. This placed residents at risk for unmet discharge needs and failed discharge. Findings include: Resident 60 admitted to the facility in 2/2026 with diagnoses including femur fracture.A 2/14/26 admission Skin/Wound Evaluation revealed Resident 60 had a stage 2 pressure wound to her/his right buttock.A 3/12/26 Face to Face/Discharge Orders revealed the facility requested orders for Resident 60 to have home health physical therapy and occupational therapy. Home health nursing services were not included in the orders.A review of the 3/2026 TAR revealed a 3/15/26 order to clean sacrum wound with wound cleanser, pat dry and apply medihoney to wound bed and cover with a bordered dressing daily and prn.A 3/16/26 Progress Note revealed Resident 60 discharged from the facility on 3/16/26.A 3/16/26 Discharge Summary/Plan of Care/Recapitulation of Stay evaluation revealed Resident 60 had a pressure injury to her/his buttock and the skin treatment was to apply barrier cream twice a day.A 3/17/26 Progress Note revealed Staff 3 (LPN/IP) was contacted by Resident 60's assisted living facility and they were not aware Resident 60 had a Stage 2 pressure injury. The progress note also indicated the new facility was not provided with updated wound care orders for Resident 60. On 7/9/26 at 10:06 AM Witness 7 (Home Health Director) stated she reviewed Resident 60's home health orders sent to the company for her/his discharge and nursing care was not requested.On 7/10/26 at 3:13 PM Staff 3 (LPN/IP) stated on discharge from the facility Resident 60 had a worsening wound on her/his coccyx. Staff 3 stated Resident 60's assisted living facility was not informed of the wound care on discharge and was not able to provide the needed care for Resident 60. Staff 3 stated Resident 60's wound care orders were changed right before discharge. Staff 3 stated Resident 60 did not have a safe discharge.On 7/13/26 at 12:51 PM Witness 9 (Assisted Living Facility Nurse) stated when Resident 60 discharged to the assisted living facility updated wound status and care was not provided to the assisted living facility. Witness 9 stated home health nursing was required for Resident 60's wound care.On 7/13/26 at 1:05 PM Staff 1 (Administrator) stated the facility should have known to request home health nursing orders for Resident 60 and Staff 1 expected all current wound care orders to be sent to the assisting living for discharge.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to conduct a Significant Change MDS assessment within the required timeframe for 1 of 4 sampled residents (#51) reviewed for choices. This placed residents at risk for unassessed needs. Findings include: Resident 51 admitted to the facility in 2025 with diagnoses including dementia.A 6/19/26 Election of Hospice Benefit form revealed Resident 51 admitted to hospice services on 6/19/26.On 7/10/26 a Significant Change MDS assessment dated [DATE] was not yet completed, 22 days after Resident 51 admitted to hospice.On 7/10/26 at 2:08 PM Staff 38 (MDS Coordinator) confirmed Resident 51's Significant Change MDS was not yet completed. On 7/13/26 at 10:55 AM Staff 2 (DNS) stated a Significant Change MDS assessment was to be completed within 14 days of Resident 51's start on hospice services.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review it was determined the facility failed to accurately complete a diabetic baseline care plan for 1 of 5 sampled residents (#2) reviewed for medications. This placed residents at risk for lack of diabetic care and monitoring. Findings include: Resident 2 admitted to the facility in 6/2026 with diagnoses including diabetes. The 6/18/26 admission MDS revealed Resident 8 received insulin. The 6/2026 and 7/2026 TAR revealed no monitoring for adverse reactions to insulin administration were in place. A 6/25/26 revised care plan revealed no diabetic focus or interventions for Resident 2. On 7/8/26 at 2:43 PM, Staff 18 (LPN) stated a Resident Care Manager was to verify orders for new residents and ensure all treatments, orders, and monitors were in place. Staff 18 stated she believed no treatments were missing for Resident 2. On 7/8/26 at 4:55 PM, Staff 25 (CNA) observed Resident 2's care plan and confirmed she was not able to identify Resident 2 was a diabetic which was important for the monitoring of hypoglycemia (low blood sugar levels). On 7/13/26 at 4:19 PM, Staff 2 (DNS) stated she expected the baseline care plan to include diabetic care within 48 hours especially because Resident 2 received insulin.		

