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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38E075 | A. Building<br>B. Wing | 06/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Tierra Rose Care Center | 4254 Weathers Street NE<br>Salem, OR 97301 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>34702<br><br>Based on observation, interview and record review it was determined the facility failed to provide appropriate foot care for 1 of 3 sampled residents (#66) reviewed for ADLs. This placed residents at risk for lack of nail care and skin impairments. Finding include:<br><br>Resident 66 admitted to the facility in 2024 with diagnoses including heart failure and weakness.<br><br>Resident 66's 5/7/24 care plan indicated staff were to check nail length, trim and clean on bath days and as necessary and report any changes to the nurse.<br><br>On 6/25/24 at 9:33 AM Resident 66 was observed wearing sandals and had thick toenails extending past the end of her/his toes.<br><br>The 6/26/24 bathing records indicated Resident 66 had a bath on 6/26/24 at 11:52 AM.<br><br>On 6/26/24 at 2:22 PM Staff 4 (CNA) stated nail care was to be provided to residents weekly and the nurse was responsible for giving CNA staff a list of who needed nail care.<br><br>On 6/26/24 at 2:30 PM Staff 5 (LPN) observed Resident 66 and confirmed Resident 66's toenails were long, thick, and extended past the end of her/his toes. |

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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>34702<br><br>Based on observation, interview and record review it was determined the facility failed to follow care planned interventions and revise care plans to prevent falls for 3 of 6 sampled residents (#s 1, 64 and 66) reviewed for falls and during a random observation. This placed residents at risk for injury from falls. Findings include:<br><br>1. Resident 64 admitted to the facility in 2024 with diagnoses including stroke and dementia.<br><br>a. The 3/1/24 care plan indicated Resident 64 was to have a fall mat on the left side of the bed.<br><br>Resident 64's 6/10/24 fall investigation indicated the following:<br><br>- Resident 64 had dementia and a history of falls.<br><br>- Resident 64 had a non-injury fall. The Resident was found on the right side of her/his bed and stated she/he attempted to transfer to the wheelchair and fell .<br><br>-Resident 64 had weakness and balance issues and overestimated the ability to transfer independently. Though the call light was in reach, the resident had poor safety awareness as evidenced by all of her/his previous falls and chose to attempt to transfer and fell . Ongoing resident education on safety was provided.<br><br>There was no indication in the clinical record to indicate an assessment was completed to determine if current interventions were effective, or if additional interventions including a right sided fall mat, were needed.<br><br>On 6/24/24 at 12:08 PM Resident 64 was observed to be in bed with a fall mat to the left side of the bed only.<br><br>On 6/24/24 at 12:21 PM Staff 8 (CNA) stated she observed Resident 64 attempt to get out of bed in the past and the resident only attempted to get up on the right side of the bed.<br><br>On 6/26/24 at 2:35 PM Staff 11 (RNCM) reviewed the 6/10/24 fall progress note and stated Resident 64 had a fall on the right side of the bed. Staff 11 stated after the fall no new interventions were put in place and a new intervention of bilateral fall mats was warranted after the 6/10/24 fall.<br><br>b. The 6/26/24 updated care plan indicated Resident 64 was to have bilateral fall mats in place.<br><br>On 6/27/24 at 9:16 AM Staff 12 (CNA) was observed to assist Resident 64 into bed and exited the room without placing bilateral fall mats.<br><br>On 6/27/24 at 9:16 AM Staff 12 was asked to review Resident 64's care plan. Staff 12 stated the care plan indicated the resident was supposed to have bilateral fall mats. Staff 12 entered the room and placed a fall mat on the left side of the bed only and then exited the room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/27/24 at 9:27 AM Staff 3 (Assistant DNS) acknowledged Resident 64 was care planned for bilateral fall mats and she/he had a fall mat on the left side of the bed but not the right side.