

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2024
NAME OF PROVIDER OR SUPPLIER  Tigard Rehabilitation and Care		STREET ADDRESS, CITY, STATE, ZIP CODE  14145 SW 105th Avenue 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to treat a diabetic wound per physician orders for 1 of 3 sampled residents (#8) reviewed for skin conditions. This placed residents at risk for worsening wounds. Findings include:</p> <p>Resident 8 admitted to the facility in 5/2023, with diagnosis including diabetes.</p> <p>Resident 8's 10/10/23 physican orders instructed staff to clean the right toe diabetic wound with wound cleanser, apply a thin layer of AD (ointment) to the wound and periwound, and to secure the wound with bordered foam. The dressing was to be changed three times per week and as needed.</p> <p>Resident 8's October 2023 TAR revealed no wound care was done between 10/11/23 through 10/27/23.</p> <p>On 4/10/24 at 11:15 AM, Staff 2 (DNS) verified wound treatments were not completed from 10/11/23 through 10/27/23.</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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