STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385244	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nehalem Valley Care Center	280 Rowe Street Wheeler, OR 97147

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide incontinent and repositioning assistance to a dependent resident in a timely manner for 1 of 3 sampled residents (#2) reviewed for ADLs. This placed residents at risk for unmet ADL needs. Findings include: Resident 2 admitted to the facility in 2025 with diagnoses including cancer and hospice. The 8/14/25 care plan indicated Resident 2 had mixed bladder incontinence and was dependent on staff for toileting needs. Interventions included for staff to provide check and change during repositioning and as needed. Staff were to check throughout the shift as required for incontinence. The care plan also indicated the resident had a pressure injury to the coccyx and staff were to provide turn/repositioning assistance at least every two hours, and more often as needed. A 9/5/25 facility investigation indicated it was reported Staff 8 (CNA) did not provide incontinent care or repositioning to Resident 2 during a span of seven hours during her shift. When Staff 8 was asked about the incident, Staff 8 indicated she had not changed the resident (time was 1:11 PM) during her shift and only checked [her/his] brief. When Staff 8 was asked if she provided repositioning during her shift, Staff 8 indicated no. Staff 8 was removed from the floor and placed on suspension. Based on staff interviews the facility determined Staff 8 was untruthful about the care she presumably provided during the first seven hours of her shift. Resident 2 was unable to provide any information due to her/his cognition. Resident 2 passed away on 9/6/25 and Staff 8 was terminated on 9/8/25. The investigation indicated Resident 2's care plan was updated and education was provided to staff regarding the importance of timely care. The facility Investigation included the following statements:Staff 4 (LPN Resident Care Manager) indicated at 12:40 PM Staff 6 (CNA) and Staff 5 (CNA) reported they were going to provide Resident 2 a bed bath. Staff 6 reported that Staff 8 made a comment alluding to the fact she had not changed Resident 2 and needed to check to make sure the resident's bedding was not wet before Staff 4 went into the room. Staff 4 indicated she and Staff 7 (HR) spoke with Staff 8 regarding what was reported. Staff 8 indicated she went into the resident's room around 7:15 AM and changed Resident 2's brief. Staff 8 was asked if the resident's brief was wet or not and she indicated, oh well I looked at [her/his] brief and it looked dry, so I left it. Staff 8 was asked if she repositioned the resident as she/he was supposed to be repositioned every two hours per the care plan. Staff 8 indicated she pulled on her/his [NAME] pad and grimaced so she did not turn the resident. Staff 8 acknowledged she did not change or reposition Resident 2 during the previous seven hours. Staff 5 indicated Staff 8 was aware Staff 4 was about to complete wound care on Resident 2. Staff 4 indicated at 1:00 PM Staff 8 quickly rushed to change Resident 2's brief and reposition her/him as she did not do so prior in the day. On 2/18/26 at 1:23 PM and 2/19/26 at 9:47 AM Staff 5 was attempted to be contacted for this investigation. No return call was received. On 2/18/26 at 1:27 PM Staff 3 (RN) stated she was the charge nurse on 9/5/25. Staff 3 stated it was almost the end of the shift when she became aware Staff 8 did not provide any care to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385244	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nehalem Valley Care Center	280 Rowe Street Wheeler, OR 97147

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 the entire shift. Staff 3 asked other CNA staff to assist with completing cares for the resident. Staff 3 stated the staff indicated it was obvious Resident 2 had not been changed.On 2/18/26 at 2:34 PM Staff 4 stated when she was notified of Resident 2 not being assisted with incontinence care or repositioning, she questioned Staff 8. Staff 4 stated Staff 8 confirmed she did not change or reposition Resident 2 in seven hours. Staff 4 stated it was a standard of practice to complete cares including incontinence care and repositioning at least every two hours or according to the care plan. Staff 4 stated there was no negative outcome to Resident 2.On 2/19/26 at 9:51 AM Staff 6 stated Staff 8 wrote a note on the CNA message board indicating to not let Staff 4 go into Resident 2's room because she did not yet change the resident. Staff 6 stated she showed Staff 4 the message written by Staff 8. Staff 6 stated she made a comment to Staff 5 about not providing incontinent care to Resident 2. Staff 6 stated as a standard of care CNA staff were to check on residents and provide incontinence care and repositioning according to the care plan.On 2/19/26 at 10:14 AM Staff 8 stated she worked in the facility for approximately ten years. Staff 8 stated she asked other CNAs to assist her with Resident 2, but the other staff were busy, and she was unable to get help for seven hours. Staff 8 stated she did not change Resident 2's brief or provide incontinence care because she/he was dry for seven hours. Staff 8 further stated she also did not reposition the resident due to the resident's pain, but spoke with the staff about pain medication and was working on it when Staff 4 questioned her. Staff 8 acknowledged her statement to Staff 4 was correct and she did not provide incontinent care, change resident 2's brief or reposition her/him for seven hours.On 2/19/26 at 10:28 AM Staff 1 (Administrator) acknowledged the incident occurred on 9/5/25 and Resident 2 was not provided ADL assistance by Staff 8 for a prolonged period of time.On 9/10/25 the facility provided information to indicate an action plan to prevent further occurrences was completed, staff education and audits were completed related to providing ADL assistance timely. The deficient practice was determined to be past non-compliance, corrected on 9/5/25.