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	12/19/2025

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide notice of bed hold policies for 2 of 2 sampled residents (#s 8 and 18) reviewed for hospitalizations. This placed residents at risk for miscommunication of the discharge process. Findings include:1.Resident 8 was readmitted to the facility in 9/2025 with diagnoses including mechanical complications of an indwelling ureteral stent (a tube from the kidney to the bladder to maintain drainage). Resident 8's medical record indicated she/he was transferred to the hospital on 5/18/25, 6/15/25, 7/23/25 and 9/18/25. No evidence was found in Resident 8's clinical record indicating written notice of the facility's bed hold policy was provided to her/his representative when she/he was transferred to the hospital on 6/15/25, 7/23/25 and 9/18/25. On 12/18/25 at 10:43 AM, Staff 9 (RN) stated the nurses, or social services staff completed the bed hold policy. Staff 9 stated she didn't complete the bed hold policy when Resident 8 was hospitalized . On 12/19/25 at 10:51 AM, Staff 14 (Social Services Director) stated all residents were provided a bed hold policy when they admitted . Staff 14 stated she provided a bed hold policy once to the Resident 8's family representative. She acknowledged Resident 8's family representative wasn't provided a bed hold policy on 6/15/25, 7/23/25 and 9/18/25 when the resident was hospitalized . On 12/19/25 at 3:49 PM, Staff 2 (DNS) stated he expected staff to complete and provide the bed hold policy to the resident or representative prior to residents leaving to the hospital. Staff 2 acknowledged Resident 8's family representative was not provided a bed hold policy prior to his/her hospitalization on 6/15/25, 7/23/25 and 9/18/25. 2. Resident 18 was admitted to the facility in 12/2024 with diagnoses including ischemic stroke (obstruction of blood flow to a part of the brain) and hemiplegia (decrease or loss of function of one side of the body). A review of Resident18's medical records revealed the resident was hospitalized on [DATE], 4/14/25, 9/13/25, 10/15/25, and 10/29/25. Resident 18 was not provided a physical copy of the bed hold policy on those dates. On 12/17/25 at 3:51 PM Staff 14 (Social Services Director) stated a bed hold policy was to be provided to residents when they discharged to the hospital and were expected to return to the facility. Staff 14 confirmed the bed hold policy was not provided to Resident 18 on 3/12/25, 4/14/25, 9/13/25, 10/15/25, and 10/29/25. (continued on next page)

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
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/25 at 4:14 PM Staff 7 (RN) stated the paperwork provided to residents upon hospitalization was a face sheet, current orders, progress notes and a transfer notice. Staff 9 stated a bed hold policy form was not part of the paperwork provided to residents upon hospitalization. On 12/18/25 at 1:32 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 18 should have received a bed hold policy every time she/he was hospitalized and expected to return to the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview it was determined the facility failed to provide a safe and clean homelike environment for 1 of 1 sampled resident (#11) reviewed for environment. This placed residents at risk for an unkept environment. Findings include: Resident 11 was admitted to the facility in 4/2025 with diagnoses including Alzheimer's disease.The 12/8/25 Quarterly MDS indicated Resident 11 had a BIMS score of zero and was not cognitively intact. The 4/15/24 Care Plan indicated, notifying maintenance when the padded mobility bars were damaged or removed. On 12/15/25 through 12/16/2025 from 8:00 AM to 4:00 PM, the padding around the bed rails in Resident 11's room was unkept, the metal was rusty, and parts of the mobility bars were left uncovered, and the metal was exposed. On 12/17/25 at 1:19 PM, Staff 15 (CNA) stated she told maintenance, the nurses and the administrator when equipment was damaged and made sure equipment was safe before she used it. Staff 15 stated she didn't report any damaged equipment in Resident's 11 room. Staff 15 entered Resident 11's room and acknowledged the padding on the mobility bars were damaged. On 12/17/25 at 4:09 PM, Staff 12 (CNA) stated she didn't have concerns with the equipment in Resident 11's room. Staff 12 stated she reported broken and damaged equipment to maintenance and the nurses. Staff 12 entered Resident 11's and stated she guessed the padding on the bed rails needed replacement. Staff 12 acknowledged the padding was ripped. On 12/17/25 at 4:23 PM, Staff 3 (LPN- Unit Manager) stated she communicated with staff on the floor when damaged equipment was observed. Staff 3 stated she notified maintenance immediately. Staff 3 stated the paddings around the mobility bars were used for all residents to help prevent injury. Staff 3 stated she was unaware the padding in Resident 11's room was damaged. Staff 3 stated all staff had access and were expected to utilize the communication system to report damaged and broken equipment. On 12/19/25 at 3:48 PM, Staff 16 (Maintenance Director) stated he wasn't notified about damaged padding around the mobility bars in Resident 11's room. Staff 16 stated all staff had access to a communication system when damaged equipment was reported and should be entered in the system to alert him. Staff 16 stated he monitored the communication system daily.