STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385254	A. Building B. Wing	04/10/2026

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

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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 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 ensure residents were provided activities of choice for 4 of 4 sampled residents (#s 5, 8, 13, and 19) reviewed for choices and activities. This placed residents at risk of diminished psychosocial well-being. Findings include: The 1/2/26 Resident Council notes revealed resident concerns regarding not having enough social events and a lack of outings. Residents requested opportunities for bus rides, coffee outings, shopping, attendance at community events, and trips such as countryside drives and beach visits. The facility response indicated, we're working on getting more employees covered by company insurance so that we can take more residents on outings. The 2/27/26 Resident Council notes revealed residents expressed confusion about outings and concerns they are no longer able to go on outings. Residents requested clarification regarding the facility's plan to facilitate outings, including availability of a driver, and concerns the facility van was too small to accommodate multiple residents. The 3/26/26 Resident Council notes revealed residents expressed dissatisfaction with activities and they wanted to go off the property to do activities. Residents indicated activities are dead. 1. Resident 5 was admitted to the facility in 2/2024 with diagnoses including Parkinson's disease. The 2/28/26 Annual MDS indicated Resident 5 had a BIMS of 14 and was cognitively intact. Resident 5 indicated going outside was very important to her/him. The 9/13/25 revised Care Plan indicated Resident 5 had a variety of activity interests and liked to participate in group activities. Staff were to assist with arranging community activities and transportation. On 4/9/26 at 11:50 AM, Staff 13 (CNA) stated she was aware Resident 5 requested more outings but it's been a while since they had outings.On 4/10/26 at 9:06 AM and 4/10/26 at 10:38 AM, Staff 8 (Social Service Director/Activity Director) stated multiple residents had been asking to go on outings for the past couple months and it had not happened despite resident request. On 4/10/26 10:12 AM, Resident 5 stated she/he would like to go on outings, but it's been too long since they last had any outings. Resident 5 further stated she/he would really like to go on outings. On 4/10/26 at 10:50 AM, Staff 3 (Corporate Nurse Manager) and Staff 20 (Regional Director) reviewed the resident council documentation and confirmed residents had requested outings and acknowledged delays addressing the residents' requests. On 4/10/26 at 11:50 AM, Staff 2 (DNS) stated she was aware residents had requested to go on outings for the past three months and confirmed a solution had not been implemented.2. Resident 8 was admitted to the facility in 8/2024 with diagnoses including heart failure. The 8/16/24 admission MDS indicated Resident 8 had a BIMS of 15 and was cognitively intact. Resident 8 indicated going outside was very important to her/him.On 4/6/26 at 12:45 PM, Resident 8 stated the bus had not been used. Resident 8 stated she/he wanted to go outside to go fishing at the ponds.On 4/9/26 at 11:50 AM, Staff 13 (CNA) stated she was aware of Resident 8 requesting more outings, but it's been a while since they had outings.On 4/10/26 at 9:06 AM and 4/10/26 at 10:38 AM, Staff 8 (Social Service Director/Activity Director) stated multiple residents had been asking to go on outings for the past couple months and it had not happened despite resident requests. On 4/10/26 10:12 AM, Resident 8 stated she/he would really like to go on outings. Resident 8 further stated she/he would like to go on outings but its been too long since they last had any outings.On 4/10/26 at 10:50 AM, Staff 3 (Corporate Nurse Manager) and Staff 20 (Regional Director) (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed the resident council meeting documentation and confirmed residents had requested outings and acknowledged delays addressing the request. On 4/10/26 at 11:50 AM, Staff 2 (DNS) stated she was aware of residents had requested to go on outings for the past three months and confirmed a solution had not been implemented.3. Resident 13 admitted to the facility in 10/2024 with diagnoses including heart failure and diabetes.The 10/30/24 admission MDS indicated Resident 13 had a BIMS of 15 and was cognitively intact. Resident 13 indicated going outside was very important to her/him. On 4/9/2026 at 1:59 PM, Resident 13 stated she/he was the Resident Council President. Resident 13 reported residents were not been informed why they were unable to go on outings. Resident 13 stated multiple residents voiced concerns about not going on outings. Resident 13 reported she/he could understand not going on outings during