STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385031	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Crestview of Portland	6530 SW 30th Avenue Portland, OR 97239

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on observation and interview it was determined the facility failed to maintain a homelike environment for 4 of 7 facility halls reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include: Observations of the facility's general environment and residents' rooms from 9/9/24 through 9/13/24 identified the following issues: -Rooms 20, 23, 24, 27, 33, 35, 36, 38, 40, 45, 46, 49, 60, 61, 62, 64, 65, 66, 68 and 69 had resident doors with missing pieces of wood with sharp/jagged edges on the lower portions of the doors. -Rooms 61, 64, 65, 68, 69, 71 and 78 had walls where the in room sinks were with gouges along the walls, missing paint and exposed drywall. -room [ROOM NUMBER]-1 had a chunk of missing paint on the wall behind the resident bed. -room [ROOM NUMBER] had broken blinds and a jagged edge with missing paint and exposed drywall behind the resident door. -room [ROOM NUMBER]-1 had large scratches to the right of the head of bed and across the room from the foot of the bed. -room [ROOM NUMBER] had wall base peeling away from the wall next to the bathroom and the wall to the left of the resident door was gouged with missing paint, exposed drywall and had multiple missing chunks out of the blinds. -Carpet outside rooms [ROOM NUMBERS] was rippled approximately six feet by six feet causing a potential tripping hazard. -Carpet was pulled away from the wall base outside Rooms 17, 22, 23 and 46. -Carpet was pulled away from the wall base at nurses station 2 along with a sharp/jagged edges along the entryway with missing paint and exposed drywall. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurses station 1 had sharp/jagged edges along the lower portion of the entryway with pieces of wood that had separated. -The alcove adjacent to Hall 70 had two dirty light fixtures and two faux [NAME] chairs with exposed substrate fabric which was uncleanable and stained. -Blinds in the main dining room leading to the Activity Director's office had multiple missing and broken slats. -The entryway to the main dining room from the 300 Hall had a sharp/jagged wall edge with missing paint and exposed drywall approximately five feet up the wall. On 9/13/24 at 10:37 AM Staff 1 (Administrator) and Staff 8 (Maintenance Director) acknowledged the identified rooms were not homelike and the identified maintenance concerns needed to be repaired.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 47001 Based on interview and record review it was determined the facility failed to ensure a recapitulation of the resident's stay was completed accurately for 1 of 2 sampled residents (#261) reviewed for discharge. This placed residents at risk for unmet discharge needs. Findings include: Resident 261 was admitted to the facility in 12/2023 with diagnoses including hemiplegia (inability to move) of the right dominant side. A 1/1/24 Progress Note indicated Resident 261 had two pressure ulcers noted on her/his right and left buttock. A 2/8/24 Progress Note indicated Resident 261 had multiple superficial open areas and excoriation noted to buttocks. A review of Physician Orders indicated Resident 261 had a 2/28/24 order to apply calmoseptin barrier cream daily and as needed to Resident 261's buttocks. A 3/14/24 Discharge Skin Summary stated Resident 261 had no skin impairments at time of discharge. A 3/14/24 Discharge Summary stated Resident 261 had treatment orders for A&D cream to bilateral lower extremities with no evidence of any other treatment orders. A 3/19/24 Discharge MDS stated Resident 261 did not have any pressure ulcers. A 3/20/24 public complaint indicated Resident 261 was discharged to an adult foster home on 3/19/24 with a wound to her/his buttocks. A picture of the wound was sent with the complaint in an email dated 3/20/24 which shows open areas on the right and left buttock. On 9/9/24 at 6:27 PM Witness 1 (Complainant) stated the facility said Resident 261 had no skin issues. On 9/9/24 at 6:30 PM Witness 2 (Representative) identified herself as an RN and stated the nursing facility stated Resident 261 did not have any skin issues upon discharge. Witness 2 stated she observed Resident 261's coccyx on 3/19/24 at the adult foster home and Resident 261 had a stage 2 pressure ulcer to her/his coccyx. On 9/9/24 at 6:36 PM Witness 3 (Representative) stated Resident 261 was discharged to her adult foster home facility on 3/19/24. Witness 3 stated the nursing facility informed her Resident 261 did not have any skin issues. Witness 3 stated when Resident 261 admitted , she/he had wounds to her/his coccyx area. On 9/12/24 at 10:35 AM Staff 13 (RNCM) stated she did not remember if Resident 261 had any pressure wounds, she thought the resident may have had excoriation to her/his bottom. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:44 AM Staff 12 (LPN Resident Care Manager) stated Resident 261 had orders for barrier cream to her/his bottom upon discharge. Staff 12 stated she did not recall if Resident 261 had pressure ulcers. On 9/12/24 at 10:55 AM Staff 5 (Social Services) stated Resident 261 did not discharge with orders for home health wound care and the discharge instructions did not include wound care. Staff 5 stated home health nursing for wound care would have been ordered for Resident 261 if she had been aware of the need. On 9/12/24 at 2:22 PM Staff 23 (LPN) stated she assessed Resident 261's wounds in 1/2024 after the wounds were discovered. Staff 23 stated Resident 261 did not have a pressure ulcer at that time, but she/he had moisture associated damage to her/his buttocks. On 9/12/24 at 2:29 PM Staff 16 (RNCM) stated there was no wound assessment documentation for Resident 261's wounds.