STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385203	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Clackamas	220 E. Hereford Gladstone, OR 97027

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 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. 38140 Based on observation and interview the facility failed to provide a comfortable and homelike environment for 1 of 1 facility reviewed for physical environment. This placed residents at risk for a lessened quality of life. Findings include: The facility's 2021 Homelike Environment Policy revealed residents were provided with a safe, clean, comfortable and homelike environment. Comfortable and adequate lighting was provided in all areas of the facility. Resident 24 admitted to the facility in 2019 with diagnoses including hypertension (high blood pressure) and depression. Resident 24's 4/21/24 Annual MDS indication she/he was cognitively intact. On 7/16/24 at 9:24 AM Resident 24 stated she/he was going to an activity in the dining room where the lighting was bad, and her/his vision was not so great so she/he sat by the window or the doors to see better. On 7/16/24 at 3:40 PM Resident 24 stated the lights in the dining room could be brighter because when residents were in activities in the dining room, other residents would ask if the lights could be turned on, but the lights were already on. During the Resident Council meeting on 7/16/24 at 1:00 PM the council members stated the lights in the dining room, where they had activity groups, had light bulbs out for a while and made it difficult to see. On 7/16/24 at 1:53 PM the dining room was observed with three of the six ceiling lights to not produce light. The dining room floor had four large pieces of black tape on the light-colored floor and the flooring was buckled up near the soda machine. On 7/17/24 at 11:10 AM the shared bathroom between room one and room three was observed with brown and yellow stained caulking around the base of the toilet. The floor was stained with brown markings and appeared dirty. (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	On 7/17/24 at 11:12 AM the shared bathroom between room two and room four was observed with brown and yellow stained caulking around the base of the toilet and appeared dirty. On 7/17/24 at 11:13 AM room four's wall under the window was observed with the paneling peeling away from the wall in several spots. On 7/19/24 at 9:58 AM Staff 11 (Maintenance Director) confirmed the lights in the dining room were not working properly and needed new bulbs. Staff 11 stated he found out about the lights on Tuesday (7/16/24) from the Resident Council meeting and was unaware prior to 7/16/24. Staff 11 confirmed the taped flooring in the dining room and the other identified areas were in disrepair. Staff 11 stated the facility did not have a plan in place to fix flooring repairs. Staff 11 acknowledged the stained caulking in the shared resident bathrooms between rooms one and three and rooms two and four. Staff 11 stated the caulking needed to be repaired. Staff 11 acknowledged the paneling pulled away from the wall in room four and stated the facility did not have a plan in place to fix the wall. On 7/19/24 at 10:10 AM Staff 1 (Administrator) confirmed the needed repairs of lights in the dining room, flooring in the dining room, shared resident bathrooms between rooms one and three and rooms two and four, and the wall in room four. Staff 1 stated he expected a plan to be in place to make the repairs.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on observation, interview and record review it was determined the facility failed to ensure staff adhered to professional standards related to disinfection of common use glucometers for 1 of 2 licensed nurses (Staff #3) reviewed for infection control and medication administration. This placed residents at significant risk for bloodborne illness. Findings include: Per [NAME] [PHONE NUMBER] Scope of Practice Standards for All Licensed Nurses (1) Standards related to the licensee's responsibility for safe nursing practice. The licensee shall: (A) Adhere to professional practice and performance standards; Per [NAME] [PHONE NUMBER] Conduct Derogatory to the Standards of Nursing Defined: Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to: (2) Conduct related to achieving and maintaining clinical competency: (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established; (3) Conduct related to the client's safety and integrity: (a) Developing, modifying or implementing policies that jeopardize client safety; The Evencare G2 blood glucose monitoring system manufacturer instructions indicated to disinfect the meter with EPA registered wipes. The 9/2014 facility policy for Blood Sampling Capillary (Finger Sticks) indicated to follow the manufacturer's instructions. On 7/17/24 at 11:29 AM Staff 3 was observed to obtain a CBG for Resident 299. Staff 3 exited the room and cleaned the glucometer with alcohol wipes. Staff 3 stated she primarily used alcohol wipes to clean the glucometer. Staff 3 then started to proceed down the hall to complete a CBG for Resident 296 using the same glucometer. The State Surveyor intervened, and Staff 3 went back to the treatment cart and used a bleach wipe to clean the glucometer. Staff 3 then started to proceed down the hall without allowing the glucometer to dry (manufacturer instructions indicated a 3-minute contact time). The State Surveyor intervened and asked Staff 3 to review the contact time on the bleach wipes. Staff 3 then set the glucometer down and obtained another glucometer from the cart to use. On 7/17/24 at 12:11 PM Staff 3 stated she worked on all resident halls. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 1:30 PM Staff 2 (DNS) stated the expectation was for staff to use microkill bleach wipes between every glucometer use and to rotate glucometers to ensure proper dwell times were reached. Refer to F880.