poor weather; however, the weather had been mild, and residents had repeatedly asked about outings. Resident 13 described the activities as boring. Resident 13 further stated the activity bus was available and could hold up to six residents.On 4/10/26 at 9:06 AM and 4/10/26 at 10:38 AM, Staff 8 (Social Service Director/Activity Director) stated multiple residents requested to go on outings over the past several months; however, outings had not occurred due to lack of approved staff to drive the bus. Staff 8 stated she requested to be added to the facility insurance without resolution. Staff 8 confirmed residents requests for outings had not been resolved. On 4/10/2026 at 9:14 AM, Staff 19 (Maintenance Director) confirmed he was the only staff approved to drive the bus and stated the last outing occurred in approximately August or September 2025.On 4/10/26 at 10:50 AM, Staff 3 (Corporate Nurse Manager) and Staff 20 (Regional Director) reviewed the resident council meeting documentation and confirmed residents requested outings and acknowledged delays addressing the request.On 4/10/26 at 11:50 AM, Staff 2 (DNS) confirmed awareness of residents' requests for outings for approximately three months and stated a resolution had not been implemented.4. Resident 19 was admitted to the facility in 11/2025 with diagnoses including anxiety and depression. The 11/18/25 admission MDS indicated Resident 19 had a BIMS of 15 and was cognitively intact. Resident 19 indicated going outside was very important to her/him. The 2/7/25 revised Care Plan indicated Resident 19 enjoyed going outside. On 4/10/26 at 9:06 AM and 4/10/26 at 10:38 AM, Staff 8 (Social Service Director/Activity Director) stated multiple residents had been asking to go on outings for the past couple months and it has not happened despite resident requests. On 4/10/26 at 10:20 AM, Resident 19 stated she/he would love to go on outings. Resident 19 stated she/he would like to go anywhere just to get out of the facility. Resident 19 further stated she/he was told they have a bus but no one has talked to her about going on outings and she/he would like to go on drives and to the park.On 4/10/26 at 11:50 AM, Staff 2 (DNS) confirmed awareness of residents' requests for outings for approximately three months and stated a resolution had not been implemented.On 4/10/26 at 10:50 AM, Staff 3 (Corporate Nurse Manager) and Staff 20 (Regional Director) reviewed the resident council meeting documentation and confirmed residents had requested outings and acknowledged delays addressing the request.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review it was determined the facility failed to ensure dignity was maintained for 1 of 1 sampled resident (#1) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include:Resident 1 was admitted to the facility in 4/2024 with diagnoses including stroke and a fractured femur (thigh bone). A 1/12/26 Significant Change MDS and associated CAAS indicated Resident 1 had a BIMS assessment score of 10 (moderately impaired cognition), exhibited poor safety awareness, and required assistance by one staff for toileting transfers.A 4/4/26 Alleged Abuse indicated Staff 9 (LPN) directed Staff 6 (CNA) to assist Resident 1 with her/his urinal in bed. The report indicated Staff instructed Resident 1 to urinate in her/his brief because she/he continued to try and stand.A 4/5/26 statement by Staff 6 indicated she was only able to yell at Resident 1 because she/he was hard of hearing. Staff 6 acknowledged she told Resident 1 to urinate in her/his brief.On 4/9/26 at 7:30 PM, Staff 17 (CNA) stated she worked with Staff 6 on 4/4/26 and heard Resident 1 yell for help to use the bathroom. Staff 17 stated she reported to Staff 9 about Staff 6's anger towards Resident 1 during the shift.On 4/9/26 at 8:00 PM, Staff 6 stated she believed Resident 1 was not medicated properly and required one on one care due to her/his impulsiveness. Staff 6 stated she did not identify any issues between herself and Resident 1.On 4/10/26 at 8:44 PM, Staff 9 stated she told Staff 6 to be patient with Resident 1 due to Staff 6's frustration and confirmed the care for Resident 1 was manageable with one staff.On 4/10/26 at 9:01 AM, Resident 1 was interviewed about the incident on 4/4/26, and did not recall the event.On 4/10/26 at 4:04 PM, Staff 2 (DNS) stated Staff 6 provided her own statement of admission to inappropriate actions. Staff 2 acknowledged it was unacceptable to instruct a resident to use her/his brief than provide assistance with toileting. Staff 2 stated she expected resident concerns to be addressed immediately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review it was determined the facility failed to update a care plan to reflect changes in care needs for 1 of 1 sampled resident (#22) reviewed for bowel and bladder. This placed residents at risk for skin breakdown. Findings include:Resident 22 was admitted to the facility in 4/2025 with diagnoses