STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385132	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of King City	16485 SW Pacific Highway Tigard, OR 97224

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47000 Based on observation, interview and record review it was determined the facility failed to accurately assess a resident's cognition for 1 of 1 sampled resident (#47) reviewed for communication. This placed residents at risk for unassessed needs. Findings include: Resident 47 was admitted to the facility in 11/2023 with diagnoses including dementia. Resident 47's 11/27/23 Admission MDS, 2/27/24 Quarterly MDS and 5/29/24 Quarterly MDS Assessments indicated the resident's preferred language was Vietnamese, and the resident needed or wanted an interpreter to communicate with a doctor or health care staff, was usually able to understand others and was usually able to make her/himself understood. Resident 47's 11/27/23 Admission MDS, 2/27/24 Quarterly MDS and 5/29/24 Quarterly MDS Assessments indicated a BIMS interview was not attempted with the resident as the resident was rarely/never understood. No evidence was found in Resident 47's clinical record to indicate an interpreter was utilized to help assess the resident's cognition during the 11/27/23 Admission MDS, 2/27/24 Quarterly MDS or 5/29/24 Quarterly MDS Assessments . On 7/17/24 at 11:31 AM Resident 47 was observed in her/his room in her/his wheelchair. With the assistance of a Vietnamese translator, Resident 47 stated she/he felt as if no one at the facility understood her/him. On 7/17/24 at 12:24 PM Staff 25 (Social Services Director) stated when she evaluated Resident 47's cognition, she completed a staff assessment instead of using a translator with the resident. On 7/17/23 at 12:36 PM Staff 23 stated he was unaware of Resident 47's preference for an interpreter when communicating with health care staff. Staff 23 confirmed he completed all MDS interviews with the resident in English and without an interpreter. On 7/17/24 at 4:40 PM Staff 2 (DNS) acknowledged the findings and stated she expected staff to utilize a translator during all interactions with Resident 47, especially when completing interviews required for the MDS.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 41458 Based on interview and record review it was determined the facility failed to ensure a Level I PASARR (Preadmission Screening for Individuals with a Mental Disorder and Individuals with Intellectual Disability) was completed for 1 of 1 sampled resident (#45) reviewed for PASARR. This placed residents at risk for inappropriate placement in a nursing facility and a lack of needed services. Findings include: Resident 45 was admitted to the facility in 6/2023 with diagnoses including stroke and schizophrenia (a mental disorder). A review of the resident's electronic health record revealed no evidence Resident 45 had a screening Level I PASARR completed prior to admission. On 7/17/24 at 11:13 AM Staff 11 (Medical Records) and Staff 1 (Administrator) confirmed they were unable to locate a screening Level 1 PASARR for Resident 45.

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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 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. 41458 Based on observation, interview and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 2 of 7 sampled residents (#s 45 and 48) reviewed for ADLs and falls. This placed residents at risk for unmet needs. Findings include: 1. Resident 45 was admitted to the facility in 6/2023 with diagnoses including stroke and schizophrenia (a mental disorder). Resident 45's 6/14/24 Annual MDS indicated the resident required supervision or touch assistance for eating. Resident 45's current Care Plan indicated Resident 45 required one person assistance for eating. Observations from 7/15/24 through 7/18/24 between the hours of 8:00 AM to 4:30 PM revealed Resident 45 ate her/his meals without assistance. On 7/17/24 at 7:43 AM, 7:48 AM and 8:05 AM Staff 9 (CNA), Staff 10 (CNA) and Staff 16 (CNA) reported Resident 45 ate her/his meals without assistance. Staff 9 stated staff set-up Resident 45's tray and then the resident was independent with eating. On 7/19/24 at 8:43 AM Staff 3 (LPN-Care Manager) stated Resident 45 was independent with eating and no longer required one person assistance. Staff 3 stated she expected the care plan to accurately reflect the resident's current level of functioning. 2. Resident 48 was admitted to the facility in 6/2024 with diagnoses including osteomyelitis (inflammation or swelling in the bone caused by an infection) and muscle weakness. A 6/24/24 Fall Investigation indicated Resident 48 required bilateral mobility bars on her/his bed to aid in bed mobility and provide tactile reminders as to where the edge of the bed was in order to prevent Resident 48 from rolling out of bed. A 6/25/24 Physician Order indicated Resident 48 required bilateral mobility bars for bed mobility. A 6/25/24 Safety Device Assessment and Consent indicated Resident 48 consented to have bilateral mobility bars on her/his bed. Resident 48's 6/17/24 Bed Mobility Care Plan indicated Resident 48 assisted staff with turning herself/himself in bed. Resident 48's Fall Care Plan indicated the resident required one person assistance with transfers. There were no care plan interventions reflective of Resident 48's use of bilateral mobility bars to aid in bed mobility or provide reminders as to where the edge of the bed was in order to prevent the resident from rolling out of bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations from 7/15/24 through 7/17/24 between the hours of 8:35 AM to 8:27 PM revealed Resident 45 had mobility bars on her/his bed. On 7/18/24 at 11:09 AM Staff 2 (DNS) confirmed Resident 48's care plan was not revised to reflect the resident's use of bilateral mobility bars and she expected the care plan to accurately reflect the resident's current bed mobility and fall prevention interventions.