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NAME OF PROVIDER OR SUPPLIER Windsor Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Cottage Street NE Salem, OR 97301	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review it was determined the facility failed to provide ROM for 1 of 1 sampled resident (#16) reviewed for decreased ROM. This placed residents at risk for contractures. Findings include: Resident 16 was admitted to the facility in 2017 with diagnoses including flaccid hemiplegia (complete lack of movement) of the right side following a cardiovascular accident (stroke). On 7/6/26 at 10:00 AM Resident 16 stated she/he was unable to move her/his right side and Resident 16 stated staff did not assist her/him with ROM exercises. A 5/12/25 revised Care Plan indicated Resident 16 was to receive ROM in the morning and evening. A review of Resident 16's chart revealed no documentation of ROM exercises being completed. On 7/10/26 at 10:04 AM Staff 27 (CMA) stated she never saw ROM exercises being completed with Resident 16. On 7/10/26 at 10:21 AM, Staff 29 (CNA) stated there was no time to complete ROM exercises with residents. On 7/10/26 at 11:19 AM, Staff 21 (CNA) stated Resident 16's extremities were moved when they got her/him dressed but ROM exercises were not completed. On 7/10/26 at 11:57 AM, Staff 22 (LPN) stated she never saw ROM exercises being completed with Resident 16. On 7/13/26 at 8:46 AM, Staff 31 (CNA) stated Resident 16 did not receive ROM exercises. On 7/13/26 at 8:47 AM, Staff 7 (LPN Resident Care Manager) stated Resident 16 was not on the RA program and she was unaware if ROM exercises were completed with Resident 16. On 7/13/26 at 12:03 PM, Staff 2 (DNS) stated staff were expected to complete ROM exercises with Resident 16 while providing care and dressing alone was not sufficient replacement for ROM exercises.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review it was determined the facility failed to ensure residents received appropriate supervision during meals for 1 of 3 sampled residents (#58) reviewed for accidents. This placed residents at risk for choking and aspiration. Findings include: Resident 58 was admitted to the facility in 5/2024 with diagnoses including lung cancer and dysphagia (difficulty swallowing). A 1/17/26 SLP progress note indicated Resident 58 needed distant supervision while eating. A review of Resident 58's current care plan indicated no information related to the provision of distant supervision while eating. A 5/4/26 facility investigation indicated Resident 58 was eating without supervision and the 1/17/26 recommendation for distant supervision while eating was never put in place for Resident 58. On 7/10/26 at 11:13 AM, Staff 37 (RN) stated Resident 58 had difficulty swallowing. Staff 58 stated distant supervision meant staff needed to keep the residents within line of sight while the residents were eating. On 7/10/26 at 11:16 AM, Staff 21 (CNA) stated Resident 58 had difficulty chewing and swallowing. Staff 21 stated distant supervision would be staff remaining in the doorway while the resident eats. On 7/10/26 at 1:36 PM, Staff 18 (LPN) stated Resident 58 had difficulty swallowing and was supervised eating at some point. Staff 18 stated distant supervision meant staff needed to keep the resident within line of sight while the resident was eating. On 7/10/26 at 1:53 PM, Staff 28 (LPN Resident Care Manager) stated distant supervision meant staff needed to keep residents within sight while the resident was eating, if the resident was eating in their room, staff remained by the door so they could see the resident. On 7/13/26 at 3:45 PM, Staff 2 (DNS) stated when a resident was care planned for distant supervision, staff were expected to stay in the room until the resident was done eating. Staff 2 stated Resident 58 received the correct diet but was not supervised. Staff 2 stated SLP failed to inform staff of the recommendation made for Resident 58 in 1/2026 to have distance supervision while eating. The deficient practice was identified as Past Noncompliance based on the following: On 4/27/26 the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined Resident 58's care plan was not updated for distant supervision based on a 1/17/26 SLP recommendation. The Plan of Correction included: 1. An audit was completed which reviewed all SLP notes since 1/2026 to ensure all recommendations and orders were correct, 2. Meal supervision care plan were assigned to the Kardex (CNAs care plan) for CNA viewing of supervision requirements for meals, 3. All nursing staff were educated regarding various level of supervision during meals, what the various levels of supervision mean, where to find the information, and timely entering of new SLP or provider orders related to diet, 4. Education provided to therapy staff to ensure they are consistently utilizing their communication forms with nursing for all care plan updates, 5. Education provided to dietary staff regarding residents who require supervision for meals.