STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385121	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Health Center	3320 SE Holgate Blvd Portland, OR 97202

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 0661 Level of Harm - 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. 38139 Based on interview and record review, the facility failed to complete a discharge summary with required information for wound care and possible wound infection for 1 of 1 sampled resident (# 17) reviewed for unsafe discharge. The facility's failure to provide instructions for the care of the wound and the possible wound infection in the discharge summary information caused the resident's wound to worsen at home resulting in re-admission to a hospital. Findings include: Resident 17 was admitted to the facility in 5/2024 with diagnoses including hip fracture with surgical repair, heart failure, and a history of falling. Resident 17's care plan dated 5/14/24 indicated the resident required frequent skin inspections. Staff were to observe for redness, open areas, scratches, cuts, bruises, and report changes. Resident 17 was also at risk for developing pressure injuries and new skin issues related to her/his right hip fracture from a ground level fall. A hospital Discharge Summary dated 5/14/24 directed the following: follow up with orthopedic surgeon for post operative care, X-ray and staple removal on 5/27/24 and complete INRs (blood test) per facility protocol while on Warfarin. Resident 17 was subsequently discharged from the nursing facility on 6/3/24. At that time, the surgical staples had not been removed, there was no evidence a timely follow-up appointment with the orthopedic surgeon, and an INR scheduled for 6/3/24 was not completed. Resident 17's Weekly Skin Evaluation dated 5/28/24 at 9:38 AM listed the resident's wounds and skin issues as including the following: -Superior incision to the right hip with 9 staples intact. Scant serosanguinous (fluid with small amount of blood) drainage noted. -Inferior incision to the right hip with slough (dead tissue within a wound) and 14 staples intact. Scant serosanguinous (fluid with blood) drainage noted. -Anterior incision to the right thigh with 2 staples intact. 1 staple had fallen out. (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 0661 Level of Harm - Actual harm Residents Affected - Few	-More posterior incisions to the right thigh, one with 3 staples intact and another with 2 staples intact. Mild redness noted to staples of all incisions, no abnormal warmth, periwound with moderate bruising and swelling. The resident complained of pain related to the incisions. -Right hip with moderate bruising and swelling. -Scattered scabbing and bruising. -MASD (moisture associated skin damage) to the rectum. -New: mild rash to both axilla (armpits). -Right shin, calf and foot with increased redness and warmth -3+ pitting edema to both flanks, hips, and thighs. -Monitor redness and warmth to the right lower extremities (alert charting) On 5/28/24 at 9:53 AM Staff 25 (LPN) wrote a note to the provider: Resident 17's right shin, calf and foot had increased redness, warmth, and pain. The resident was also noted with new 3+ pitting edema (swelling) to bilateral flanks, hips & thighs. Please assess. On 5/29/24 at 10:01 PM an Alert Note indicated the resident remained on alert to monitor redness and warmth to right lower extremities. On assessment, redness was noted to the right lower extremity, right upper quadrant, and the right lower quadrant. On 5/29/24 at 2:58 PM Staff 27's (Provider) progress note indicated the right lower extremity was no longer warm but still with redness. Please contact surgeons' office and alert them of the change. Did the patient have a follow-up appointment with the surgeon? On 5/29/24 at 2:59 PM Staff 27's (Provider) additional progress note included: The resident's right leg seems somewhat improved today but right lower incision with slough. Continue to monitor closely and alert providers if warmth returns or further concerns. Would like to defer to surgeons' office if able but please call if not able to get a return call within 24 hrs or there is worsening of condition. Discharge Condition: Guarded. Resident 17 will need close follow up. Discharge Instructions: The facility was to provide instructions upon discharge. Home Health needs: Nursing, Physical Therapy, Occupational Therapy Follow up Appointments: Follow up with PCP and specialists upon discharge. Erythema noted to the RLE. Continue to monitor. Continued slough in the lower incision to the right lateral thigh. The resident will need to follow up with surgeon. (continued on next page)