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 38140 Based on interview and record review it was determined the facility failed to implement resident-centered care plan interventions to ensure residents with dementia maintained their highest practicable level of well-being for 1 of 1 sampled resident (#18) reviewed for dementia. This placed residents at risk for a lack of psychosocial well-being and increased behaviors. Findings include: The facility's revised 2018 Dementia - Clinical Protocol revealed for individuals with confirmed dementia, the IDT (Inter-Disciplinary Team) would identify a resident-centered care plan to maximize their remaining function and quality of life. Resident 18 admitted to the facility in 2020 with diagnoses including dementia with agitation and depression. Resident 18's 8/21/23 Annual MDS indicated behaviors including rejection of care, combative behavior and agitation. Resident 18's 5/21/24 Quarterly MDS assessed her/him as severely cognitively impaired. Review of Resident 18's 7/18/24 behavioral care plan identified her/him as confrontational, rude, demanding, suspicious, manipulative and anxious. The care plan identified behaviors of verbal aggression, physical aggression, yelling, hitting, interference with roommate's care, and history of false accusative statements. The care planned interventions were that sometimes she/he would calm down when chocolate was given, discharge planning, separate from other residents, approach calmly and unhurriedly, notify physician if behaviors interfered with medical needs, leave the room and leave her/him alone to give space. Review of Resident 18's 7/18/24 ADL care plan revealed she/he refused ADLs and showers. The interventions were to document refusals and re-approach at a different time. No other interventions for ADLs and shower refusals were documented. On 7/19/24 at 8:43 AM Staff 10 (CNA) stated she received her information to care for residents from the care plan and shift reports from other staff members. Staff 10 stated Resident 18 had behaviors often, ate meals in her/his room due to behaviors and the staff kept her/him away from people. No other interventions were provided to prevent negative behaviors. On 5/19/24 at 9:13 AM Staff 2 (DNS) acknowledged Resident 18's care plan was not resident centered. Staff 2 acknowledged the interventions were for staff and were not specific to Resident 18 as an individual. Staff 2 reported some interventions were attempted but they were not documented or care planned in Resident 18's health record. No further information was provided.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on observation, interview and record review it was determined the facility failed to ensure the community use CBG glucometer was properly cleaned and sanitized between resident use for 1 of 1 sampled resident (# 299) reviewed during CBG checks. This failure, determined to be an Immediate Jeopardy situation, placed all residents who required CBG checks at significant risk for bloodborne illness. Findings include: The Evencare G2 blood glucose monitoring system manufacturer instructions indicated to disinfect the meter with EPA-registered wipes. The 9/2014 facility policy for Blood Sampling Capillary (Finger Sticks) indicated to follow the manufacturer's instructions. On 7/17/24 at 11:29 AM Staff 3 was observed to obtain a CBG for Resident 299. Staff 3 exited the room and cleaned the glucometer with alcohol wipes. Staff 3 stated she primarily used alcohol wipes to clean the glucometer. Staff 3 then started to proceed down the hall to complete a CBG for Resident 296 using the same glucometer. The State Surveyor intervened, and Staff 3 went back to the treatment cart and used a bleach wipe to clean the glucometer. Staff 3 then started to proceed down the hall without allowing the glucometer to dry (manufacturer instructions indicated a three-minute contact time). The State Surveyor intervened and asked Staff 3 to review the contact time on the bleach wipes. Staff 3 then set the glucometer down and obtained another glucometer from the cart to use. On 7/17/24 at 11:55 AM Staff 2 (DNS) provided a list of 15 residents who required CBG checks, which included Resident 15. Resident 15's clinical record indicated she/he admitted to the facility on [DATE] with diagnoses including human immunodeficiency virus (HIV) and required CBG checks three times a day and used a shared glucometer. Resident 15's Diabetic Administration Record indicated Staff 3 first completed Resident 15's CBG checks twice on 6/14/24. On 7/17/24 at 12:11 PM Staff 3 stated she worked on all resident halls. On 7/17/24 at 1:30 PM Staff 2 (DNS) stated the expectation was for staff to use microkill bleach wipes between every glucometer use and to rotate glucometers to ensure proper dwell times were reached. On 7/17/24 at 2:15 PM the facility was informed that the facility's failure to improperly clean and sanitize the common use glucometer between residents constituted an Immediate Jeopardy situation. An IJ removal plan was requested. On 7/17/24 at 5:30 PM an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Glucometers in the facility have been immediately collected and disinfected using an EPA-approved disinfectant for bloodborne pathogens prior to the next CBG checks. 2. Staff 3 was suspended, will receive 1:1 education/training on glucometer disinfection between uses, and dedicating CBG equipment for residents with diagnoses of bloodborne pathogens prior to return to work. 3. Licensed nurses, prior to start of shift, will be educated on the proper procedure for disinfecting blood glucose monitors and complete a Blood Glucose Monitoring Competency and will have dedicated CBG equipment for residents with bloodborne pathogens. 4. Resident 15 was provided with dedicated blood glucose monitoring equipment. 5. Residents in the facility will be audited for diagnoses of bloodborne pathogens and provided with dedicated blood glucose monitoring equipment if indicated. 6. The Medical Director was notified. Residents potentially exposed also notified. Testing will be offered as requested. 7. To ensure ongoing compliance, the DNS/designee will observe blood glucose monitor disinfection for routine blood glucose checks x 1 week, weekly x 3 weeks, monthly x 2 months to ensure proper disinfection. 8. All findings to be reported to the QAPI Committee. On 7/18/24 at 2:30 PM it was determined the immediacy was removed after verification of completion of the IJ removal plan.