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, interview and record review it was determined the facility failed to accurately complete MDS assessments for 1 of 1 resident (#19) reviewed for communication and sensory needs. This placed residents at risk for lack of timely assessed care needs. Findings include:The facility's 11/2017 Resident Assessment policy and procedure specified the following:-The facility would address residents' needs and strengths regardless of whether or not the issue was included in the MDS or CAAs.-The facility would use resident observation and communication as the primary source when completing assessments and also review records, communicate with staff and other sources as needed to complete residents' assessments.Resident 19 was admitted to the facility in 5/2025 with diagnoses including metabolic encephalopathy (a change in brain function due to an underlying condition) and hearing loss.A review of Resident 19's 6/5/25 admission MDS and 12/6/25 Quarterly MDS revealed she/he had severe cognitive impairment and she/he did not have hearing aids. The CAA for communication indicated she/he was hard of hearing without hearing aids and staff were to elevate their voices when speaking to her/him.On 12/18/25 at 5:17 PM Staff 4 (MDS Coordinator) stated she was responsible for completing the facility's MDS assessments and acknowledged information about Resident 19's need to use hearing aids was not captured in the 6/5/25 admission MDS or the 12/6/25 Quarterly MDS assessment. Staff 4 stated it was necessary for MDS assessments to be accurate to ensure care plan interventions would be developed in a timely manner.

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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. Based on interview and record review it was determined the facility failed to ensure care plans accurately reflect bowel care needs for 1 of 1 resident (#1) reviewed for constipation. The placed residents at risk for constipation and fecal impaction. Findings include.The facility's 11/2017 Comprehensive Care Plans policy and procedure indicated a care plan will be comprehensive and person-centered. It will drive the type of care and services that a resident receives and will describe the resident's medical and nursing needs as well as how the facility will assist in meeting those needs.Resident was admitted to the facility in 7/2019 with diagnoses including quadriplegia (a form of paralysis that affects all four limbs and torso).A Care Plan revised 9/6/25 stated Resident 1 was at risk of constipation as result of bowel incontinence and was to have one bowel movement every three days. No information was included regarding Resident 1's normal bowel movement consistency.On 12/18/25 at 4:58 PM Staff 9 (RN) stated Resident 1 was at risk for constipation due to quadriplegia and she/he was monitored daily to ensure she/he had two bowel movements each day. Staff 9 stated Resident 1's normal bowel movements were of loose consistency. Staff 9 stated if the expected frequency or consistency did not occur, a bowel assessment was to be performed on Resident 1 and she/he was to receive a suppository to prevent constipation and fecal impaction.On 12/19/25 at 12:20 PM Staff 2 (DNS) confirmed Resident 1's care plan did not accurately reflect Resident 1's bowel care needs including frequency of bowel movements, bowel movement consistency and what Resident 1's normal bowel movements were. Staff 2 stated having Resident 1's care plan reflect her/his bowel care needs was important to prevent complications from constipation and fecal impaction.