STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385241	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keizer Nursing and Rehabilitation	4062 Arleta Avenue NE Keizer, OR 97303

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record reviewed it was determined the facility failed to follow physician orders for 1 of 2 residents (# 302) reviewed for medication. This placed residents at risk for unmet needs. Findings include:Resident 302 was admitted to the facility in 8/2025 with diagnoses including spinal stenosis, (a condition in which the spine becomes too narrow and presses on the nerves) and pain. An 8/25/25 physician's order instructed staff to administer tizanidine HCl 2 mg tablets three times a day for muscle spasms. Another 8/25/25 physician's order instructed staff to administer tizanidine HCl 2 mg tablets every eight hours PRN for muscle spasms. A 9/26/25 Significant Change in Status MDS indicated Resident 302 was cognitively intact. A 10/22/25 physician order indicated staff were to administer oxycodone 5 mg every four hours PRN for pain or discomfort. The 11/11/25 MAR indicated at 10:30 PM Resident 302's tizanidine was not administered and directed staff to see progress note. The 11/12/25 at 1:08 AM, progress note indicated the facility was out of Resident 302's tizanidine medication. The 11/12/25 MAR indicated at 9:30 AM indicated tizanidine was not available. The 11/12/25 at 10:43 AM, progress noted indicated staff notified the pharmacy and requested Resident 302's tizanidine. The 11/12/25 MAR indicated Resident 302's pain was a 10 out of 10 and her/his oxycodone was ineffective. A 11/12/25 at 11:45 AM, progress note indicated Resident 302 had break through pain due to tizanidine not being available. A 11/12/25 physician order indicated staff were to administer oxycodone 5 mg tablet PRN for pain until tizanidine arrived. On 12/4/25 a public complaint was received which alleged the facility failed to administer residents' medications as ordered. On 12/16/25 at 9:29 AM, Resident 302 stated several weeks prior, the facility did not order her/his muscle relaxant in a timely manner, resulting in the medication running out. Resident 302 reported having increased pain during that time. Resident 302 further stated when her/his medication are not given on time she/he becomes a rolling mess. On 12/16/25 at 10:34 AM, Staff 3 (Agency RN) confirmed Resident 302's muscle relaxant was not ordered in a timely manner and was unavailable. Staff 3 stated Resident 302 had increased pain, and she contacted the physician and requested a one-time authorization to increase her/his oxycodone for breakthrough pain. Staff 3 also contacted the pharmacy to refill the resident's muscle relaxant. On 12/16/25 at 2:40 PM, Staff 4 (LPN) confirmed Resident 302's medication was not ordered in a timely manner. Staff 4 reported there had been ongoing issues with medications not being ordered on time, particularly non-narcotic medications. Staff 4 explained that nurses were responsible for reordering medications timely, but she was unsure who monitored to ensure this occurred. Staff 4 further stated agency staff were also expected to reorder medications timely but often did not. On 12/16/25 at 3:30 PM, Staff 5 (Agency LPN) stated 11/11/25 was her first day working at the facility. Staff 5 stated she believed Resident 302's muscle relaxant had already been ordered and she did not check with the pharmacy. She became aware later the resident had not received her/his muscle relaxant, and she/he was in a lot of pain. Staff 5 stated both the resident and her/his family were upset about the situation. On 12/17/25 at 11:24 AM, Staff 6 (Pharmacist) confirmed Resident 302 had two separate orders for tizanidine: a scheduled order for 2 mg three times a day for muscle spasms, and a PRN order for 2 mg every eight hours for muscle spasms. Staff 6 reviewed the facility's refill record and confirmed on 10/24/25, a refill was requested for the resident. Staff 6 stated the facility called again on 11/12/25 and requested the refill. Staff 6 confirmed the resident ran out of medication before the facility placed the refill request. On 12/17/25 at 12:12 PM, Staff 2 (DNS) confirmed staff were expected to reorder medications timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure resident meals were prepared in a sanitary manner for 1 or 1 kitchens reviewed for sanitation. This placed residents at risk for foodborne illnesses. Findings include:On 12/16/25 at 10:01 AM, Staff 7 (Cook) stated the residents were given meal tickets to complete each day and those tickets were tallied and utilized by the facility during meal planning and plating. During observations on 12/16/25 at 12:10 PM, Staff 7 picked up resident tickets with gloved hands, then picked up bread rolls and placed them on lunch plates with the same gloved hands. This pattern repeated throughout the meal service. During observations on 12/16/25 at 12:20 PM, Staff 9 (Dietary Aide) picked up meal tickets and then touched resident plates, silverware, desserts, and condiments for service to residents. On 12/16/25 at 12:42 PM, Staff 7, 8 (Dietary Manager), and 9 acknowledged meal tickets were an unclean surface. Staff 8 stated she previously had concerns about the use of resident-completed meal tickets on the tray line. On 12/26/25 at 1:30 PM, Staff 1 (Administrator) stated he agreed resident-completed meal tickets were an unclean surface and food, dishes and other clean surfaces should not be touched after touching an unclean meal ticket.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation and interview it was determined the facility failed to ensure the resident food refrigerator was free of outdated food items for 1 of 1 refrigerator. This placed residents at risk for consuming spoiled food. Findings include: On 12/16/25 at 12:58 PM, the resident food refrigerator was observed with food containers dated 11/9/25 and 11/20/25, take-out food dated 11/15/25 and 11/29/25, and a jar of soup with no date.The freezer section was observed with two opened and partially used ice cream containers with no open date. Some of the containers did not identify which resident room the food belonged to. Staff 8 (Dietary Manager) stated it was her responsibility to monitor foods in the resident refrigerator and she had not done it recently. She stated foods should be removed after 3 days unless unopened and unexpired and marked with resident room numbers. Staff 2 (DNS) stated staff should be marking foods with the room number of the resident.