| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385254 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Myrtle Point Rehabilitation & Care | 637 Ash Street<br>Myrtle Point, OR 97458 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on interview and record review it was determined the facility failed to provide residents a private environment for physical intimacy for 2 of 4 sample residents (#s 1 and 2) reviewed for abuse. This placed residents at risk for lack of privacy. Findings include: Resident 1 was admitted to the facility in 6/2023 with a diagnosis of chronic lung disease. Resident 1's 9/15/25's Quarterly MDS indicated she/he was moderately cognitively impaired. Resident 2 was admitted to the facility in 10/2025 with a diagnosis of heart disease. Resident 2's 10/6/25's admission MDS revealed she/he was cognitively intact. Resident 1's 10/6/25 Progress Notes revealed on 10/5/25 staff spoke to Resident 1 about an incident when there was heavy petting outside the building and once inside the building where a resident of the opposite gender had her/his hands inside Resident 1's shirt. Resident 1 reported to staff the incident was consensual. Resident 1's 10/10/25 Sexual Consent Capacity Evaluation revealed she/he had the capacity to consent and had the desire to be sexually active. Resident 2's 10/10/25 Sexual Consent Capacity Evaluation revealed she/he had the capacity to consent and had the desire to be sexually active. Resident 2's 10/11/25 Progress Note revealed a CNA reported she observed Resident 2 and Resident 1 with their hands down each other's pants while outside. The residents were separated and informed private time could be provided but public displays were inappropriate.On 10/13/25 at 3:52 PM Resident 2 stated Resident 1 did not do anything physical with him/her that she/he did not want. Resident 2 denied an ongoing relationship with Resident 1. On 10/14/2025 10:38 AM Resident 1 stated the facility never provided a private place for her/him to meet for intimacy. Resident 1 stated she/he was allowed to meet Resident 2, but it was chaperoned. On 10/14/2025 11:20 AM Staff 2 (DNS) stated there was no location in the facility designated for residents to meet privately if they chose to have a sexual or intimate relationship. |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review it was determined the facility failed to ensure a resident was assessed for sexual consent for 1 of 4 sampled residents (#1) reviewed for abuse. This placed residents at risk for trauma. Findings include:Resident 1 was admitted to the facility in 6/2023 with a diagnosis of chronic lung disease. Resident 1's 9/15/25's Quarterly MDS indicated she/he was moderately cognitively impaired. Resident 2 was admitted to the facility in 10/2025 with a diagnosis of heart disease. Resident 2's 10/6/25's admission MDs indicated she/he was cognitively intact. Resident 1's 10/6/25 Progress Notes revealed on 10/5/25 staff spoke to Resident 1 about an incident when there was heavy petting outside the building and once inside the building when a resident of the opposite gender had her/his hands inside Resident 1's shirt. Resident 1 reported to staff the incident was consensual. On 10/13/25 at 4:17 PM Staff 3 (CNA) stated on 10/5/25 he went outside to bring the residents in from a smoke break and observed Resident 2 to have her/his hands up Resident 1's shirt. Staff 3 assisted Resident 1 back to the facility and notified the nurse. Staff 3 stated the rest of the evening shift both residents were in the sunroom watching a movie. Staff 3 also stated he monitored both residents until the shift ended at 10:00 PM and then he provided report to the oncoming CNA. Staff 3 stated Staff 4 (Charge Nurse) was the same nurse for the night shift. On 10/13/25 at 4:32 PM Staff 11 (CNA) stated she worked the night shift on 10/5/25 to 10/6/25. She was told Resident 1 and Resident 2 could be together, but they needed to be in a private area if they wanted to be intimate. On 10/14/25 at 6:14 AM Staff 4 stated on 10/5/25 on the evening shift there were two incidents with Resident 1 and Resident 2. The first incident occurred outside when Resident 2 had her/his hands up Resident 1's shirt. The residents were separated, then they both sat in the sunroom, and watched a movie. Initially, when both residents were brought back from the smoking area, they did not want to go to their separate rooms. Staff 4 stated he did not have the opportunity to talk to either resident separately to ensure the interaction was consensual until after the second event. Initially Resident 2 denied the incident but then indicated it was consensual. Resident 1 reported the interactions were consensual. Staff 4 stated after the first interaction between Resident 1 and Resident 2 he should have ensured both residents were able to consent, and the interaction was consensual. 10/14/2025 11:59 AM Staff 1 (Administrator) stated staff were to ensure residents were assessed after an incident to ensure resident safety. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review it was determined the facility failed to ensure an allegation of abuse was reported within two hours for 1 of 4 sampled residents (#1) reviewed for abuse. This placed residents at risk for ongoing abuse. Findings include: Resident 1 was admitted to the facility in 6/2023 with a diagnosis of chronic lung disease. Resident 1's 9/15/25's Quarterly MDS indicated she/he was moderately cognitively impaired. Resident 2 was admitted to the facility in 10/2025 with a diagnosis of heart disease. Resident 2's 10/6/25's admission MDs indicated she/he was cognitively intact. A FRI dated 10/6/25 indicated on 10/5/25 at 8:30 PM Resident 2 was observed to have her/his hands up Resident 1's shirt. The incident was not reported to the administrator until 10/6/25 at 9:30 AM and was reported to the State agency on 10/6/25 at 11:08 AM. This was over 12 hours after the initial incident of potential abuse.On 10/14/2025 at 6:14 AM Staff 4 (Charge Nurse) stated he was not aware he needed to report potential abuse within two hours. On 10/14/25 11:59 AM Staff 1 (administrator) stated allegations of abuse were to be reported within two hours. The deficient practice was identified as Past Noncompliance based on the following: On 10/6/25 administration identified the deficient practice and immediately provided training on the following:-types of abuse-timeframes for reporting abuse-evaluating incidents-investigating events and reporting incidents as abuse until ruled out |