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review it was determined the facility failed to ensure staff assisted a resident with wearing hearing aids for 1 of 1 sampled resident (#19) reviewed for hearing. This placed residents at risk for a decline in communication. Findings include:Resident 19 was admitted to the facility in 5/2025 with diagnoses including metabolic encephalopathy (a change in brain function due to an underlying condition) and hearing loss.A review of Resident 19's 6/5/25 admission MDS revealed she/he had severe cognitive impairment, functional limitation in range of motion of both sides of her/his upper body, was dependent on staff for completion of ADLs and she/he did not have hearing aids. The CAA for communication indicated she/he was hard of hearing without hearing aids and staff were to elevate their voices when speaking to her/him.A review of Resident 19's care plan revealed she/he had a communication deficit related to being hard of hearing without hearing aids. No evidence was found in the care plan for staff to provide Resident 19 with assistance to use her/his hearing aids.Random observations from 12/15/25 through 12/16/25 from the hours of 11:00 AM through 2:00 PM, Resident 19 was observed without hearing aids.On 12/16/25 at 3:29 PM Resident 19 was observed wearing hearing aids. Resident 19 stated they were her/his hearing aids but she/he did not know who helped her/him put them in or take them out. Resident 19 stated she/he did not know who was supposed to put her/his hearing aids in the charger when she/he was ready for bed.On 12/17/25 at 10:47 AM Staff 10 (CNA) stated he normally worked with Resident 19 during the day shift and was unaware she/he had hearing aids because it was not listed in her/his Kardex (a quick reference summary of resident needs). He stated when Resident 19 stated she/he could not hear him he spoke louder.On 12/17/25 at 12:49 PM Staff 11 (CNA) stated Resident 19 was hard of hearing and her/his family told him she/he had hearing aids. Staff 11 stated Resident 19's hearing aids were not listed in her/his Kardex and he thought it was odd because she/he lived in the facility for several months.On 12/17/25 at 2:02 PM Staff 12 (CNA) stated she worked with Resident 19 in the evening three days each week. Staff 12 stated when Resident 19 was in bed, she occasionally found hearing aids sitting on the windowsill next to her/his bed. Staff 12 stated she believed they were Resident 19's and she put them in the charger on her/his nightstand. Staff 12 stated Resident 19's hearing aids were not listed in her Kardex and her/his family never said anything about the hearing aids when they visited her/him.On 12/18/25 at 1:28 PM Resident 19 was observed in her/his room and not wearing hearing aids. Resident 19 was unable to hear questions asked of her/him by the Surveyor in a normal speaking voice. Resident 19 stated she/he had hearing aids and wanted to wear them when she/he was out of bed. On 12/18/25 at 5:00 PM Staff 3 (LPN, Unit Manager) acknowledged Resident 19 was very hard of hearing and required hearing aids which the resident had in her/his room for hearing and communication. Staff 3 stated staff members did not provide adequate assistance with Resident 19's hearing aids because it was not reflected in the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review it was determined the facility failed to provide the necessary care and assistance to maintain good grooming and hygiene for 1 of 2 sampled residents (#11) reviewed for ADLs. This placed residents at risk for poor grooming. Findings include:Resident 11 was admitted to the facility in 2024 with diagnoses including Alzheimer's disease. The 4/15/24 Care Plan indicated Resident 11 required one person substantial to dependent assistance completing personal hygiene and directed staff to offer and encourage nail care twice per week on shower days. The 12/8/25 Quarterly MDS, revealed Resident 11 had a BIMS score of zero which indicated the resident was not cognitively intact and required maximum assistance to complete personal hygiene. The 12/2025 Documentation Survey Report indicated Staff 15 (CNA) completed a shower for Resident 11 on 12/16/25 and didn't provide nail care. On 12/15/25 through 12/17/25 from 8:00 AM to 4:00 PM, Resident 11 had untrimmed nails. The left hand had uneven trimmed fingernails. Two nails had a brown substance under the nailbed. The right hand had untrimmed fingernails, and four nails had a yellow and brown substance under the nailbed. On 12/15/25 at 3:35 PM and 12/15/25 at 2:22 PM, Resident 11 stated she/he was unsure when staff performed nail care and would allow staff to complete nail care when they offered. On 12/17/25 at 1:35 PM, Staff 15 stated Resident 11 was pleasant and cooperative. Staff 15 stated she had great rapport with the resident and was able to complete personal hygiene tasks. Staff 15 stated she didn't provide nail care on 12/16/25 and stated she didn't double check her/his nails post shower. Staff 15 stated she was unsure if nail care was supposed to be provided on shower days. Staff 15 entered Resident's 11 room and acknowledged the resident's nails were dirty, cracked and needed to be trimmed. On 12/17/25 at 4:13 PM, Staff 12 (CNA) stated CNAs were able to perform nail care since Resident 11 was not diabetic. Staff 12 stated she performed nail care when resident's nails were long and typically completed nail care post shower. Staff 12 entered