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined the facility failed to ensure physician orders for respiratory care, an individualized respiratory care plan, and ongoing respiratory monitoring and assessment were in place for 1 of 2 sampled residents (#4) reviewed for respiratory care. This placed residents at risk for breathing difficulty. Findings include: Resident 4 was admitted to the facility in 1/2026 with diagnoses including COPD (chronic obstructive pulmonary disease- a lung disease that restricts airflow and makes breathing difficult) and respiratory failure. Physician Orders dated 1/30/26 indicated Resident 4 used a CPAP (Continuous Positive Airway Pressure- a device that blows a steady stream of pressurized air into your airway through a mask) machine while sleeping, but if she/he removed the CPAP, or refused to wear it, then the facility was to implement supplemental oxygen. The order further indicated the resident was to be on room air (natural breathing with no supplemental oxygen) when awake. The 2/11/26 Care Plan reiterated the same information as the 1/30/26 Physician Orders. The Oxygen Monitoring Task revealed staff intermittently monitored Resident 4's oxygen saturation levels, but not daily. For example, monitoring was not completed 6/25/26 through 6/28/2026 or 7/6/26 through 7/9/26. Resident 4's electronic health record did not have orders and indications for use of supplemental oxygen when she/he was not wearing a CPAP device. There was no information on the Care Plan or Treatment Activity Record of the supplemental oxygen delivery system or equipment, parameters for when to administer supplemental oxygen, how or when to monitor oxygen saturation levels, or documentation of ongoing assessment of the resident's respiratory status or response to supplemental oxygen use. From 7/6/26 through 7/9/26 many observations were made of Resident 4, and she/he consistently received supplemental oxygen via nasal cannula (tubing that delivers oxygen into the nostrils), either from an oxygen tank affixed to the back of her/his wheelchair or an oxygen concentrator when in bed. On 7/9/26 at 4:24 PM Staff 10 (CNA) stated Resident 4 received supplemental oxygen at all times. On 7/10/26 at 10:19 AM Staff 7 (Resident Care Manager LPN) stated Resident 4 required the use of supplemental oxygen at all times. Staff 7 acknowledged the facility did not have orders or a care plan in place to administer supplemental oxygen, and the electronic health record lacked sufficient assessment and monitoring for use of the supplemental oxygen. On 7/10/26 at 10:51 AM Staff 2 (DNS) acknowledged appropriate orders, care planning, assessment, and monitoring were not in place for Resident 4's use of supplemental oxygen.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review it was determined the facility failed to ensure dialysis (a procedure which removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly) services were in place including communication with the dialysis provider for 1 of 1 sampled resident (#46) reviewed for dialysis. This placed residents at risk for dialysis complications and delayed treatment. Findings include: Resident 46 admitted to the facility in 6/2026 with diagnoses including end stage renal disease.A 6/26/26 Care Plan revealed resident 46 had dialysis on Mondays, Wednesdays, and Fridays.A review of Resident 46's Pre Dialysis Evaluation and Post Dialysis Evaluations from 6/24/26 and 7/8/26 revealed the following days when the facility did not have a Pre Dialysis or Post Dialysis Evaluation:-6/26: no Pre Dialysis Evaluation was completed;-7/1: no Pre Dialysis Evaluation was completed;-7/6: no Pre Dialysis Evaluation or Post Dialysis Evaluation was completed;-7/8: no Pre Dialysis Evaluation was completed.A 7/3/26 Progress Note indicated the dialysis center communication included directions to increase potassium in Resident 46's diet.A review of Resident 46's health record revealed no evidence the 7/3/26 Progress Note was implemented or of additional communication with the dialysis center.On 7/9/26 at 1:34 PM Staff 32 (Registered Dietitian) stated she was unaware of the 7/3/26 Progress Note to increase Resident 46's potassium and it was not implemented.On 7/9/26 at 4:14 PM Staff 2 (DNS) confirmed the facility was to communicate with the dialysis center and complete the pre and post dialysis evaluations. Staff 2 confirmed no Pre Dialysis Evaluations were completed on 6/26/26, 7/1/26, 7/6/26, and 7/8/26; and no Post Dialysis Evaluations were completed on 7/6/26 and 7/8/26. Staff 2 also stated she was unaware of the 7/3/26 Progress Note to increase potassium in Resident 46's diet and was unaware of any communications to the dialysis center to confirm the order.		