<br><br>2. Resident 66 admitted to the facility in 2024 with diagnoses including heart failure and weakness.<br><br>The 5/29/24 care plan indicated Resident 66 was to have a fall mat on the right side of the bed.<br><br>On 6/24/24 at 12:05 PM Resident 66 was observed to be in bed with a fall mat on the left side of the bed and no fall mat on the right side of the bed.<br><br>On 6/24/24 at 12:19 PM Staff 8 (CNA) observed Resident 66 and acknowledged the fall mat was on the left side of the bed and no fall mat was located on the right side of the bed.<br><br>On 6/26/24 at 2:30 PM Resident 66 was observed in bed and had a fall mat on the left side of the bed. There was no fall mat located on the right side of the bed.<br><br>On 6/26/24 at 2:30 PM Staff 5 (LPN) observed Resident 66 and acknowledged the fall mat was on the left side of the bed and no fall mat was located on the right side of the bed. Staff 5 acknowledged the care plan indicated she/he was to have a right sided fall mat.<br><br>On 6/26/24 at 2:35 PM Staff 11 (RNCM) stated Resident 66's care plan indicated a fall mat was to be on the right side of the bed. Staff 11 stated Resident 66 was to have bilateral fall mats in place and the care plan was not updated.<br><br>3. Resident 1 admitted to the facility in 2009 with diagnoses including weakness and stroke.<br><br>The 7/28/21 care plan indicated Resident 1 had a history of falls and was to have bilateral fall mats in place.<br><br>On 6/27/24 at 9:16 AM Resident 1 was observed to have one fall mat to the right side of the bed and no fall mat on the left side of the bed.<br><br>On 6/27/24 at 9:16 AM Staff 12 (CNA) was observed to remove Resident 1's fall mat on the right side of the bed and place it across the room next to the bed of the resident's roommate.<br><br>On 6/27/24 at 9:27 AM Staff 3 (Assistant DNS) observed Resident 1 and acknowledged her/his care plan indicated she/he was to have bilateral fall mats and acknowledged there were no fall mats in place for Resident 1. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50930<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure proper storage and labeling of medication and biologicals for 1 of 2 medication carts and 1 of 1 medication and biologicals refrigerator reviewed for biologicals and medication storage. This placed residents at risk for inaccurate tuberculosis testing, decreased vaccine efficacy, improper medication administration, and reduced efficacy of medication. Findings include:<br><br>According to the facility Medication Labeling and Storage Policy Statement, Revised 2/23, Multi-dose vials that are opened were dated and discarded within 28 days unless the manufacturer specified a shorter or longer date for the open vial. The policy also stated that medications may not be transferred between containers, and medications and biologicals were stored in the packaging, containers, or other dispensing systems in which they were received.<br><br>On 6/26/24 at 10:15 AM a review of the biologicals and medication storage area was conducted with Staff 5 (LPN). One medication cart, and one refrigerator were reviewed for proper medication and biologicals storage and labeling.<br><br>On 6/26/24 at 10:19 AM the refrigerator was noted to contain one sealed multi-dose vial of Tubersol (solution used in testing for Tuberculosis), and one opened multi-dose vial of Tubersol. Staff 5 (LPN) and Staff 10 (CMA) verified the opened vial of Tubersol did not have a date on the box or the vial.<br><br>On 6/26/24 at 10:33 AM the medication cart was noted to have a small cup that contained multiple round white pills with no markings and another small cup placed on top of the pills. The bottom small cup was labeled with the word, Loratadine.<br><br>On 6/26/24 at 10:33 AM Staff 5 (LPN) indicated the white pills were improperly stored and, we shouldn't be doing that, we need to get rid of those.<br><br>On 6/26/24 at 2:45 PM Staff 3 (Assistant DNS) acknowledged the vial of Tubersol and the cup of white pills were not labeled and stored appropriately. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830<br><br>Based on observation and interview it was determined the facility failed to ensure food was stored appropriately and discarded in a timely manner, and failed to maintain a clean freezer for 1 of 1 kitchen and 1 of 1 resident refrigerator reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include:<br><br>1. On [DATE] at 7:48 AM during the initial tour of the facility's walk-in refrigerator and walk-in freezer the following was observed:<br><br>Walk-in refrigerator:<br><br>*An opened half-gallon heavy whipping cream container with a manufacturer use by date of [DATE].