Resident 11's room and acknowledged the resident's nails were covered in gunk under the nailbed and required trimming. Staff 12 stated she didn't perform nail care for Resident 11. On 12/17/25 at 4:23 PM, Staff 3 (LPN- Unit Manager) stated CNAs were able to perform nail care on non-diabetic residents. Staff 3 stated Resident 11 was combative and refused nail care. Staff 3 acknowledged Resident 11's nails were unkept and expected staff to perform nail care after showers. Staff 3 stated Resident 11 was dependent on staff for personal hygiene and expected CNAs to implement and follow the care plan. On 12/18/25 at 10:51 AM, Staff 9 (RN) stated she was unaware Resident 11 refused nail care and expected staff to perform nail care after Resident 11 showered.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activities program for 1 of 1 sampled resident (#13) reviewed for activities. This placed the resident at risk for a decline in psychosocial well-being and diminished quality of life. Findings include:The 11/2017 Quality of life: Activities Policy indicated the following:-The facility activities will be meaningful to the residents. -Activities will enhance the physical, cognitive and emotional health of the residents.-Activities are scheduled daily, and residents are given an opportunity to contribute to the planning, preparation and conducting of the program as able and as appropriate.-The activity program consists of individual, small and large activities which are designed to meet the assessed needs and interest of each resident.Resident 13 was admitted in 9/2025 with diagnoses including chronic pain and muscle weakness. The 9/29/25 Care Plan indicated the following:-Resident 13 wishes to attend spiritual activities. -Staff to post calendar in room and remind and offer her/him to participate in activities. The 10/5/25 admission MDS indicated Resident 13 was cognitively intact. The MDS indicated the resident liked listening to music, being around animals, read the newspapers/magazines and participating in religious services were important activities to the resident. The 11/2025 Documentation Survey Report indicated Resident 13 didn't participate in any in or out of the room activities.On 12/15/25 through 12/18/25 from 8:00 AM to 4:00 PM, Resident 13 was observed in her/his room in bed. No music, books, magazines or newspapers were visible in the resident's room. No activity calendar was posted in her/his room.On 12/15/25 at 1:33 PM, Resident 13 was lying flat in bed and stated she/he was in pain and didn't tolerate sitting in the wheelchair to participate in group activities. Resident 13 stated staff didn't offer an alternative activity to do in her/his room. On 12/17/25 at 8:51 AM, Resident 13 was lying flat in bed and stated using the Hoyer (mechanical) lift and frequent incontinence episodes were barriers to getting out of bed and participating in group activities. Resident 13 stated an activities calendar was not offered. Resident 13 stated group activities were offered daily including the weekends.On 12/18/25 at 10:10 AM, Staff 10 (CNA) stated Resident 13 tolerated being out of bed for one hour but preferred to stay in bed due to pain in her/his legs. Staff 10 stated Resident 13 participated in group activities when she/he was out of bed but was unsure in room activities were offered. Staff 10 stated Resident 13 was discouraged because she enjoyed activities in her/his room but was not offered things to do in her/his room. On 12/18/25 at 10:35 AM, Staff 17 (CNA) stated Resident 13 preferred staying in bed when group activities were offered. Staff 17 stated one on one visits were not an option due to lack of staffing, but group activities were offered daily. Staff 17 stated Resident 13 refused coloring pages and books when offered. On 12/18/25 at 10:58 AM, Staff 9 (RN) stated Resident 13 participated in group activities. Staff 9 stated Resident 13 didn't get out of bed due to chronic pain. Staff 9 stated in room activities included card games and were facilitated by the CNAs or the Staff 18 (Activity Director). On 12/18/25 at 11:10 AM, Staff 18 stated she offered residents who preferred to stay in bed word searches, coloring pages and card games. Staff 18 stated she provided activity calendars for all residents. Staff 18 stated Resident 13 preferred staying in bed and didn't participate in group activities. Staff 18 stated a sound machine and activities calendar was in Resident 13's room. Staff entered Resident 13's room and acknowledged the resident didn't have an activities calendar or sound machine in her/his room. On 12/19/25 at 10:55 AM, Staff 3 (LPN Unit Manager) stated residents who preferred to stay in bed were offered one on one visits. Staff 3 stated Resident 13 participated in group activities, napped and watched tv. Staff 3 was aware Resident 13 refused participating in group activities. Staff 3 stated Resident 13 complained staying out of bed for long periods of time due to chronic pain. Staff 3 acknowledged Resident 13 wasn't offered in room activities.