

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of King City		STREET ADDRESS, CITY, STATE, ZIP CODE 16485 SW Pacific Highway Tigard, OR 97224	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to ensure there were sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet care needs. Findings include:</p> <p>The facility's 10/2019 Staffing Policy indicated the facility provided an on-going review of resident acuity and ensured adequate staffing to meet scheduled and unscheduled needs of the residents.</p> <p>1. A review of the Resident Council notes revealed the following:</p> <ul style="list-style-type: none"> -The 9/2024 Resident Council notes revealed resident concerns about call light wait times. -The 10/2024 Resident Council notes revealed residents call lights were deactivated without providing care. -The 12/2024 Resident Council notes revealed residents stated the 300 Hall required heavy care. The residents felt more staff was needed and the residents stated they had to wait a long time for food trays to be removed. <p>The facility's 9/2024 through 12/2024 Direct Care Staff Daily reports revealed the facility was understaffed for CNAs for 39 of 116 days reviewed for the state minimum staffing requirements.</p> <p>On 1/7/25 the facility had a census of 60 residents. On 1/7/25, Staff 1 (Administrator) provided a list of residents who:</p> <ul style="list-style-type: none"> -Required two-person mechanical lift transfers:16; -Were dependent for ADLs: 13; -Were considered high fall risks: 21 and -Were at risk for elopement: 3 <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/9/25 at 2:45 PM Staff 20 (Scheduling Coordinator) confirmed, from 9/7/24 through 12/31/24, CNA staffing was short on many shifts.</p> <p>On 1/10/25 at 1:32 PM Staff 1 (Administrator) acknowledged the facility struggled to maintain adequate staffing levels and made efforts to meet the state minimum CNA requirements.</p> <p>2. On 10/22/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs resulting in long call light response times and basic care not being met.</p> <p>On 10/25/24 three public complaints were received by the State Agency which alleged the facility was short staffed CNAs on 9/28/24, 10/6/24 and 10/7/24 resulting in decreased quality of care, requests not met timely, safety of residents at risk for a fall, and long call light response times. It was reported that residents were anxious, agitated, and worried they would not receive the care they needed.</p> <p>On 12/26/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs on 12/24/24 and 12/26/24 resulting in residents not receiving showers and long call light response times.</p> <p>On 12/30/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs resulting in residents not receiving showers, lack of timely incontinence care and long call light response times of over an hour.</p> <p>On 1/7/25 at 11:26 AM and 11:35 AM Staff 23 (CNA) and Staff 3 (CNA) stated the evening shift often ran short staffed CNAs. Staff 23 stated several residents required two person assistance and some residents were at risk for elopement. Staff 3 stated residents' scheduled showers often were not completed when the facility ran short staffed.</p> <p>On 1/7/25 at 1:34 PM, 3:19 PM and 3:36 PM Staff 10 (CNA), Staff 17 (CNA) and Staff 16 (CNA) stated when the facility ran short staffed CNAs on the evening and night shifts they were directed to provide residents with basic care, which resulted in increased behaviors from residents.</p> <p>On 1/8/25 at 2:32 PM Staff 24 (RN) stated the night shift on weekends ran short staffed of CNAs and there were several residents who are up all night.</p> <p>On 1/8/25 at 2:43 PM Staff 25 (CNA) stated evenings and weekends tended to have longer call light wait times due to the short staffed CNAs.</p> <p>On 1/8/25 at 3:02 PM and at 3:08 PM Staff 26 (CNA) and Staff 14 (CNA) stated due to short staffed CNAs the staff did not receive their scheduled breaks and lunches. Staff 14 stated it was very tough to complete tasks like showers.</p> <p>On 1/9/25 at 10:12 AM Staff 21 (CMA) stated on 12/24/24 the evening shift was short staffed CNAs; only three CNAs arrived for work. Staff 21 stated ADL tasks were not offered and documentation in resident medical records was not completed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/9/25 at 2:45 PM Staff 20 (Scheduling Coordinator) stated she staffed CNAs based on the census and by the CNA mandatory minimum staffing ratios. Staff 20 confirmed, from 9/7/24 through 12/31/24, CNA staffing was short on many shifts.