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services in the area of communication for 1 of 1 sampled resident (#47) reviewed for communication. This placed residents at risk for diminished quality of life and potential decline in their ability to carry out activities of daily living. Findings include: Resident 47 was admitted to the facility in 11/2023 with diagnoses including dementia. Resident 47's 11/27/23 Admission MDS, 2/27/24 Quarterly MDS and 5/29/24 Quarterly MDS Assessments indicated the resident's preferred language was Vietnamese, and the resident needed or wanted an interpreter to communicate with a doctor or health care staff, was usually able to understand others and was usually able to make her/himself understood. Resident 47's 4/11/24 Communication Care Plan indicated the following: -Arrange translator for Vietnamese as necessary to communicate with the resident. -Use the iPad (a small touchscreen computer) at the nurse's station to log in and indicate the language needed. Resident 47's 6/4/24 Comprehensive Plan of Care Review indicated the resident was able to understand very simple instructions and responded at times. On 7/15/24 at 1:09 PM Staff 26 (CNA) stated the facility did not have a translation service available to use with Resident 47. Staff 26 further stated staff asked Resident 47 yes or no questions and the resident usually said yes to everything. On 7/15/24 at 1:13 PM Witness 6 (Family Member) stated Resident 47's native language was Vietnamese and the resident spoke and understood limited English. Witness 6 stated the resident was able to communicate only her/his basic needs in English. On 7/17/24 at 10:19 AM Staff 14 (CNA) stated she thought Resident 47's native language was Taiwanese and did not know if the facility had a translation service available to use when interacting with the resident. Staff 14 stated Resident 47 said yes to everything and there were things [she/he] did not understand. Staff 14 stated she was unaware of the resident's interests and preferences, and since [she/he] got here, it is just room to dining room for meals and back to [her/his] room. On 7/17/24 at 10:45 AM Staff 20 (CNA) stated she never utilized a translation service when interacting with Resident 47. Staff 20 stated Resident 47 was only able to say excuse me, yes, no and usually said nothing. On 7/17/24 at 11:00 AM Staff 27 (CNA) stated she had trouble communicating with Resident 47 because she did not speak Cantonese. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 11:31 AM with the assistance of a Vietnamese translator, Resident 47 stated she/he felt as if no one at the facility understood her/him. Resident 47 further stated no one at the facility had ever asked her/him about her/his likes, interests or preferences. On 7/17/24 at 12:24 PM Staff 25 (Social Services Director) stated she did regular check-ins with Resident 47 in English. Staff 25 stated Resident 47 did not respond appropriately at times or respond at all due to her/his dementia and confirmed her interactions with the resident were exclusively in English. On 7/17/24 at 4:40 PM Staff 2 (DNS) stated she expected staff to utilize the translation service on the iPad all the time when interacting with Resident 47 and acknowledged the resident's communication care plan was unclear.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41458 Based on observation, interview and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 2 of 5 sampled residents (#s 19 and 28) reviewed for ADLs. This placed residents at risk for unmet ADL needs and loss of dignity. Findings include: Resident 19 was admitted to the facility in 1/2017 with diagnoses including respiratory failure with hypoxia (when the respiratory system can not provide adequate oxygen to the body) and major depressive disorder. Observations from 7/15/24 through 7/17/24 between the hours of 8:12 AM and 2:39 PM revealed Resident 19 had numerous hairs, approximately 1/2 inch long, on her/his upper lip and lower portion of her/his chin. Resident 19's 5/16/24 Quarterly MDS indicated the resident had severe cognitive impairment and required substantial to maximal assistance from staff for personal hygiene care which included shaving. On 7/16/24 At 2:39 PM Resident 19 indicated she/he did not like hair on her/his upper lip and chin and she/he wanted the hair removed. On 7/17/24 at 8:13 AM Staff 14 (CNA) stated she had never been instructed to remove Resident 19's facial hair and she did not shave the resident's upper lip or chin hair. On 7/17/24 at 12:36 PM Staff 13 (LPN) confirmed Resident 9 had facial hair on her/his upper lip and lower portion of the chin. Staff 13 stated CNA staff would shave a resident's facial hair if the resident agreed. Resident 19 indicated to Staff 13 that she/he wanted her/his facial hair removed. On 7/18/24 at 8:57 AM Staff 2 (DNS) stated she expected staff to offer Resident 19 the opportunity to have her/his face shaved and to shave the resident if she/he agreed. 43691 2. Resident 28 was admitted to the facility in 2/2019 with diagnoses including obesity and polyneuropathy (damage to nerves in extremities resulting in weakness, numbness and/or pain). A 5/8/24 cognitive assessment indicated Resident 28 had normal cognitive function. A 5/10/24 Care Plan indicated Resident 28 required assistance from two staff members with bed baths. Review of bathing records from 3/2024 through 7/2024 indicated Resident 28 was to receive bed baths twice a week. During this period, Resident 28 was documented to have refused bed baths on the following dates: - 3/7/24, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/11/24, - 4/4/24, - 4/7/24, - 4/28/24, - 5/12/24, - 5/26/24, - 6/16/24 and - 6/23/24. On 7/18/24 at 10:27 AM Staff 12 (CNA) stated multiple residents especially those who required assistance from two member did not receive showers or bed baths during 3/2024 and 4/2024 due to staffing shortages. On 7/19/24 at 9:51 AM Resident 28 stated she/he had refused only two bed baths since she/he was admitted . Resident stated she/he had been told by CNAs a bed bath could not be provided during 3/2024 and 4/2024 because only one staff member was available. On 7/19/24 at 12:18 PM Staff 2 (DNS) confirmed missed showers/bed baths were determined to a problem, potentially due to CNA staffing levels, but was unable to determine if this issued had been resolved. Refer to F725 and M183.