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47001 Based on observation, interview, and record review it was determined the facility failed to assess pressure ulcers and update care plans for 1 of 2 sampled residents (#19) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: 1. Resident 19 was admitted to the facility in 2016 with diagnoses including a stroke. A 9/10/24 review of Resident 19's physician orders revealed an 8/23/24 order for her/his right ear to clean with normal saline, pat dry, leave open to air and monitor for signs of infection every day for a pressure sore. A 9/10/24 review of Resident 19's care plan revealed no evidence of a care plan for Resident 19's pressure ulcer on her/his right ear. A 9/10/24 review of Resident 19's medical record revealed no evidence of a wound assessment of her/his right ear pressure ulcer. On 9/11/24 at 10:04 AM Resident 19 was observed to have a wound on the front, external part of her/his right ear. The wound was red, raised and had a scab on it. The wound had the appearance of a stage 2 pressure ulcer (a wound with partial thickness loss of the first layer of skin caused by pressure). On 9/12/24 at 10:21 AM Staff 12 (LPN Resident Care Manager) stated Resident 19's wound on her/his right ear occurred due to Resident 19 not being able to reposition her/himself causing pressure on the right ear. Staff 12 stated Resident 19's wound should be but was not in her/his care plan. Staff 12 stated wounds are assessed weekly but was unable to locate a wound assessment for Resident 19's right ear pressure wound. On 9/12/24 at 10:30 AM Resident 19's wound was observed with Staff 12. Staff 12 stated the wound appeared to be a stage 2 pressure ulcer and she was going to have the wound nurse assess the wound on 9/12/24 so weekly wound assessments and appropriate treatment will get done right away.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate care and services related to enteral (tube) feeding for 1 of 4 sampled residents (#28) reviewed for nutrition. This placed residents at risk for nutritional complications and weight loss. Findings include: The facility's 11/2018 Enteral Tube Feeding via Continuous Pump Policy and Procedure revealed the following: -Check the label on the enteral formula against the physician order (prior to starting the feed). -Hang the feeding bag on the IV (intravenous) pole and label initials, date and time the formula was hung/administered and initial that the label was checked against the order directly on the formula bag. Resident 28 was readmitted to the facility in 7/2024 with diagnoses including dysphagia (difficulty swallowing foods or liquids). Resident 28's 7/7/24 Admission MDS revealed the resident was moderately cognitively impaired, had a feeding tube and received more than 51 percent of her/his calories by way of tube feeding. Resident 28's 8/26/24 Physician Orders directed the resident to receive Nutren 2.0 (a calorically-dense and nutritionally-complete tube-feeding formula) at an infusion rate of 75 ml per hour for eight hours to provide 1500 calories, one time a day. The tube feed was to start at 8:00 PM. A review of Resident 28's 9/2024 TAR revealed the resident received 600 ml of Nutren 2.0 each day. On 9/9/24 at 1:02 PM Resident 28 was observed in her/his room in bed with her/his nasogastric tube (a tube inserted through the nose, down the throat and esophagus and into the stomach and used to give drugs, liquids and liquid food) in place. Resident 28 stated her/his tube feed started at night and finished early in the morning. At this time, a partially used and undated bag of Nutren 2.0 was observed to hang from the resident's IV pole. The bag indicated the formula contained two calories per ml. On 9/11/24 at 9:42 AM Staff 21 (LPN) stated he labeled a resident's feeding bag with his initials, the date and what time he connected the tubing to the feeding bag each time he started a resident's tube feed. Staff 21 stated he would dispose of a feeding bag as soon as a resident's tube feed finished. Staff 21 further stated Resident 28 was supposed to receive 1500 calories from the tube feed each night and 600 ml equaled 1500 calories. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 10:36 AM Staff 2 (DNS) and Staff 16 (Regional Nurse Consultant) observed an unused bag of Resident 28's Nutren 2.0 and stated 600 ml of Nutren 2.0 was equivalent to 1200 calories. Staff 16 reviewed Resident 28's TAR and confirmed the resident received 1200 calories per day and she/he should receive 1500 as ordered by her/his physician. Staff 16 further stated she expected staff to remove the used feeding bag from the resident's room when the tube feed finished and formula bags should be dated upon use.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview, and record review it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for 5 of 14 sampled residents (#s 7, 20, 34, 46 and 51) reviewed for behaviors, communication and sensory care, dental and PASARR. This placed residents at risk for unmet needs and decreased dignity. Findings include: The facility's 9/2004 Social Services Program Policy and Procedure revealed the following: -The social services program shall assist facility staff, family and friends of the resident to help meet the resident's personal and emotional needs. -Duties of the social services department include assessing the psychosocial and emotional needs of each resident, developing interventions to address residents' needs and preferences to ensure or enhance quality of life and dignity, making referrals as needed and documenting the outcomes and assisting each resident in obtaining appropriate clothing. 