</p> <p>On 1/10/25 at 1:32 PM Staff 1 (Administrator) acknowledged the facility struggled to maintain adequate staffing levels and made efforts to meet the state minimum CNA requirements. Staff 1 stated he was unaware of residents not receiving scheduled showers due to short staffing.</p> <p>3. Resident 6 was admitted to the facility in 2019 with diagnoses including fibromyalgia and diabetes.</p> <p>The 10/26/24 Quarterly MDS indicated Resident 6 was cognitively intact and required substantial assistance with showering.</p> <p>On 12/30/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs on 12/24/24 and 12/26/24 resulting in residents not receiving showers.</p> <p>A review of the 12/2024 shower log revealed the resident was not available and did not receive a shower on 12/26/24, and the last shower received was on 12/22/24.</p> <p>A review of the 12/26/24 progress notes revealed Resident 6 was offered a shower by the CNA and refused.</p> <p>On 1/8/25 at 2:31 PM Witness 2 (Complainant) stated the facility was often understaffed, especially on evening shift. Witness 2 stated Resident 6 did not receive a scheduled shower on 12/26/24 due to short staffed CNAs.</p> <p>On 1/9/25 at 11:40 AM Staff 19 (CNA) stated they worked the evening shift on 12/26/24 and the facility was short staffed three CNAs. Staff 19 stated Resident 6's scheduled shower was not completed due to low staffing and the resident required two-person assistance. Staff 19 stated Resident 6 never refused a shower on 12/26/24.</p> <p>On 1/9/25 at 1:04 PM Resident 6 stated she/he did not receive a shower on 12/26/24 as the facility was short staffed CNAs so the shower was skipped. The resident stated that was a common occurrence.</p> <p>On 1/9/25 at 11:52 AM Staff 2 (Regional RN) confirmed Resident 6 did not receive a shower on 12/26/24.</p> <p>On 1/10/25 at 12:40 PM Staff 22 (RN) stated they worked the evening shift on 12/26/24 and recalled the facility was short staffed CNAs that shift. Staff 22 stated Resident 6 required two-person assistance with showering and that was difficult to complete when they are short staffed.</p> <p>On 1/10/25 at 1:33 PM Staff 1 (Administrator) stated he was unaware of residents not receiving scheduled showers due to short staffing.</p> <p>47005</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident 15 was admitted to the facility in 6/24/24 with diagnoses including urinary tract infection and diabetes.</p> <p>The 12/29/24 Quarterly MDS indicated Resident 15 was cognitively intact and required substantial assistance with showering.</p> <p>On 1/9/25 at 1:08 PM Resident 15 stated her/his shower days were on Tuesdays and Fridays and was unsure if she/he missed any showers.</p> <p>Resident 15's December 2024 shower log revealed the resident received a shower on 12/13/24, refused a shower on 12/17/24, and received showers on 12/20/24 and on 12/27/24. Resident 15 went seven days between showers for two weeks.</p> <p>On 1/10/25 at 11:32 AM Staff 16 (CNA) stated Resident 15 did not receive a shower due to staffing shortage. Staff 16 stated Resident 15 was scheduled for a shower on 12/24/24, however, due to staffing shortage, no scheduled showers were completed on that day.</p> <p>On 1/10/25 at 12:16 PM Staff 2 (Regional RN) stated it was her expectation that all showers were completed as scheduled. If a shower was refused or missed, it would be completed at the next shift or next day. Staff 2 confirmed Resident 15 received three showers in two weeks.</p> <p>50928</p> <p>5. Resident 10 admitted to the facility 2014 with a diagnosis of a stroke.</p> <p>Resident 10's 9/30/24 Annual MDS revealed a BIMS score of 15 (cognitively intact).</p> <p>A review of the updated 12/24/24 Facility Shower Schedule indicated showers were given to Resident 10 on Tuesdays and Fridays.</p> <p>A review of the Documentation Survey Report from 12/2024 revealed a shower were not provided to Resident 10 on 12/24/24.</p> <p>On 1/9/25 at 12:22 PM Staff 16 (CNA) stated they worked the evening shift on 12/24/24 with two other CNAs. Staff 16 stated with three CNAs during the evening and a census of 58 it was impossible to complete ADL tasks for the residents. Staff 16 stated during the evening shift on 12/24/24 showers were not provided to any residents.</p> <p>On 1/9/25 at 12:34 PM Staff 18 (CNA) stated during the evening shift on 12/24/24 showers were not provided to residents due to being understaffed.</p> <p>On 1/10/25 at 12:09 PM Staff 2 (Regional RN) acknowledged a shower was not provided to Resident 10 on 12/24/24. Staff 2 confirmed the expectation for the facility was to offer residents showers as scheduled and if the facility was short staffed the resident must be offered a shower the next day.</p>