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 41458 Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activity program for 3 of 3 sampled dependent residents (#s 9, 24 and 47) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's 2/2005 Activities Policy revealed the facility was to encourage each resident to maintain normal leisure activity. The facility would provide an activities program that addressed the intellectual, social, spiritual, creative and physical needs, capabilities and interests of each resident. The activity program would promote each resident's self-respect by providing activities that supported self-expression and choice. 1. Resident 9 was admitted to the facility in 5/2021 with diagnoses including major depressive disorder and dementia. Resident 9's 6/11/21 and revised 11/16/21 Activities Care Plan indicated the following: -Resident 9 liked music, pet therapy, visiting with the chaplain, gardening, flowers and birds. -Resident 9 was to have one-on-one bedside visits and activities to include music, animal visits, bird watching discussions, manicures, hand massages and assistance looking through magazines. -Resident 9 was Christian and the Activities Department was to provide gospel music and set-up Chaplain visits as needed. Resident 9's 6/24/24 Significant Change MDS revealed the resident had severe cognitive impairments. Her/his activity preferences indicated it was somewhat or very important to have books, newspapers and magazines to read, do favorite activities, participate in religious services and practices and be around animals. Resident 9's 6/16/24 through 7/16/24 Group Activity Task Log and One-On-One Activity Task Log contained no data regarding activity participation. A review of Resident 9's electronic health record contained no evidence the resident participated in any activities. The facility's 7/2024 Activity Calendar revealed the following scheduled activities: Monday, 7/15/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Birdhouse Building & Painting (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3:00 PM Afternoon Rounds & Mail -6:00 PM Independent Activities (CNA led) Tuesday, 7/16/24: -8:30 AM Morning Room Rounds -11:30 AM Resident Shopping -1:00 PM Gardening Club -3:00 PM Afternoon Rounds & Mail -6:00 PM Featured Movie (CNA led) Wednesday, 7/17/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Resident Council -3:00 PM Afternoon Rounds & Mail -6:00 PM Independent Activities (CNA led) Observations from 7/15/24 through 7/18/24 between the hours of 8:00 AM and 7:30 PM revealed Resident 9 was in her/his room, typically with the blinds closed and the lights low, and was not engaged in any activities. No magazines, books or newspapers were observed; no music was playing and no one-on-one activities took place. On 7/16/24 at 2:30 PM Resident 9 stated she/he liked to play bingo and the balls. Resident 9 stated she/he loved to read anything I can get my hands on. On 7/17/24 at 7:40 AM Staff 9 (CNA) stated Resident 9 rarely got up out of bed. She stated she had not seen any activities occurring in Resident 9's room and she was not aware of any one-on-one activities being done in residents' rooms, just group activities being conducted in the dining room. On 7/17/24 at 8:16 AM Staff 14 (CNA) stated she had never seen Resident 9 engaged in any one-on-one activities in the resident's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 8:33 AM Staff 6 (Activities Director) stated she was the only person in the activities department and she was responsible for completing all of the care conferences, Activity MDS Assessments, Activity Admission Profiles, shopping for the residents, delivering mail, engaging residents in group and one-on-one person-centered activities; as well as assisting with many resident requests. She stated there was no one to provide activities on the weekends. Staff 6 was unable to provide dates or times of any specific activities completed with Resident 9 and confirmed no activities documentation was completed. On 7/19/24 at 9:40 AM Staff 1 (Administrator) stated his expectation was all residents received activities according to their person-centered care plan and he needed to work on getting additional help in the activities department. 2. Resident 24 was admitted to the facility in 10/2023 with diagnoses including dementia. Resident 24's 10/30/23 Activity Profile indicated the resident spoke Farsi/Arabic and required a translator. Resident 24's 11/8/23 and revised 11/16/23 Activities Care Plan indicated the following: -Resident 24 liked visits from her/his spouse, eating ice cream and other comfort foods, watching television and reading. -Resident 24 was to have twice weekly social visits for special updates on activities and assistance with self-directed activities. Resident 24's 4/30/24 Significant Change MDS revealed the resident had short and long term memory deficits. Her/his activity preferences indicated it was somewhat or very important to listen to music, be around animals, go outside to get fresh air when the weather was good, do things with groups of people, do favorite activities and participate in religious services or practices. Resident 24's 6/16/24 through 7/16/24 Group Activity Task Log and One-On-One Activity Task Log contained no data regarding activity participation. A review of Resident 24's electronic health record revealed no evidence the resident participated in any activities. The facility's 7/2024 Activity Calendar revealed the following scheduled activities: Monday, 7/15/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Birdhouse Building & Painting -3:00 PM Afternoon Rounds & Mail (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6:00 PM Independent Activities (CNA led) Tuesday, 7/16/24: -8:30 AM Morning Room Rounds -11:30 AM Resident Shopping -1:00 PM Gardening Club -3:00 PM Afternoon Rounds & Mail -6:00 PM Featured Movie (CNA led) Wednesday, 7/17/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Resident Council -3:00 PM Afternoon Rounds & Mail -6:00 PM Independent Activities (CNA led) Observations from 7/15/24 through 7/18/24 between the hours of 8:00 AM and 8:00 PM revealed the resident was in her/his room with no music, books or materials to complete self-directed activities. Resident 24 was typically awake in bed with her/his television on without sound and closed captioning (text that reflects an audio track that can be read while watching visual content) on in English. On one occasion in the evening, Resident 24 was observed up in her/his wheelchair in a lobby area, placed in front of a television being broadcast in English, with four other