STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385283	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Scappoose	33910 E. Columbia Avenue Scappoose, OR 97056

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to honor a grievance resolution for 1 of 3 residents (#401) reviewed for grievances. This placed residents at risk of not having their preferences honored regarding ADL care. Findings include:Resident 401 was admitted to the facility in 3/2025 with diagnoses including dementia and a femur fracture.A 3/30/25 admission MDS indicated Resident 401 had significant cognitive impairments.A 6/19/25 Grievance Form revealed concerns of Staff 4 (CNA) forcing Witness 1 (Power of Attorney) to leave Resident 401's room when care was provided. When Witness 1 requested to remain present, Staff 4 was reported to have stormed out of the room. A request was made by Witness 1 for Staff 4 to no longer provide care to Resident 401.A 6/24/25 Grievance Summary Report completed by Staff 2 (DNS) revealed the resolution was for Staff 4 to no longer provide care to Resident 401. Review of the 6/2025 and 7/2025 Documentation Survey Reports revealed Staff 4 provided ADL care which included brief changes, oral hygiene and/or showers to Resident 401 on 6/25, 6/27, 7/2, 7/3, 7/4, 7/5, 7/16 and 7/22.Review of vital tracking records during 6/2025 and 7/2025 revealed Staff 4 assessed Resident 4's vitals on 6/25 and 7/22. A 7/23/25 Interdisciplinary Team Care Plan Conference Quarterly Review included comments from Witness 1 ensuring Staff 4 did not provide care to Resident 401.On 8/26/25 at 12:18 PM ADL care and vital records from 6/2025 and 7/2025 were reviewed with Staff 4. Staff 4 acknowledged her initials were were recorded as having provided care to Resident 401 on 6/25, 6/27, 7/2, 7/3, 7/4, 7/5, 7/16 and 7/22. On 8/26/25 at 2:23 PM Witness 1 stated she/he visited Resident 401 on 7/16/25 and observed Staff 4 providing one on one care to Resident 401. Witness 1 stated she/he reported her/his concerns regarding Staff 4 not providing care to Resident 401 on 7/16/25 and again during a care conference on 7/23/25.On 8/26/25 at 2:40 PM Staff 2 was informed Staff 4 continued to provide care to Resident 401 after the grievance was addressed. Staff 2 did not provide any additional information. Staff 2 confirmed records showed Staff 4 continued to provide care to Resident 401 following the resolution of the grievance.

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