including cerebral palsy (impaired muscle coordination) and chronic kidney disease. The 2/14/25 physician signed Skin Protocols for the facility indicated barrier cream (protection for the skin from urine or feces) was to be applied as needed per facility protocol. The 2/5/26 Quarterly MDS revealed Resident 22 was always incontinent of bowel and bladder and had a BIMS assessment score of 10 (moderately cognitively impaired).A 3/25/26 Skin Integrity report revealed a CNA reported skin discoloration and abrasions on both of Resident 22's upper inner thighs. The area was cleaned, barrier cream was applied and the resident's physician was notified. The 4/2026 TAR and physician orders revealed nystatin powder (antifungal medication) was topically applied to Resident 22's upper inner thighs three times a day for redness at the resident's groin area for ten days. A 4/5/26 revised Care Plan indicated Resident 22 had bowel and bladder incontinence and to clean the area around her/his groin after each incontinence episode. On 4/7/26 at 10:34 AM, Resident 22 stated she/he urinated without knowing and was not aware of ongoing treatments to her/his groin area. On 4/9/26 at 1:37 PM, Staff 13 (CNA) stated she cared for Resident 22 and only applied nystatin powder to her/his groin area. On 4/9/26 5:36 PM, Staff 15 (CNA) stated she only applied powder to Resident 22's groin area and no barrier cream. On 4/9/26 at 8:44 PM, Staff 9 (LPN) stated she contacted Resident 22's physician for the nystatin powder order on 3/25/26. She stated the skin abrasions to the resident's groin area were not open at the time.On 4/10/26 at 12:16 PM, Resident 22's groin area was observed with skin areas that were slightly open and red. Staff 2 (DNS) stated Resident 22's skin abrasions to the groin area had improved and the area was no longer fungal. The 4/2026 TAR revealed nystatin powder was topically applied to Resident 22's upper inner thighs three times a day for redness at the resident's groin area for ten days. There was no order found for the application of barrier cream in the resident's clinical record. On 4/10/26 at 12:17 PM, Staff 7 (LPN) stated she only applied nystatin powder to Resident 22's groin area because that was what was ordered and did not apply barrier cream. In an interview on 4/10/26 at 8:47 AM, Staff 2 (DNS) stated she expected the application of barrier cream as an intervention for all incontinent residents and acknowledged Resident 22's care plan did not include interventions to apply barrier cream.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review it was determined the facility failed to ensure residents were free of significant medication errors for 1 of 1 sampled Resident (#32) reviewed for medication errors. This placed residents at risk for adverse medication side effects. Findings include: Resident 32 was admitted to the facility in 10/2025 with diagnoses including chronic pain and fibromyalgia (widespread pain and stiffness).The 4/2019 Administering Medication Policy Statement indicated: The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. The 11/6/24 admission MDS indicated Resident 32 was cognitively intact.A review of the 1/2/25 Facility Investigation Summary revealed on 1/2/25 Staff 22 (Former CMA) administered Resident 32 her/his morning dose of Lyrica at 6:00 AM and then again at 11:00 AM. The second dose of Lyrica was to be administered 12 hours after the first dose.A physician order revealed Resident 32 had hydrocodone (narcotic pain medication) for pain. Staff 22 administered the second dose of Lyrica instead of the hydrocodone. Resident 32 developed adverse medication side effects and was sent to the ER for physician evaluation. On 1/6/25 the investigation concluded Resident 32's dosing schedule was every 12 hours for Lyrica. Resident 32 received a 6:00 AM dose of Lyrica and the second dose was given approximately five hours later. Resident 32 was transported to the ER for evaluation due to possible adverse side effects from the medication. Poison control was called by the ER and stated the Lyrica was not a high enough dose to cause adverse side effects. Resident 32 returned to the facility and was placed on alert charting. The medication error should have been prevented. Education and coaching provided to Staff 22.On 4/7/26 at 1:38 PM Witness 4 (Family Member) stated Resident 32 was given her/his pain medications too close together and was sent to the ER with adverse medication side effects.On 4/7/26 at 2:02 PM Staff 22 indicated she did not remember the incident and no longer worked in the facility.On 4/10/26 at 2:42 PM Staff 13 (Corporate Nurse Consultant) stated Resident 32's Lyrica order was one dose in the AM and one dose in the PM. Staff 13 acknowledged Staff 22 did not follow the five rights of administering medications and Resident 32 received the wrong medication. The deficient practice was identified as Past Noncompliance based on the following:On 1/3/25 the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a medication error. The plan of correction included: retraining of staff for medication administration including the five rights of administering medications properly, review of the Medication Administration Policy and Procedure, and audits showing compliance. The facility identified the issue, implemented a systemic plan of correction, and verified its effectiveness before the start of the survey, this tag is cited as past non-compliance. Corrective actions were completed on 1/6/25.