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	08/16/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46053 Based on observation, interview and record review it was determined the facility failed to implement a comprehensive person-centered care plan for 1 of 1 sampled resident (#24) reviewed for communication-sensory services. This placed residents at risk for decreased ability to communicate their wants and needs. Findings include: Resident 24 was admitted to the facility in 6/2024 with diagnoses including aphasia (a language disorder that affects a person's ability to communicate) following non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane) and dysarthria (weakness in the muscles used for speech, causing slowed, slurred speech) following non-traumatic subarachnoid hemorrhage. A review of Resident 24's 6/27/24 Admission MDS revealed she/he had adequate hearing but did not speak during the assessment. On 8/13/24 at 9:31 AM Resident 24 was observed sitting up in bed. Her/his eyes were closed and she/he was awake. She/he did not speak when asked how she/he felt, but she/he gestured to a pool of saliva on her/his shirt. A review of Resident 24's 6/20/24 care plan revealed she/he was at risk of impaired communication related to low tone of voice, post subarachnoid hemorrhage and some cognitive impairment. Resident 24's care plan revised on 6/28/24 indicated she/he was able to read written communication and had a picture board for communication kept at the nurses' station. On 8/13/24 at 10:41 AM Resident 24 was observed in her/his room with a caregiver. Resident 24 did not communicate verbally with the caregiver and there was no evidence of a communication board in her/his room. On 8/14/24 at 9:15 AM Staff 7 (CNA) reported Resident 24 nodded to indicate she/he understood but and used weird facial expressions to indicate she/he did not understand. Staff 7 stated staff did not have a communication board for Resident 24 and she thought, it would be a great idea. She also stated, I don't know if a board is in the works. (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

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	08/16/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 12:49 PM Staff 6 (Activities / Recreation Director) reported she was not aware of a communication board on Resident 24's care plan but she thought it would be a good tool for many departments to use when communicating with her/him. On 8/14/24 at 1:21 PM Staff 6 reported she found the communication board at the nurses station under a big pile of stuff and stated I didn't even know it was there. It's not specific for her. I don't know if she has ever used it. On 8/14/24 at 1:30 PM Staff 1 (Administrator) acknowledged staff members were not using the communication board as instructed on Resident 24's care plan. He stated, I expect that if it is on the care plan, the caregivers and nurses should be following it. There should be a copy of it for her in her room rather than just at the nurses station.

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	08/16/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38138 Based on interview and record review it was determined the facility failed to provide care in accordance with care planned interventions while pushing a resident in a wheelchair for 1 of 1 sampled resident (#1) reviewed for accidents. This failure resulted in an avoidable fracture to Resident 1's left ankle. Findings include: Resident 1 was admitted to the facility in 2015 with diagnoses including dementia. The 6/2023 Annual MDS revealed Resident 1 had a BIMS of 11 (moderate cognitive impairment). Resident 1's mobility care plan dated 12/9/22 instructed staff to promote Resident 1's independence with locomotion as tolerated without leg rests and revealed Resident 1 needed assistance with leg rests in place for wheelchair mobility when being pushed by staff. A 12/6/23 FRI report revealed on 12/3/23 Resident 1 mobilized her/himself independently while in her/his wheelchair from the dining room toward her/his room. Resident 1 became tired and Staff 11 (CNA) pushed Resident 1 towards her/his room. Staff 11 felt resistance while pushing Resident 1 and immediately stopped while Resident 1 yelled Ow! Staff 12 (LPN) was nearby and told Staff 11 to put Resident 1 into bed so he could look at Resident 1's ankle. Resident 1's ankle had a normal range of motion. Staff 12 administered medication for pain management and applied ice to the resident's ankle. Resident 1's physician was notified and staff were instructed to obtain an X-ray if the resident experienced increased pain or swelling. The FRI revealed Resident 1 had moderate pain and swelling to her/his left ankle, and 12/5/23 X-ray notes revealed she/he sustained an .oblique [slanting] fracture involving the distal fibula [a prominent bone on outside of the ankle] with minimal callus [a temporary development that occurs at the site of a bone fracture and helps the bone move from the inflammatory phase to the repair phase] and mild displacement. The joint alignment is maintained. There is associated soft tissue swelling . The resident was taken to the emergency department for an evaluation. A 12/4/23 5:57 PM progress note by Staff 12 revealed Resident 1 was on alert charting, rested in bed, and her/his behavior was at baseline. Resident 1 stated her/his left ankle hurt when it was moved. The resident's left ankle was noted to be slightly swollen and tender, and she/he complained of pain twice during the shift. Staff 12 administered pain medication. A 12/5/23 3:10 AM progress note by Staff 13 (LPN) revealed Resident 1's left ankle was swollen and painful to touch. The resident requested an ice pack for comfort which was effective. A 12/5/23 10:15 PM progress note by Staff 14 (LPN) revealed a new physician's order was received for a left ankle X-ray to rule out a fracture. A 12/6/23 1:54 AM progress note by Staff 15 (LPN) revealed X-ray results of Resident 1's left ankle found an oblique fracture with mild displacement and soft tissue swelling. Resident 1's physician was notified and orders were provided to offer ice packs and to send Resident 1 to the emergency department in the morning since the resident was stable and effective pain management was in place. (continued on next page)