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F 0661 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's 5/31/24 Discharge Instructions Tool revealed the discharge tool was not complete and failed to include the following required information: -No facility physician, Primary Care Physician (PCP), or pharmacy information was included and no contact information was provided. -The In-Home Care section listed To Be Determined. A Home Health Agency was not identified, home health needs were not listed, and no appointments were set up for the resident. Per a medical provider progress note the resident required: Nursing, Physical Therapy, and Occupational Therapy Home Health upon discharge. -No medication education was provided to the resident or representative. -Prevention and Disease Management education was not provided. -COVID testing and Vaccination information was not provided. -A Brief Medical History and Review of Reason for Admission was not included. - Current treatments, Therapies, and Education provided: there was only one note present which directed to follow up with hospital ACC (Anticoagulation Clinic) as an INR was due that day. No provider was identified for the follow up INR which was due that day. The resident discharged after 3:30 PM but the INR due that day was not completed by staff. -No infection information was included in the Discharge Tool. On 5/28/24 Staff 25 (LPN)identified lower extremity redness, warmth, and pain. The concern for those symptoms would be a possible infection in the wound. There was no follow-up by staff related to the possible infection and no wound care information or instructions were provided to the resident or family at discharge. The Discharge Tool revealed no information related to the following: mobility level, transfer status, scheduled appointments or tests, or barriers to discharge. A 6/3/24 at 3:27 PM progress note indicated the resident discharged home at 3:30 PM via medical transport. A facility Discharge Summary dated 6/3/24 signed by the physician on 6/15/24 (12 days later) contained a final diagnosis and a summary of the treatment provided but was not given to the resident at the time of discharge. A 6/5/24 hospital Emergency Department discharge to hospital Neurotrauma ICU Admission report included the following information: -The resident's family brought the resident into the hospital because she/he had become more lethargic over the last 24 hours and they were concerned about infection in her/his hip. The resident had discharged to home two days prior on 6/3/24 from a skilled nursing facility. -Resident 17 was admitted with a post-operative wound infection and persistent encephalopathy (brain disease which alters brain function or structure). The resident had a progressive and notable decline in mental and functional status over the last few months. (continued on next page)

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F 0661 Level of Harm - Actual harm Residents Affected - Few	-Recent right neck fracture with surgical intervention. Recovered at a skilled nursing facility but did not have follow-up with Orthopedic surgeon. Staples remained in place and per report should have been removed 10 days postoperative. Surgical sites with erythema (redness), exudates (oozing fluid or pus), induration (hardening of soft tissue). Orthopedic surgery consults for evaluation of surgical sites, with follow-up surgical swab completed and now growing Gram-positive bacteria and Gram-negative bacteria. The resident was started on an antibiotic and further antibiotics would be determined pending speciation (formation of new species of bacteria) -SKIN: The resident's skin was pale, warm, dry, with multiple areas of wounds over the chest wall, abdomen, buttock, bilateral arms, and fingertips. The right hip surgical wounds were reviewed and staples remained in place. Upper linear wound with significant drainage. The lower vertical lateral wound had sutures still in place with exudates and some wound dehiscence (wound reopened) and erythema. -Wound History: break in the right femoral neck. Surgical site infection with wound dehiscence. A 6/10/2024 hospital Intraoperative Wound note indicated a right hip irrigation and debridement was performed by the surgeon. On 7/3/24 at 12:30 PM Witness 10 (Family member) stated when the resident discharged home her/his mentation was