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review it was determined the facility failed to ensure meal preferences were honored during posted mealtimes for 1 of 1 kitchen and 2 of 4 sampled residents (#s 13 and 21) reviewed for food, choices, and kitchen. This placed residents at risk for lack of meal satisfaction. Findings include:The Undated Mealtimes postings located near the nurse station and kitchen indicated the following: -Breakfast was served from 7:30 AM to 8:30 AM.-Lunch was served from 12:00 PM to 1:00 PM.-Dinner was served from 5:30 PM to 6:30 PM.1. Resident 13 was admitted to the facility in 10/2024 with diagnoses including diabetes and heart failure.A 11/6/25 Annual MDS revealed a BIMS assessment score of 14 (cognitively intact) for Resident 13. On 4/6/26 at 12:23 PM, Resident 13 stated she/he received less food than normal during mealtimes. Resident 13 stated she/he received one pancake and wanted more and requested two bowls of cereal on another day but they ran out. On 4/9/26 at 9:56 AM, Staff 11 (Dietary Aide) stated staff were aware CNAs had complaints from residents who requested additional food during meal service. Staff 11 stated sufficient food supplies were sometimes not pulled from the freezer to thaw and prepare for the meal.On 4/10/26 at 10:27 AM, Staff 10 (Cook) stated she held breakfast for 30 minutes after meals were served and was verbally instructed to prepare two to three additional servings which were utilized for pureed foods and left no additional servings after food trays were served. Staff 10 stated there were no guidelines in writing and confirmed she was unsure if additional food for residents was to be offered if requested. On 4/10/26 at 11:17 AM, Staff 4 (Dietary Manager) acknowledged the expectation was to provide residents the food on the menu for one hour once food trays were delivered. Staff 4 stated the expectations were not communicated to residents and staff in writing and ample food was not always available. 2. Resident 21 was admitted to the facility in 10/2025 with diagnoses including spinal stenosis (narrowing of spaces in the spine causing pain). The 3/3/26 Quarterly MDS revealed a BIMS assessment score of 15 (cognitively intact) for Resident 21.On 4/9/26 at 9:56 AM, Staff 11 (Dietary Aide) stated staff were aware CNAs had complaints from residents who requested additional food during meal service. Staff 11 stated sufficient food supplies were sometimes not pulled from the freezer to thaw and prepare for the meal.On 4/10/26 at 10:11 AM, Resident 21 stated, on 4/10/26, she/he received one pancake and two sausage links and was still hungry. Resident 21 stated Staff 18 (CNA) contacted the kitchen a few minutes after meals were served and was informed there were no additional pancakes or sausage. On 4/10/26 at 10:27 AM, Staff 10 (Cook) stated she held the breakfast for 30 minutes after the meal was served and was verbally instructed to prepare two to three additional servings which were utilized for pureed foods and left no additional servings. Staff 10 stated there were no guidelines in writing and confirmed she was unsure if additional food for residents was to be offered if requested. On 4/10/26 at 10:52 AM, Staff 18 acknowledged, on 4/10/26 during breakfast, kitchen staff stated there was no additional food from the menu and the request for additional food was made within the one hour window. Staff 18 stated she trained new CNAs and the expectation was food was available from the kitchen for one hour once the food trays arrived to resident rooms. Staff 18 stated on 4/9/26 breakfast was served at 8:45 AM and the mealtime was not sufficient to allow residents a one hour window for service and food requests. On 4/10/26 at 11:17 AM, Staff 4 (Dietary Manager) acknowledged the expectation was to provide residents the food on the menu for one hour once food trays were delivered. Staff 4 stated the expectations were not communicated to residents and staff in writing and ample food was not always available. 