residents. No one-on-one activities were observed during any observations. On 7/17/24 at 9:53 AM Staff 4 (CNA) stated she tried to get an I-Pad for Resident 24 to watch television on because her/his room television did not have Arabic channels but she was not successful getting an I-Pad. Staff 4 stated she had not seen any one-on-one activities occurring with Resident 24 and the resident just sits in her/his room unless her/his spouse comes to visit. On 7/18/24 at 8:33 AM Staff 6 (Activities Director) stated she was the only person in the activities department and she was responsible for completing all of the care conferences, Activity MDS Assessments, Activity Admission Profiles, shopping for the residents, delivering mail, engaging residents in group and one-on-one person-centered activities; as well as assisting with many resident requests. She stated there was no one to provide activities on the weekends. Staff 6 was unable to provide dates or times of any specific activities completed with Resident 24 and confirmed no activities documentation was completed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/19/24 at 9:40 AM Staff 1 (Administrator) stated his expectation was all residents received activities according to their person-centered care plan and he needed to work on getting additional help in the activities department. 47000 3. Resident 47 was admitted to the facility in 11/2023 with diagnoses including dementia. Resident 47's 11/23/23 Activity Profile indicated the resident spoke Vietnamese and was unable to communicate or answer questions in English. Resident 47's 11/27/23 Admission MDS indicated the resident experienced short-and-long-term memory loss and identified the following as activity preferences for the resident: -Reading books, newspapers or magazines; -Listening to music; -Being around animals such as pets; -Keeping up with the news; -Doing things with groups of people; -Participating in favorite activities; and -Spending time outdoors. Resident 47's 2/27/24 Social Determinants of Health Form indicated the resident spoke Vietnamese, she/he needed or wanted an interpreter to communicate with a doctor or health care staff and she/he sometimes felt lonely or isolated from those around her/him. Resident 47's 3/17/24 Activity Care Plan revealed the following: -The resident's activity goal was to attend/participate in activities of choice two-to-three times per week. -The resident was dependent upon staff for activities. -The resident's activity interests included passively participating in large group activities, watching television, one-to-one conversation and chair exercises. -One-to-one in-room activities were needed if the resident was unable to attend out of room events. -The resident required an escort to activity functions. (continued on next page)

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Avamere Rehabilitation of King City	16485 SW Pacific Highway Tigard, OR 97224

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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	A review of Resident 47's 6/17/24 through 7/15/24 activity participation records revealed no evidence the resident participated in a group, one-to-one or self-directed activity during this timeframe. The facility's 7/2024 Activity Calendar revealed the following scheduled activities: Monday, 7/15/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Birdhouse Building & Painting -3:00 PM Afternoon Rounds & Mail -6:00 PM Independent Activities (CNA led) Tuesday, 7/16/24: -8:30 AM Morning Room Rounds -11:30 AM Resident Shopping -1:00 PM Gardening Club -3:00 PM Afternoon Rounds & Mail -6:00 PM Featured Movie (CNA led) Wednesday, 7/17/24: -8:30 AM Morning Room Rounds -11:00 AM Large Group: Exercises -1:00 PM Resident Council -3:00 PM Afternoon Rounds & Mail -6:00 PM Independent Activities (CNA led) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident 47 conducted from 7/15/24 to 7/17/24 between 9:41 AM through 4:28 PM revealed the resident to be in bed in her/his room or in her/his wheelchair in her/his room or in the dining room. The resident's eyes were observed to be closed during each observation. When the resident was observed in her/his room, no television or music played and no books, magazines or newspapers were observed. Resident 47's roommate's television could be heard from the hallway and the content was in English. When the resident was observed in the dining room, the television was on and content played in English. On 7/15/24 at 1:04 PM, 7/17/24 at 9:41 AM and 7/17/24 at 11:31 AM the resident verbally responded to the surveyor's greeting with her/his eyes closed. On 7/15/24 at 1:13 PM Witness 6 (Family Member) stated Resident 47's native language was Vietnamese and the resident spoke and understood limited English. Witness 6 stated the resident was able to communicate only her/his basic needs in English. On 7/17/24 at 10:19 AM Staff 14 (CNA) stated she was unaware of any activity interests for Resident 47. Staff 14 stated since the resident came to the facility, it was just room to dining room for meals and back to [her/his] room to lay down. Staff 14 further stated the resident never participated in group activities, went outside, had the television or music on in her/his room or had books, newspapers or magazines available to read. On 7/17/24 at 10:45 AM Staff 20 (CNA) stated Resident 47 spent all of her/his time either sleeping or eating. Staff 20 stated the resident did not participate in group activities or go outside. Staff 20 further stated she had never seen the resident with books, newspapers or magazines. On 7/17/24 at 11:00 AM Staff 27 (CNA) stated she thought Resident 47 enjoyed listening to music and watching television but it was difficult for her/him to do either in her/his room because the resident's roommate's television was really loud. Staff 27 stated Resident 47 did not open her/his eyes often. On 7/17/24 at 11:17 AM a group of residents was observed in the facility's dining room and participated in an exercise activity with a ball and parachute. Resident 47 was observed at this time in her/his room in bed with the lights and television off. On 7/17/24 at 11:31 AM Resident 47 was observed in her/his room and sat in her/his wheelchair with her/his eyes closed. The State Surveyor, with the assistance of a Vietnamese translator attempted an interview at this time. As soon as the resident heard the translator speak in Vietnamese, the resident pulled opened her/his eyelids with her/his hand and verbally engaged in the interview. Resident 47 stated I don't do anything here. Resident 47 stated she/he would love to participate in group activities and go outside when the weather was nice but no one offered these activities. Resident 47 further stated she/he enjoyed reading, songs, exercise and pets but no one at the facility had ever asked her/him about her/his likes and preferences. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 4:09 PM Staff 6 (Activity Director) stated she did not attempt the Preferences for Customary Routine and Activities interview required at the time of Resident 47's 11/27/23 Admission MDS Assessment with the resident because she was informed the resident did not speak English, so she interviewed Witness 6 instead. Staff 6 stated she typically added the resident activity preferences and interests she learned from this interview to the resident's care plan and stated Resident 47's activity care plan needed to be updated. Staff 6 stated she completed one-to-one visits with Resident 47 during mealtimes when she would primarily ask the resident in English about her/his meal. Staff 6 stated she did not use a translator during her interactions with Resident 47. Staff 6 stated she documented resident activity participation in each resident's clinical record which included any refusals and if the resident was sleeping. Staff 6 acknowledged Resident 47 did not have any activities, refusals or instances of sleeping documented from 6/17/24 to 7/15/24 and stated she sometimes did not get to charting at the end of the day. Staff 6 stated CNAs were responsible to turn on Resident 47's television when she/he was in her/his room and the resident watched television with English programming when in the dining room. Staff 6 further stated she did not invite Resident 47 to the group exercise activity this morning because the resident's eyes were closed and she did not like to bother residents if they were sleeping. On 7/17/24 at 4:40 PM Staff 2 (DNS) stated she expected resident activity participation to be documented daily and staff to utilize a translation service when interacting with Resident 47. Staff 2 further stated she expected books, newspapers and magazines to be provided to Resident 47, television and music to be available to Resident 47 and one-to-one visits to be offered to Resident 47 daily, all in Vietnamese.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 41458 Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 1 of 5 sampled residents (#24) reviewed for unnecessary medications. This placed residents at risk for adverse medication consequences. Findings include: Resident 24 was admitted to the facility in 10/2023 with diagnoses including dementia A 12/7/23 Physician Order indicated Resident 24 was prescribed a lidocaine 4% pain patch to be applied to the resident's lower back, one patch once daily. The lidocaine 4% pain patch was to be on for 12 hours and off for 12 hours. A review of Resident 24's 7/1/24 through 7/31/24 MAR indicated the resident's lidocaine 4% pain patch was not administered according to the physician orders on the following days: -7/6/24, 7/8/24, 7/9/24 and 7/10/24. On 7/18/24 at 12:17 PM Staff 7 (CMA) stated there were no lidocaine 4% pain patches available in the facility on 7/10/24, so she was unable to provide Resident 24 with her/his lidocaine pain patch. On 7/18/24 at 12:27 PM Staff 8 (Maintenance Director) stated he was responsible for ordering Resident 24's lidocaine 4 % pain patches and the pain patches were not ordered timely because ordering supplies was a new task for him and he was unsure how the ordering system worked. On 7/19/24 at 10:23 AM Staff 1 (Administrator) stated Staff 8 took over the responsibility of ordering supplies on 7/1/24 so he was not familiar enough with the supply ordering process but that should never happen.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 ensure residents with limited range of motion and/or mobility received restorative services and equipment to prevent a further decrease in range of motion for 2 of 4 sampled residents (#s 10 and 25) reviewed for position/mobility and rehab/restorative. This placed residents at risk for worsening contractures and physical decline. Findings include: 1. Resident 10 was admitted to the facility in 12/2016 with diagnoses including hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following a stroke. Resident 10's 5/2/24 Annual MDS revealed the resident experienced short-and-long-term memory loss, upper and lower extremity impairment on one side of her/his body and did not utilize splint or brace assistance. Resident 10's 7/2024 Physician Orders directed the resident to wear a right hand splint as tolerated. Observations conducted from 7/15/24 to 7/18/24 between 7:42 AM through 8:19 PM revealed Resident 10 to be in her/his wheelchair or bed. The resident's right hand was in a fist and the resident did not wear a splint. On 7/16/24 at 3:12 PM Resident 10 was able to partially open the four fingers on her/his right hand with visual prompting but was unable to answer any questions regarding her/his hand, a splint or pain. On 7/17/24 at 8:07 PM Staff 10 (CNA), on 7/17/24 at 8:27 PM Staff 19 (CNA) and on 7/18/24 at 12:02 PM Staff 20 (CNA) stated they had never seen Resident 10 wear a brace and did not know she/he had one. No evidence was found in Resident 10's clinical record to indicate the resident's upper extremity impairment was comprehensively assessed, ongoing monitoring of her/his upper extremity impairment was being provided, a care plan was developed to address the resident's upper extremity impairment or the right hand splint was available and offered to the resident. On 7/18/24 at 12:39 PM Staff 2 (DNS) and Staff 21 (Resident Care Coordinator) acknowledged the findings of this investigation. Staff 2 stated assessments and on-going monitoring of Resident 10's right hand contracture were not completed and she was unsure if the resident's hand splint was even appropriate. 50930 2. Resident 25 admitted to the facility in 10/2022 with diagnoses including history of falls, and stroke with hemiplegia and hemiparesis (paralysis and weakness of one side of the body). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS, dated [DATE], showed a BIMS score of 15 which indicated she/he was cognitively intact, and required minimal assistance from one staff for eating and oral/personal hygiene, maximal assistance from one to two staff for ADLs/cares, and she/he was dependent on one to two staff for wheelchair mobility and transfers. The resident's care plan, updated 4/6/23, revealed that she/he was at moderate risk for falls and needed a restorative care program to prevent decline in level of function. Interventions were updated on 6/6/24 to include a detailed ROM plan with monthly reviews. On 7/15/24 at 1:11PM Resident 25 demonstrated her/his ability to move arms effectively, and inability to move their legs effectively. Resident 25 stated they were supposed to receive restorative therapy three times a week, she/he received restorative therapy once a week on average, and during care conference on 6/13/24 a restorative therapy plan was discussed with her/him and their responsible party. Review of 5/2/24 restorative therapy program referral for Resident 25 noted ROM and balance exercises, with interventions for upper and lower body, to be conducted in sessions three to five times per week. A care conference note on 6/13/24 indicated Resident 25 was encouraged to work with restorative therapy daily for four weeks prior to a resident requested physical therapy evaluation. Review of RA documentation for Resident 25 from 6/15/24 to 7/16/24 indicated nine therapy sessions and one resident refusal out of 13 to 22 ordered sessions. There was no documentation to indicate Resident 25 experienced a decline in functional abilities. On 7/17/24 at 8:55 AM Staff 15 (CNA/RA) stated RA staff had a restorative therapy plan for Resident 25 averaging three days per week, and Resident 25 had shown increased willingness to do work and participate. She stated RA staff had been pulled to the floor to work as CNA staff frequently this summer. On 7/17/24 at 2:13 PM Staff 23 (MDS Coordinator) stated he implemented and monitored restorative therapy, and three sessions per week was a standard schedule. He stated if restorative therapy staff were pulled to the floor as CNA staff, the restorative therapy team attempted make up sessions with residents. He stated some missed days could not be made up, and he prioritized sessions for residents with multiple missed sessions. On 7/19/24 at 1:42 PM findings were discussed with Staff 2 (DNS), and no additional information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41458 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: On 7/25/24 the facility had a census of 62 residents. On 7/18/24, Staff 1 (Administrator) provided a list of residents who: -Required two-person mechanical lift transfers: 23; -Required one or two-person extensive or total assistance for bathing: 47; -Required one or two-person extensive or total assistance for toileting: 47; -Required one or two-person extensive or total assistance for dressing: 49; -Required two person assistance at all times for all care: 11; -Had behavioral healthcare needs which required monitoring: 28; -Were at risk for elopement: 5 and -Were considered high fall risks: 14 1. On 2/1/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs on all shifts resulting in residents not being toileted timely, long call light response times and basic care not being met. The complaint indicated the facility had been short staffed for months. On 2/12/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs on all shifts but evening shift was impacted the most, staff were unable to provide showers and, in general, resident care was diminished. On 4/8/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs which resulted in residents not receiving showers and staff not being able to properly monitor residents who required supervision when eating. On 5/20/24 a public complaint was received by the State Agency which alleged the facility was short staffed CNAs, especially on night shift which resulted in residents not getting needed care. On 6/17/24 two public complaints were received by the State Agency which alleged the facility was short staffed CNAs for the past several months resulting in staff not being able to properly monitor and supervise residents during meals and some residents were unable to be showered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/24 at 11:16 AM Resident 35 stated she/he sometimes waited over 30 minutes, pretty much daily, for someone to answer her/his call light. Resident 35 stated long call light times occurred across all shifts. On 7/15/24 at 1:15 PM Resident 22 stated call light response times could take up to one hour. Resident 22 stated the facility was short-handed, especially on the weekends. Resident 22 stated, I filled my diaper a couple of times because they didn't get here in time. On 7/15/24 at 1:24 PM Resident 36 stated the facility needed more staff. Resident 36 stated she/he required two persons using a mechanical lift to transfer her/him and sometimes she/he was told there were not enough staff to transfer her/him to the chair. On 7/16/24 at 8:34 AM Witness 4 (Complainant) reported since 2/2024 there was constant low CNA staffing. Witness 4 stated the facility was often three to four CNA staff short. Witness 4 stated staffing was bad which resulted in increased falls, residents missing showers and residents having to remain up in their chairs longer than they should. On 7/16/24 at 8:21 AM Witness 3 (Complainant) reported CNA staffing was bad, especially on weekends, since approximately 2/2024. Witness 3 stated the facility was three or four CNA staff short on many shifts in 2/2024 and 3/2024 and now CNA staffing was often one to two CNAs short on many shifts. Witness 3 stated when CNA staffing was low, call light response times were longer and CNA staff did not have time to provide showers to residents. On 7/16/24 at 1:28 PM Witness 1 (Complainant) stated the facility did not staff CNAs to meet the mandatory CNA minimum staffing ratio requirements. Witness 1 stated CNAs were frequently working one to two CNAs short, especially on the weekends. Witness 1 stated low staffing occurred off and on for months. Witness 1 stated low CNA staffing impacted staff's ability to monitor residents which resulted in increased falls. Witness 1 stated the facility continued