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review it was determined the facility failed to provide pressure ulcer care consistent with professional standards of practice for 1 of 2 sampled residents (#1) reviewed for pressure ulcer. This placed residents at risk for new and worsening pressure ulcers. Findings include: The 8/2018 Quality of Care Skin Integrity Policy indicated the following:A weekly evaluation of the PU/PI (Pressure Ulcer/Pressure Injury) will include:-Evaluation of the PU/PI, if no dressing is present.-Evaluation of the status of the dressing, is present.-Status of the area surrounding the PU/PI (without removing existing dressing).-If pain is present, is it being controlled. PU/PI documentation will include:-The type of injury (pressure versus non-pressure)-The stage-A description of the PU/PI's characteristics-Progress toward healing and identification of potential complications-If infection is present. Resident 13 admitted to the facility in 9/2025 with diagnoses including quadriplegia (paralysis or significant weakness in both arms and legs).A 2024 Care Plan indicated the following:-Monitor/document wound size, depth, margins: peri wound skin, sinuses, undermining, exudate, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. A 11/2025 Skin & Wound Evaluation indicated Resident 1 developed a facility acquired stage three pressure ulcer (wound extends through skin into fat). Revealed the following.-11/20/25 the wound measured 1.6 in length and 0.9 in width. New wound. Staff did not include a description of the wound.-11/29/25 the wound measured 0.2 in Length and 0.2 in width. Wound was improving. Staff did not include a description of the wound.-12/9/25 the wound measured 1.45 in length and 1.23 in width. Wound was improving. Staff did not include a description of the wound.-12/17/25 the wound measured 2.95 in length and 3.11 in width. The wound was healed and resolved. Staff did not include a description of the wound.The medical record indicated Resident 1's wound care order started on 11/21/25 and ended on 12/18/25. The wound care order indicated the following:-Cleanse buttocks, apply collagen and hydrogel, pack with alginate and cover with a foam dressing. Change every 2 days and as needed. One time a day every 2 day(s).On 12/18/25 at 11:38 AM and 2:01 PM, Staff 9 (RN) performed PPE (Personal Protective Equipment) prior to exposing Resident 1's coccyx (bone located at the end of the spine). There was no dressing over the area which was closed and was blanchable. Staff 9 stated the residents wound was healed and wound care orders were discontinued. On 12/18/25 at 2:11 PM, Staff 9 stated staff used a wound care app which monitored progression and measurements of wounds. Staff 9 stated no training was offered for the wound app and she was trained by other staff who utilized the wound app. Staff 9 stated she was unsure what the wound app measured when she documented the wound. Staff 9 stated the measurements she took were not accurate and additional instructions were not provided on how to utilize the wound app.On 12/19/25 at 2:14 PM, Staff 3 (LPN-Unit Manager) stated staff used a wound app to monitor progression and the size of wounds. When staff used the wound app they used a paper measuring tape to compare wound measurements for accuracy. Staff 3 stated her and Staff 2 (DNS) monitored the wound app daily. Staff 3 stated the wound app measured growth and progression of wounds when a sticker was placed near the wound. Staff 3 stated staff were able to manually enter measurements if the wound app measured the wounds incorrectly. Staff 3 stated no policy or education was provided relating to the wound app. Staff 3 stated a healed wound wouldn't have measurements. Staff 3 stated the wound to Resident 1's buttocks was not measured or documented accurately. Staff 3 acknowledged proper measurements and documentation were an important part of wound care to ensure appropriate healing of a wound. On 12/19/25 at 3:00 PM, Staff 2 stated staff used a wound care app that was used for pictures and measurements. The wound care app included a sticker and communicated with a cell phone. The sticker was placed near the wound and Staff 2 expected staff to place the sticker accurately to ensure accurate measurement of the wound. Staff 2 stated no formal education was provided on how to use the wound app but Staff 9 trained other staff on the floor on how to use the wound care app. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff 2 stated he was unsure what the wound care app measured taken by Staff 9 once Resident 1's wound was healed. Staff 2 acknowledged measurements were not accurate and expected staff verified measurements and used a paper measuring tape for accuracy.