very different from her/his baseline and her/his physical condition had deteriorated. Witness 10 said the resident was home less than 48 hours when they had to send her/him to the hospital. The resident broke her/his hip on 5/6/24 and the staples should have been removed within 2-3 weeks but they were never taken out and both large incisions were swollen and weeping. The lower incision staples were zigzagged and there were pitted holes along the suture line. When the resident went back to the hospital on 6/5/24, she/he had surgery again to open the wound and flush out an infection. The facility staff did not provide any oral or written communication for wound care or follow up for the possible infection to the resident or family. No plan of care was provided when the resident discharged and Witness 10 said she was completely unprepared for how to care for the resident. On 7/25/24 at 2:23 PM Staff 3 (RNCM) acknowledged the Discharge Tool for Resident 17 was not completed thoroughly. A copy of the completed Tool was supposed to go home with the resident. Staff should be using the Tool which was in place. The resident did not receive all the information required for discharge. On 7/29/24 at 12:38 PM Staff 25 (LPN) stated Resident 17's surgical wounds were draining since admission. There was no follow-up provided with the surgeon while the resident was at the facility. Staff 25 said staff called the surgeon for an urgent appointment but for after the resident discharged . The incision staples were not removed. Staff 25 stated staff must have missed the staple removal order on the admit orders. The admit orders also indicated a surgical follow-up appointment was needed in 3 weeks. Staff 25 said no appointment was mentioned, or the need to make an appointment, in the Discharge Tool. Staff 25 also stated when she looked at the Discharge Tool there were no instructions for the resident's wound care or possible infection and wound care information should have been in the discharge paperwork. On 7/30/24 at 1:08 PM Staff 2 (DNS) acknowledged the Discharge Summary Tool was not complete, thorough or contain the required information for the resident's discharge which should have included wound care instructions and follow-up for the possible wound infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33179 Based on interview and record review it was determined the facility failed to follow physician orders and provide correct oxygen administration for 1 of 3 sampled residents (#12) reviewed for physician orders. This placed residents at risk for improper oxygen administration. Findings include: Resident 12 admitted to the facility in 8/2020 with diagnoses including diabetes and kidney disease. 1. The 3/26/24 Hospital After Visit Summary revealed an order to increase Resident 12's oxygen via nasal cannula to 3/lpm (liters per minute). The March 2024 TARS revealed the following dates and shifts when oxygen was administered incorrectly: -3/26/24 night shift - 2/lpm -3/30/24 day, evening and night shift - 4/lpm -3/31/24 day and evening - 4/lpm On 7/23/24 at 12:15 PM Staff 15 (LPN Resident Care Manager) verified Resident 12's oxygen administration orders were not followed on 3/26/24, 3/30/24 and 3/31/24. 2. The RN Educator website instructed a (regular) oxygen face mask was used for oxygen flow rates from 6 - 12/lpm. A minimum of 6/lpm of oxygen flow was needed to prevent re-breathing of exhaled carbon dioxide. The 3/26/24 Hospital After Visit Summary revealed an order to increase Resident 12's oxygen via nasal cannula to 3/lpm. The 3/26/24 Progress Note revealed Resident 12 complained of difficulty breathing, her/his O2 sat was 88% - 92% (normal range is 95% - 100%), and the resident's oxygen was increased to 3/lpm via face mask. The 4/10/24 Progress Notes revealed the following: -2:44 PM: The previous shift placed Resident 12 on oxygen at 3/lpm via face mask. -2:44 PM: The oxygen flow rate was increased to 4/lpm via face mask. -3:37 PM: Resident 12 requested to use a nasal cannula, her/his current O2 sat was 85% on 4/lpm which was above her/his current O2 order, and the resident would not wear the face mask because she/he was unable to breathe. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3:56 PM: Resident 12 refused to wear the face mask and her/his O2 sat was 85% on 4/lpm via nasal cannula. The resident requested and was transferred to the hospital. On 7/24/24 at 11:40 AM Staff 19 (RN) verified she incorrectly placed an oxygen face mask on Resident 12 on 3/26/24. On 7/23/24 at 12:15 PM Staff 15 (LPN Resident Care Manager) verified Resident 12 was placed on an oxygen face mask incorrectly on 3/26/24 and 4/20/24.