<br><br>*A red and brown liquid approximately 60 inches in length on the floor directly under a metal rack with food items including raw meat defrosting.<br><br>Walk-in freezer:<br><br>*An opened bag of pre-made egg and cheese omelets, undated.<br><br>*Food crumbs and small dirt clumps approximately one centimeter and smaller on the floor throughout the entire freezer.<br><br>On [DATE] at 8:05 AM Staff 6 (Dietary Manager) acknowledged the identified findings.<br><br>2. On [DATE] at 12:54 PM the resident refrigerator located in the therapy gym was reviewed. The following was observed:<br><br>-Opened bottle of sriracha mustard, expired [DATE].<br><br>-Undated plastic container of moldy strawberries.<br><br>-Undated plastic sandwich bag of moldy blueberries and strawberries.<br><br>-Styrofoam container with a lid of chocolate pudding with a use by date of [DATE].<br><br>On [DATE] at 1:03 PM Staff 1 (Administrator) and Staff 3 (Assistant DNS) acknowledged the identified items. Staff 3 stated food was to be labeled and discarded after three days or after the use by dates. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>50930<br><br>Based on interview and record review it was determined the facility failed to ensure resident records were complete and accurate for 1 of 1 sampled resident (#7) reviewed for therapy services. This placed residents at risk for inaccurate medical records and unassessed needs. Findings include:<br><br>Resident 7 was admitted to the facility in 4/2024 with diagnoses including arthritis, gait and mobility abnormalities and muscle weakness.<br><br>Resident 7's Comprehensive Care Plan, dated 5/29/24, indicated the resident had an ADL self-care performance deficit. Interventions included the provision of a restorative nursing program with range of motion exercises for the resident's lower extremities.<br><br>Resident 7 did not have active orders for Physical Therapy, Occupational Therapy, or Restorative Aid Therapy.<br><br>On 6/26/24 at 12:55 PM Resident 7 stated she/he did not receive any therapy services or Restorative Aid Therapy services since her/his admission.<br><br>On 6/26/24 at 1:46 Staff 13 (CNA/RA) stated Resident 7 was not receiving Restorative Aid Therapy at this time.<br><br>On 6/27/24 at 1:49 PM Staff 15 (LPN/Resident Care Manager) stated all resident care plans were revised and kept up to date by the Resident Care Manager, and Resident 7 did not have a Restorative Aid Therapy program on her/his care plan.<br><br>On 6/27/24 at 2:01 PM Staff 15 (LPN/Resident Care Manager) acknowledged Resident 7's care plan included a plan for Restorative Aid Therapy services, with an initiation date of 5/29/24. She stated I don't know how that got there, she/he doesn't do Restorative Aid Therapy.<br><br>On 6/27/24 at 2:41 PM Staff 3 (Assistant DNS) stated the intervention related to a Restorative Aid Therapy plan was placed in Resident 7's care plan in error and was intended for a different resident in the facility. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>48830<br><br>Based on observation, interview, and record review it was determined the facility failed to maintain essential kitchen equipment in a safe operating condition for 1 of 1 kitchen reviewed for kitchen services. Findings include:<br><br>On 6/24/24 at 7:48 AM an observation of the walk-in freezer in the kitchen revealed long vertical ice crystals approximately 15 inches in length attached to a pipe that connected to the freezer temperature unit.<br><br>On 6/24/24 at 8:05 AM Staff 6 (Dietary Manager) acknowledged the identified findings. He stated the facility had two repair companies look at the walk-in freezer and each were unsuccessful with repairs. Staff 6 stated Staff 7 (Plant Manager) broke the ice crystals in the walk-in freezer weekly as the ice crystals accumulated rapidly and a log of this was kept.<br><br>On 6/26/24 at 9:25 AM Staff 6 provided the facility's Kitchen Freezer Maintenance log and it revealed Staff 7 completed weekly maintenance in the walk-in freezer related to the ice crystals since 9/2023. |