to admit new residents even though they were unable to meet CNA staffing ratios, which had the potential to result in injuries to the resident and/or staff. On 7/16/24 at 2:58 PM Witness 2 (Complainant) stated low CNA staffing was ongoing since 1/2024, especially on the weekends. Witness 2 stated staff were unable to provide showers to residents or properly supervise residents who were identified to be at high risk for aspiration (inhaling food or liquids into the lung). Witness 2 stated she was concerned residents might choke. Witness 2 stated the facility had many residents who required two person assistance with transfers but many times transfers were completed with only one person due to a lack of available staff. Witness 2 reported the facility continued to accept new admits even when they knew they were unable to adequately staff CNAs. On 7/17/24 at 4:51 PM Witness 5 (Complainant) stated staffing was horrible and many CNA staff quit. Witness 5 stated when CNA staffing was low, staff could not provide showers, staff were unable to complete two person mechanical lift transfers and staff were unable to toilet residents in a timely manner which resulted in a lack of dignity for the residents. Witness 5 stated CNA staffing was a dumpster fire since 1/2024. Witness 5 reported many staff did not get their breaks. Witness 5 stated the facility did not have the right staffing for the level of acuity of the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/17/24 at 7:52 AM, 8:08 AM and 8:16 AM Staff 16 (CNA), Staff 10 (CNA) and Staff 14 (CNA) reported the facility was consistently short staffed one to two CNAs, especially on the weekends. Staff 16 and Staff 14 reported CNA staff often did not get their breaks or lunches. Staff 16 and Staff 14 stated residents who required two person mechanical lift transfers often had to wait a long time, showers got bumped and staff were unable to provide supervision to residents who ate in their rooms. Staff 10 reported the facility had difficulty retaining CNA staff. On 7/18/24 at 9:14 AM Staff 18 (Staffing Coordinator) stated she staffed CNAs based on the census and by the CNA mandatory minimum staffing ratios. Staff 18 stated she heard there were staffing concerns. Staff 8 confirmed, from 2/2024 through 7/14/24, CNA staffing was short on many shifts. On 7/19/24 at 9:14 AM Staff 1 (Administrator) stated he was aware the facility had staffing issues and struggled to maintain adequate staffing levels. 2. Resident 22 was admitted to the facility in 1/2024 with diagnoses including a fractured hip. A 6/23/24 5-Day MDS indicated Resident 22 had no cognitive impairment and assistance levels ranged from moderate to maximal assistance from staff for multiple ADLs. Review of Resident 22's 6/1/24 through 7/17/24 Call Light Tracking Sheet revealed the following call light response times: -6/1/24 at 9:37 PM: call light response time 38 minutes; -6/4/24 at 5:54 AM: call light response time 32 minutes; -6/6/24 at 3:00 AM: call light response time 24 minutes; -6/6/24 at 5:27 PM: call light response time 23 minutes; -6/6/24 at 3:54 PM: call light response time 16 minutes; -6/8/24 at 9:58 AM: call light response time 20 minutes; -6/9/24 at 3:37 AM: call light response time 20 minutes; -6/9/24 at 9:09 PM: call light response time 18 minutes; -6/10/24 at 5:38 AM: call light response time 40 minutes; -6/10/24 at 2:33 PM: call light response time 37 minutes; -6/12/24 at 12:23 AM: call light response time 17 minutes; -6/12/24 at 5:37 AM: call light response time 18 minutes; -6/12/24 at 11:50 AM: call light response time 17 minutes; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-6/19/24 at 1:24 PM: call light response time 23 minutes; -6/19/24 at 8:18 PM: call light response time 40 minutes; -6/20/24 at 6:22 AM: call light response time 27 minutes; -6/20/24 at 2:23 PM: call light response time 16 minutes; -6/23/24 at 8:03 PM: call light response time one hour; -6/23/24 at 9:19 PM: call light response time 21 minutes; -6/24/24 at 3:58 PM: call light response time 18 minutes; -6/24/24 at 9:38 PM: call light response time 19 minutes; -6/27/24 at 5:03 AM: call light response time 22 minutes; -6/27/24 at 9:44 AM: call light response time 16 minutes; -6/29/24 at 10:40 AM: call light response time 24 minutes; -7/2/24 at 2:38 PM: call light response time 20 minutes; -7/3/24 at 7:17 AM: call light response time 21 minutes; -7/6/24 at 8:14 AM: call light response time 29 minutes; -7/9/24 at 10:30 AM: call light response time 19 minutes; -7/10/24 at 3:51 PM: call light response time 17 minutes; -7/11/24 at 8:21 AM: call light response time 24 minutes; -7/15/24 at 7:44 AM: call light response time 16 minutes and -7/15/24 at 9:56 AM: call light response time 20 minutes. On 7/15/24 at 1:15 PM Resident 22 stated call light response times could take up to one hour. Resident 22 stated the facility was short-handed, especially on the weekends. Resident 22 stated, I filled my diaper a couple of times because they didn't get here in time. On 7/19/24 at 9:14 AM and 12:45 PM Staff 1 (Administrator) stated he was aware the facility had staffing issues and struggled to maintain adequate staffing levels. Staff 1 stated he would like to see call light response times no longer than 15 minutes and anything longer than 15 minutes would be an issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Resident 25 was admitted to the facility in 10/2022 with diagnoses including a stroke with hemiplegia and hemiparesis (paralysis and weakness of one side of the body). Resident 25's 10/31/22 Fall Prevention Care Plan instructed staff to remind the resident to wait for staff assistance when she/he was up in her/his chair and to ensure the call light was within Resident 25's reach. A 5/30/24 Quarterly MDS indicated Resident 25 had no cognitive impairment and assistance levels ranged from maximal to dependent assistance from staff for multiple ADLs. Review of Resident 25's 6/1/24 through 7/17/24 Call Light Tracking Sheet revealed the following call light response times: -6/2/24 at 11:46 AM: call light response time 16 minutes; -6/3/24 at 5:00 PM: call light response time 40 minutes; -6/5/24 at 4:20 AM: call light response time 43 minutes; -6/6/24 at 2:47 AM: call light response time 24 minutes; -6/9/24 at 1:22 PM: call light response time 22 minutes; -6/13/24 at 2:04 PM: call light response time 