3. On 4/6/26 at 11:45 AM, Staff 10 (Cook) was observed to serve food with a team of staff to the residents on the second floor. After the meal service was completed and before 1:00 PM, staff requested lunch from the remaining food.On 4/8/26 at 11:27 AM, Staff 4 (Dietary Manager) stated staff were to request food two hours before meal service to ensure sufficient food was prepared. Staff 4 stated if food ran out before the end of meal service, she expected staff to find out (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what food was requested and prepare more food. Staff 4 stated alternative food options were verbally made known to residents when needed and the expectation was to prepare two to three extra servings each meal to ensure sufficient food for residents. On 4/8/26 at 12:20 PM lunch meal service began. A sample tray was requested to include a hamburger patty with gravy. On 4/8/26 at 1:02 PM, the sample tray was assembled and did not include a hamburger patty with gravy. Staff 4 stated she did not serve the last hamburger patty because it was dry and not edible and acknowledged it was the last serving. Staff 4 stated a substitute should be offered. On 4/9/26 at 9:56 AM, Staff 11 (Dietary Aide) stated staff were aware CNAs had complaints from residents who requested additional food during meal service. Staff 11 stated sufficient food supplies were sometimes not pulled from the freezer to thaw and prepare for the meal.On 4/10/26 at 11:17 AM, Staff 4 (Dietary Manager) acknowledged the expectation was to provide residents the food on the menu for one hour once food trays were delivered. Staff 4 stated the expectations were not communicated to residents and staff in writing and ample food for residents was not always available. On 4/10/26 at 2:42 PM, Staff 2 (DNS) expected alternative food options to be available when there was not enough food from the menu or when requested by residents.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review it was determined the facility failed to provide education to residents and monitor personal food safety for 1 of 3 sampled residents (#13) reviewed for food. This placed residents at risk for food borne illnesses. Resident 13 was admitted to the facility in 10/2024 with diagnoses including diabetes and heart failure. A 3/2022 Foods Brought by Family/Visitors policy indicated the following:-Safe food handling practices were to be explained to family and visitors in a language and format they understand.-Food left with the resident to consume later was to include a label of the item, the use by date, and stored in the refrigerator.-The nursing staff was to discard perishable foods on or before the use by date. A 11/6/25 Annual MDS revealed a BIMS assessment score of 14 (cognitively intact) for Resident 13. On 4/7/26 at 9:00 AM, Resident 13 stated her/his private refrigerator in her/his room was not monitored. The temperatures was observed at 42 degrees. Inside the bottom of the refrigerator black debris was observed with drops of liquid on the inside wall of the refrigerator. The contents of the refrigerator included: undated and opened hotdogs, unmarked bowls of fruit with contents exposed, and jam with an expiration date of 11/2024. Resident 13 stated she/he was not opposed to eating the food in her/his refrigerator. On 4/8/26 at 11:27 AM, Staff 4 (Dietary Manager) stated kitchen staff did not monitor the food in resident refrigerators and was unaware who provided residents with the Food Brought by Family/Visitors policy. On 4/8/26 at 5:03 PM, Staff 7 (LPN) did not know of any available policy related to food brought from outside the facility for residents. Staff 7 stated nursing was to check the temperatures of refrigerators in resident rooms. She did not know she was to look for expired food. Staff 7 stated she knew Resident 13 had a refrigerator in her/his room and confirmed the refrigerator was not routinely monitored because the task to monitor was not on a list. On 4/8/26 at 5:12 PM, Staff 5 (Business Office Manager) stated the information in the Resident Handbook Nursing Facility covered rules and rights of residents that were discussed with each resident at admission. Staff 5 stated she was not aware of a policy on Food Brought by Family/Visitors or of food in resident rooms. On 4/8/26 at 5:19 PM, Staff 3 (Regional Nurse Consultant) confirmed the facility did have a policy related to food brought in by family and expected a review of the policy with residents during the admission process. On 4/9/26 at 1:12 PM, Staff 4 stated the last time she checked on resident refrigerators was in 10/2025 when she provided temperature log sheets for nursing. Staff 4 stated it was understood that each resident was responsible for their own refrigerator and contents. Staff 4 acknowledged resident food was to be dated and discarded timely and the task was not getting done. On 4/10/26 at 9:21 AM, Staff 3 acknowledged the facility did not follow their own policy related to resident food safety and food brought in by family and visitors. Staff 3 expected education for all staff on the Food Brought by Family/Visitors policy and food safety expectations. On 4/10/26 at 1:48 PM, Staff 21 (Activities Assistance) was observed to deliver food to a resident's room. Staff 21 stated she was not aware of any policy related to food safety in resident's rooms or food brought in by family or visitors.