1. Resident 7 was admitted to the facility in 9/2020 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 7's 9/24/20 Social History indicated the resident had a military history and she/he was exposed to Agent Orange (a chemical herbicide and defoliant) when she/he served in the Vietnam War. Resident 7's 8/11/24 Quarterly MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 7's clinical record to indicate the resident's mental and psychosocial needs were comprehensively assessed, including an assessment of the resident's trauma and potential trauma triggers. On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated she started completing trauma assessments for residents in 7/2024, and because Resident 7 admitted to the facility prior to this date, the resident's trauma was not assessed. On 9/13/24 at 12:45 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 2. Resident 34 was admitted to the facility in 10/2023 with diagnoses including Post-traumatic stress disorder (PTSD). Resident 34's 10/5/24 Social History indicated the resident was a Vietnam War Veteran and had a diagnosis of PTSD. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 34's 10/9/23 Admission MDS indicated she/he was visually severely impaired, experienced moderate difficulty hearing, was usually able to make her/himself understood to others, required substantial-to-maximal assistance for upper body dressing and was dependent on staff for lower body dressing. The MDS also indicated it was somewhat important to the resident to be able to choose what clothes she/he wanted to wear. A 4/7/24 Personal Inventory Record revealed the resident had one hat, one gray t-shirt, one pair of red sweats and one pair of shoes. On 9/9/24 at 12:36 PM Resident 34 was observed in her/his room in bed with the lights off dressed in a hospital gown. Resident 34 stated she/he suffered from PTSD as a result of her/his service in the Army. Resident 34 stated no one at the facility had ever discussed with her/him the cause of her/his PTSD or potential triggers for re-traumatization and she/he was interested in talking to someone. Resident 34 stated her/his hearing was fair and she/he had never been offered the opportunity to have an auditory consult or obtain a hearing device and stated she/he was interested in both. Resident 34 further stated it was not her/his preference to wear a hospital gown, staff did not offer to assist her/him to get dressed, she/had been told that she/he did not have any clothes and no one at the facility had ever offered to assist her/him to obtain clothing. At this time, the only clothing items present in the resident's closet were two pairs of pants. No evidence was found in Resident 34's clinical record to indicate an assessment of the resident's trauma was completed, a care plan was developed to address the resident's potential trauma triggers, an auditory consult, or resources to obtain a hearing aid or hearing appliance were offered to the resident or any attempt had been made to assist the resident to obtain clothing items. On 9/11/24 at 10:58 AM and 12:18 PM Staff 5 (Social Services Director) stated resident trauma assessments were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. Staff 5 stated she started completing trauma assessments for residents in 7/2024, and because Resident 34 admitted to the facility prior to this date, she/he did not receive a trauma assessment. Staff 5 further stated she had not offered the resident an opportunity to have her/his hearing evaluated or assisted her/him to obtain clothing items. On 9/13/24 at 12:45 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 43690 3. Resident 51 was admitted to the facility in 6/2024 with diagnoses including Post-traumatic stress disorder (PTSD) and anxiety. Resident 51's 6/17/24 Admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. No evidence was found in Resident 51's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 10:58 AM Staff 5 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. Staff 5 stated she started completing trauma screenings for residents in 7/2024, and because Resident 51 admitted to the facility prior to this date, she/he did not receive a trauma screening. On 9/13/24 at 11:46 AM Staff 1 (Administrator) and Staff 16 (Regional Nurse Consultant) acknowledged the findings of this investigation. 50928 4. Resident 20 was admitted to the facility in 2016 with diagnoses including dementia. Resident 20's Social Determinants of Health assessment dated [DATE] indicated the primary language for Resident 20 was Laotian or Thai and the resident preferred to have an interpreter when communicating with physicians and health care staff. On 9/12/2024 at 11:40 AM Staff 5 (Social Services Director) stated she had not arranged or assisted to provide for communication needs through Resident 20's primary language. 5. Resident 46 was admitted to the facility in 5/2024 with a diagnosis including severe protein calorie malnutrition. On 9/10/2024 Resident 46 stated he wanted new dentures because it would make eating easier. On 9/11/2024 at 2:57pm Staff 5 (Social Services Director) stated she had not arranged or offered services to Resident 46 regarding her/his dental needs.