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, it was determined the facility failed to manage contractures and provide continued treatment and services to prevent decrease in ROM and mobility for 2 of 4 residents (#s 1 and 3) reviewed for contracture and mobility. This placed residents at risk for contractures and decreased mobility. Findings include:The facility's 11/2017 Quality of Life ADLs/Maintain Abilities Policy indicated the facility provided necessary care and services to prevent avoidable decline in ADLs, ensured residents received treatment to maintain or improve ADL abilities, including mobility, and staff avoided using clinical diagnoses as the sole justification for decline. 1. Resident 3 was admitted to the facility in 3/2023 with diagnoses including Alzheimer's disease, generalized weakness, and pain. Random observations from 12/15/25 through 12/19/25 from 8:50 AM to 2:47 PM revealed Resident 3 was seated in a recliner with her/his left foot and ankle resting on a footrest, and the left foot and ankle were rotated towards the midline of the body. Resident 3 was not grimacing or groaning while in the recliner. On 12/17/25 at 11:21 AM and 12/18/25 at 4:56 PM Staff 5 (CNA) stated Resident 3's left foot and ankle were rotated inward, and she adjusted the position of Resident 3's left ankle and foot when she noticed it turned inward in the recliner. Staff 5 stated she reported the issue to the DNS in 9/2025 or 10/2025, but the issue was not addressed. On 12/17/25 at 11:59 AM and 12/18/25 at 4:43 PM Staff 6 (CNA) stated Resident 3's left ankle and foot rotated inward when seated in the recliner. Staff 6 stated Resident 3 sat in her/his recliner often. Staff 6 stated he was concerned regarding Resident 3's foot positioning, and he reported the issue to a nurse a few months ago but did not recall which nurse he informed. On 12/17/25 at 1:01 PM Staff 7 (LPN) stated Resident 3 sat in her/his recliner often and noticed Resident 3's left foot rotated toward the midline whenever she/he was sitting in the recliner. Staff 7 stated she was unaware if an assessment was completed regarding Resident 3's left foot. On 12/18/25 at 11:50 AM and 12/19/25 at 9:06 AM and 11:45 AM, Staff 8 (Director of Rehabilitation) stated he worked with Resident 3 from 7/2025 to 9/2025 on gait training, transfers, and balance, and discharged her/him from physical therapy on 9/12/25. Staff 8 stated there was no foot or ankle rotation present with Resident 3 when she/he discharged from therapy. Staff 8 confirmed Resident 3's inward ankle rotation placed the ankle in an unstable position and her/his ankle bone close to the skin, increasing the risk for decreased ROM and skin impairment. Staff 8 stated Resident 3's ankle had been unstable, and the inward rotation of the left ankle had developed gradually over time. 2. Resident 1 was admitted to the facility in 7/2019 with diagnoses including quadriplegia (a form of paralysis that affects all four limbs and torso). A 12/4/23 physician order included hand splints to be placed on both hands at night and remain on the resident's hands for four hours for skin care. The order was discontinued on 9/19/25 with no information was located to indicate why the splints were discontinued. A 9/6/25 Care Plan included instructions for splints to be worn on both hands for four hours at night (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	12/19/2025

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to prevent contractures. On 12/18/25 at 12:35 PM Resident 1 stated she/he was unaware he was supposed to wear hand splints at night, and staff did not assist her/him with placing or removing the bilateral hand splints. On 12/18/25 at 1:10 PM Staff13 (CNA) stated she followed care instructions from a computer to determine Resident 1's care needs and documented when care was provided. Staff 13 reviewed Resident 1's task records for each shift and stated no instructions were found regarding Resident 1 wearing bilateral hand splints at night and no place to document if the resident wore her/his bilateral hand splints. On 12/18/25 at 1:42 PM Staff 3 (LPN - Unit Manager) stated instructions for Resident 1 wearing bilateral hand splints were missing from her/his orders. Staff 3 stated the orders for the bilateral hand splints were discontinued on 9/18/25 and she was unable to locate documentation on why the order was discontinued. Staff 3 stated Resident 1's bilateral hand splint orders should have continued after 9/17/25 to prevent contractures and skin issues. On 12/18/25 at 1:59 PM Staff 2 (DNS) confirmed Resident 1's care instruction regarding the use of wearing bilateral hand splints were missing from the order. Staff 2 stated no records indicated Resident 1 had been assisted with bilateral hand splints since 9/17/25.