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 33179 Based on interview and record review it was determined the facility failed to ensure licensed nursing staff possessed the competencies and skill sets necessary related to oxygen administration for 1 of 3 sampled residents (#12) reviewed for physician orders. This placed all residents at risk for unsafe oxygen administration. Findings include: The RN Educator website instructed a (regular) oxygen face mask was used for oxygen flow rates from 6 - 12/lpm (liters per minute). A minimum of 6/lpm of oxygen flow was needed to prevent the rebreathing of exhaled carbon dioxide. Resident 12 admitted to the facility in 8/2020 with diagnoses of diabetes and kidney disease. Resident 12's 3/26/24 Progress Note revealed she/he complained of difficulty breathing, her/his O2 sat was 88% - 92% (normal range is 95% - 100%), and the resident's oxygen was increased to 3/lpm via face mask. The 4/10/24 Progress Notes revealed the following: -2:44 PM: The previous shift placed Resident 12 on oxygen at 3/lpm via face mask. -2:44 PM: The oxygen flow rate was increased to 4/lpm via face mask. -3:37 PM: Resident 12 requested to use a nasal cannula, her/his current O2 sat was 85% on 4/lpm which was above her/his current oxygen order, and the resident would not wear the face mask because she/he was unable to breathe. -3:56 PM: Resident 12 refused to wear the face mask and O2 sat was 85% on 4/lpm via nasal cannula. The resident requested and was transferred to the hospital. On 7/24/24 at 11:40 AM Staff 19 (RN) verified she incorrectly placed an oxygen face mask on Resident 12 on 3/26/24. Staff 19 stated she now realized a minimum of 6/lpm was necessary when the face mask was utilized and she did not know what happened to a resident when less than 6/lpm was used. On 7/23/24 at 12:15 PM Staff 15 (LPN Resident Care Manager) verified Resident 12 was placed on an oxygen face mask incorrectly on 3/26/24 and 4/20/24. Staff 15 stated she did not know what the minimum oxygen requirement was to utilize a face mask, did not know what would happen to a resident when less than 6/lpm was used and had never received oxygen administration training from the facility. On 7/30/24 at 10:05 AM Staff 5 (LPN, Staff Development) acknowledged the facility nursing staff required more training on oxygen administration use. Refer to F695

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 33179 Based on observation, interview and record review it was determined the facility failed to ensure wheelchairs were clean and sanitary for 1 of 3 sampled residents (#13) reviewed for equipment. This placed residents at risk for unclean wheelchairs. Findings include: Resident 13 admitted to the facility in 11/2019 with diagnoses including multiple sclerosis (disease which deteriorates the brain and spinal cord) and paraplegia (lower body paralysis). On 7/22/24 at 10:59 AM Resident 13's wheelchair was observed to have crumbs on the bottom cushion and small (approximately 1 inch by 1 inch) brown smudge marks to the bottom cushion and the inside of the left armrest. On 7/24/24 at 10:46 AM Resident 13's wheelchair was observed to have crumbs and a small brown smudge (approximately 1 inch by 1 inch) on the bottom cushion. On 7/26/24 at 12:30 PM Resident 13's wheelchair was observed to be dirty with crumbs on the bottom cushion. [The wheelchair did not appear to be cleaned as documented in the July 2024 TARS.] Resident 13's July 2024 TARS revealed her/his wheelchair was to be cleaned monthly and as needed. The task was documented as completed on 7/26/24. The 4/30/24 Resident Council Notes revealed the residents felt their wheelchairs were either getting dirty or already very dirty and requested the wheelchairs be on a cleaning schedule. The 6/25/24 Resident Council Notes revealed the residents asked to have their wheelchairs cleaned and to start a cleaning schedule. On 7/24/24 at 10:46 Staff 28 (Agency CNA) verified Resident 13's wheelchair had crumbs over the bottom cushion and a small brown smudge mark to the bottom cushion. On 7/24/24 at 10:50 AM Resident 13 stated the facility does not keep her/his wheelchair clean and it was currently dirty. On 7/26/24 at 12:30 PM Staff 29 (LPN) and Staff 15 (LPN Resident Care Manager) verified the wheelchair was dirty. Staff 29 verified she documented the wheelchair was cleaned although she had not cleaned it.