

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2026
NAME OF PROVIDER OR SUPPLIER  Avalon Care Center - Scappoose		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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>Based on observation, interview and record review it was determined the facility failed to ensure appropriate nail care services was provided for 1 of 4 sampled residents (#2) reviewed for nail care. This placed the resident at risk for unmet care needs and potential complications related to diabetes. Findings include Resident was admitted on 9/2024 with diagnosis of diabetes. A Physician's Order dated 1/24/26 directed Resident 2 to receive diabetic nail care every week on Saturdays. Resident 2's 1/19/26 Care Plan indicated licensed nurses were responsible for providing nail care to Resident 2. On 4/2/26 at 2:11 PM, observation revealed Resident 2's left thumb nail was approximately 3/4 inches thick, significantly elevated off nail bed and discolored. Resident 2's left index finger had minimal nail bed remaining. Resident 2 denied pain to her/his left fingers at time of observation. In an interview on 4/2/26 at 11:35 AM, Staff 10 (CNA) stated they do not provide nail care to Resident 2's nails due to Resident 2's diabetic status. Staff 10 reported occasionally cleaning but indicated Resident 2's nail care was the responsibility of the nursing staff. On 4/2/26 at 1:41 PM, Staff 6 (RN) stated they had not performed nail care for Resident 2 and confirmed Resident 2's left hand nails appeared not to have been maintained for at least a month. Staff 6 reported Resident 2's nail care needs had been discussed among other nursing staff and that a note had been submitted to the provider for further evaluation; however, no follow-up has occurred. On 4/3/26 at 6:17 AM, Staff 7 (RN) stated they documented completion of Resident 2's nail care in the DAR for Resident 2's right hand only. Staff 7 reported they had not performed care on Resident 2's left hand due to lack of skill, knowledge, and comfort level. Staff 7 stated the DAR instructions were vague and acknowledged Resident 2 requires specialized nail care services. On 4/2/26 at 5:15 PM, Staff 2 (DNS) acknowledged concern regarding the condition of Resident 2's left thumb nail and stated Resident 2 had a history of ongoing fungal infection. Staff 2 stated they believed Resident 2's health insurance provider was responsible for managing Resident 2's nail care, Staff 2 was unable to provide documentation to support that nail care services had been completed.</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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