21 minutes; -6/15/24 at 2:40 AM: call light response time 23 minutes; -6/16/24 at 1:28 PM: call light response time 16 minutes; -6/17/24 at 10:39 PM: call lighte response time 29 minutes; -6/18/24 12:06 AM: call light response time 17 minutes; -6/18/24 at 1:50 AM: call light response time 17 minutes; -6/18/24 at 9:41 PM: call light response time 16 minutes; -6/25/24 at 7:42 AM: call light response time 25 minutes; -6/25/24 at 11:21 AM: call light response time 29 minutes; -6/26/24 at 5:28 PM: call light response time 32 minutes; -6/30/24 at 12:04 PM: call light response time 22 minutes; -7/1/24 at 7:13 AM: call light response time 17 minutes; -7/2/24 at 6:02 AM: call light response time 36 minutes; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385132	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of King City	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-7/2/24 at 2:54 PM: call light response time 18 minutes; -7/4/24 at 11:33 AM: call light response time 21 minutes; -7/4/24 at 6:39 PM: call light response time 17 minutes; -7/6/24 at 10:52 AM: call light response time 16 minutes; -7/6/24 at 6:00 PM: call light response time 24 minutes; -7/7/24 at 6:54 PM: call light response time 49 minutes; -7/10/24 at 11:18 AM: call light response time 36 minutes; -7/11/24 at 9:25 AM: call light response time 26 minutes; -7/11/24 at 6:48 PM: call light response time 18 minutes; -7/12/24 at 10:55 AM: call light response time 17 minutes; -7/12/24 at 4:47 PM: call light response time 22 minutes; -7/16/24 at 4:53 AM: call light response time 16 minutes and -7/16/24 at 6:32 PM: call light response time 20 minutes. On 7/15/24 at 1:11 PM Resident 25 stated her/his call light response times were up to 30 to 40 minutes, at times. On 7/19/24 at 9:14 AM and 12:45 PM Staff 1 (Administrator) stated he was aware the facility had staffing issues and struggled to maintain adequate staffing levels. Staff 1 stated he would like to see call light response times no longer than 15 minutes and anything longer than 15 minutes would be an issue.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47000 Based on observation, interview and record review it was determined the facility failed to ensure the appropriate diet texture was followed for 1 of 2 sampled residents (#10) reviewed for nutrition. This placed residents at risk for choking. Findings include: Resident 10 was admitted to the facility in 12/2016 with diagnoses including dysphagia (difficulty swallowing). The facility's 9/2019 Food Size & Testing Methods Form defined a regular, easy to chew diet as the following: -No restrictions to food piece size. -Normal, everyday foods of soft and tender texture. -Foods must break apart easily and pass the fork pressure test. Resident 10's 5/2/24 Annual MDS revealed the resident experienced short-and-long-term memory loss, was moderately impaired for decision making, required supervision or touch assistance with eating and was edentulous (without teeth). Resident 10's 7/2024 Physician Orders directed the resident to receive a regular, easy to chew diet. On 7/15/24 at 11:53 AM Resident 10 was observed to eat in bed. The resident's meal tray sat on top of an overbed table and the meal ticket on the tray stated beef fajitas. Resident 10 was observed to attempt a bite of the beef fajitas and was unable to bite through the tortilla with her/his gums. The contents of the fajita spilled out of the tortilla and landed on the resident's chest. The resident picked up the beef pieces which ranged from one-to-two inches in length and put them in her/his mouth. Resident 10 was unable to answer any questions about her/his diet. On 7/17/24 at 8:27 PM Staff 19 (CNA) stated Resident 10 was not considered at risk to aspirate and thought the resident received a regular diet. On 7/18/24 at 12:16 PM Staff 2 (DNS) and Staff 21 (Resident Care Coordinator) along with the State Surveyor observed Resident 10 in bed with her/his meal tray on an overbed table in front of the resident. Staff 2 attempted to cut the meat on the resident's plate with a fork and could not. Staff 2 confirmed the meat Resident 10 was served was not easy to chew and should have been. Staff 2 and Staff 21 were informed of the beef fajitas served to Resident 10 on 7/15/24, and Staff 2 stated beef fajitas and tortillas were not considered easy to chew foods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385132	A. Building B. Wing	07/19/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46053 Based on observation, interview and record review it was determined the facility failed to ensure beverages were labeled and stored in a manner to minimize spoilage and bulk food items were stored in a manner to minimize cross contamination in 1 of 1 kitchen reviewed for sanitary conditions. This placed residents at risk of foodborne illness. Findings include: On 7/15/24 at 9:49 AM during the initial tour of the kitchen dry storage area, a plastic scoop was observed to be partially buried in the bulk sugar. Staff 24 acknowledged the scoop was not stored appropriately and stated it should be in the provided holster above the sugar rather than in the supply of sugar, to minimize the risk of cross contamination. On 7/15/24 at 9:57 AM the following items were observed to be stored in the snack refrigerator in the facility's 100 hallway: -A previously-opened liter container of nectar-thick lemon water dated 6/23 -A previously-opened liter container of nectar-thick lemon water dated 6/4 -A previously-opened liter container of nectar-thick orange juice labeled Use by 6/26 Staff 24 acknowledged the manner in which these items were labeled was unclear as they did not indicate if the dates referred to when they were opened or when they should be discarded. He stated these items should be discarded as it was unsafe to store and use juice beyond seven days after it was opened. Staff 24 stated he was not clear about who was supposed to monitor and discard outdated items in the snack refrigerator. On 7/19/24 at 1:12 PM Staff 1 acknowledged the deficiencies observed in the kitchen's dry storage area and in the snack refrigerator. He stated he expected the facility staff to label items when they were opened and when they should be discarded in order to reduce the risk of spoilage. He stated he also expected staff to store dry goods in a manner to avoid cross contamination.