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	08/16/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's 12/6/23 hospital after visit summary and X-ray results revealed she/he had a left foot ankle fracture. The facility obtained a follow up statement from Staff 11 on 12/6/23 at 9:00 AM. Staff 11 stated Resident 1 wheeled her/himself partway down a hall. Staff 11 assisted Resident 1 as she/he sounded out of breath and wanted to go to bed. As they approached the nurses station Resident 1 dropped her/his foot. Staff 11 felt resistance and stopped pushing the wheelchair. Resident 1 cried out and her/his ankle was assessed by another staff. Staff 11 was instructed to assist the resident back to her/his room. Staff 11 stated she then pushed Resident 1 very slowly and reminded her/him to hold her/his legs up. Staff 11 stated she knew how to access care plans and thought she reviewed Resident 1's care plan. An untitled facility document dated 12/8/23 by Staff 16 (former DNS) revealed Staff 11 pushed Resident 1 in her/his wheelchair without leg rests which resulted in Resident 1's fractured left ankle. An interview with the resident found she/he felt safe and comfortable with Staff 11 continuing to provide care. On 8/12/24 at 1:00 PM Resident 1 was observed self propelling slowly in her/his wheelchair with no leg rests. During an interview on 8/12/24 at 2:46 PM Staff 12 stated he assessed the resident at the time of the incident and put ice on her/his foot because she/he complained of pain but there was no swelling or bruising at the time. He indicated the resident was able to identify pain appropriately. Staff 12 stated Resident 1 self propelled in her/his wheelchair independently but when she/he got tired staff placed leg rests on her/his wheelchair before pushing her/him. On 8/13/24 at 10:47 AM Witness 1 (resident representative) stated she was informed of the 12/3/23 incident right away and believed it was a pure accident. She added, Resident 1 would take the leg rests off her/his wheelchair or she/he would ask the staff to remove them. Witness 1 stated Resident 1 was pretty independent and liked to move her/his wheelchair on her/his own but when she/he got tired or was not feeling well she/he asked for help and staff would place the leg rests on the wheelchair before pushing her/him. On 8/14/24 at 3:58 PM Staff 11 confirmed she pushed Resident 1 down the hallway to her/his room without the leg rests on her/his wheelchair, which resulted in Resident 1 sustaining a fractured ankle. Staff 11 stated the resident's foot was not swollen and had no bruising immediately after the accident. (continued on next page)

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	08/16/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/15/24 at 7:18 PM Staff 15 confirmed the incident happened when she was not on shift but she did observe Resident 1's foot on 12/5/24. Staff 15 stated Resident 1 was placed on alert charting, was monitored every shift and received pain medication. Staff 15 stated she observed Resident 1's foot was swollen and the resident said it was slightly painful when she/he moved it. Staff 15 said the day shift nurse ordered the X-ray but she received the X-ray report. Since Resident 1 was stable at the time and it was the middle of the night, a physician's order was received for ice packs if Resident 1 needed it and the on-call doctor gave the okay to go to the hospital in the morning which allowed the resident to sleep. Staff 15 stated if Resident 1 was in a lot of pain she/he would have been sent to the emergency room sooner. Staff 15 added, she believed Resident 1 was care planned to have the footrests on the wheelchair when being pushed by staff before the incident happened and this hasn't happened again to her knowledge. During an interview on 8/16/24 at 9:40 AM Staff 1 (Administrator), Staff 2 (DON), and Staff 3 (Regional Nurse Consultant) were informed of the findings of this investigation. They all confirmed the incident occurred. On 12/8/23, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined there was a failure to follow Resident 1's care plan to ensure leg rests were on her/his wheelchair before pushing her/him. The Plan of Correction included: 1. Staff education, for all staff, on placing leg rests onto resident wheelchairs, and how to look resident care plans and resident profiles. 2. A notice was created for Resident 1's wheelchair to remind staff to put the leg rests on her/his wheelchair before pushing her/him and what to do if Resident 1 declined the use of the leg rests. 3. Licensed nursing staff monitored use of leg rests on resident wheelchairs for residents who required assistance with mobilizing in wheelchairs.

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	08/16/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50926 Based on observation, interview, and record review it was determined the facility failed to ensure proper food temperatures were maintained for meals served to residents on 3 of 3 halls reviewed for dining. This placed residents at risk for increased risk for impaired nutrition. Findings include: Observation on 8/12/24 at 11:45 AM during tray pass Resident 1 complained of cold food. Observation on 8/12/24 at 11:47 AM during tray pass Resident 4 complained of cold food. Resident Council Meeting documentation from 5/2024 recorded residents complaints that breakfast was often cold. On 8/14/24 at 3:37 PM Staff (5) Dietary Manager confirmed the residents had complained about cold food. Twelve residents were interviewed during a Resident Council meeting on 8/15/24 at 10:21 AM. The residents complained about cold food on all halls. On 8/15/24 at 2:51 PM the concern related to cold food was shared with Staff 1 (Administrator). No additional information was provided.

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	08/16/2024

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 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. 50926 Based on observation, interview, and record review it was determined the facility failed to monitor temperatures and cleanliness of 1 of 1 unit refrigerator. This placed the residents at risk for food-borne illness. Findings include: The facility guideline for Dietary Service Resident Community Refrigerator stated: -Housekeeping staff/designee will monitor the refrigerator daily for cleanliness. Concerns will be delegated to the designated department. - Each refrigerator will have an approved thermometer inside the refrigerator. Designated staff will record the temperature at least daily. On 8/14/24 at 12:48 PM the unit refrigerator used for resident snacks and personal foods was observed to have yellow liquid spilled on a lower shelf. There was no thermometer in the refrigerator. On 8/14/24 at 12:49 PM Staff 5 (Dietary Manager) stated the cleaning and monitoring of unit refridgerators was the responsibility of the kitchen staff. She confirmed the refridgerator needed to be cleaned and no thermometer was present. She was not able to locate a temperature log for the refrigerator.