STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E075	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Rose Care Center	4254 Weathers Street NE 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 implement interventions to promote wound healing for 1 of 2 sampled residents (#5) reviewed for pressure ulcers. This placed the residents at risk for worsening pressure ulcers. Findings include: Resident 5 was admitted to the facility in 2024 with diagnoses including dementia. An 8/3/25 Significant Change MDS indicated Resident 5 was not cognitively intact and was at high risk for developing sores. Resident 5 was on a turning/repositioning program.An 8/22/25 Care Plan indicated the following:- Resident 5 required limited assistance by one staff to turn and reposition in bed two to three times a shift and as necessary. - Resident 5 was assisted to reposition often to reduce the risk of pressure related skin breakdown. - Staff were to follow facility policies/protocols for the prevention/treatment of skin breakdown. An 10/5/25 physician order indicated Resident 5 had a MASD (Moisture-Associated Skin Damage) wound in her/his coccyx. From 10/13/25 through 10/16/25, on eleven occasions between 9:00 AM and 4:00 PM, the surveyor observed Resident 5 to lay flat on her/his back with no offloading or other pressure relieving devices present. On 10/14/25 at 2:43 PM, Staff 9 (RN) stated Resident 5's wound was healed and closed.On 10/15/25 at 4:16 PM, Resident 5 was observed in her/his bed and was lying flat. Resident 5 was awake and stated her/his bottom was painful and she/he was not comfortable. Resident 5 was unable to lift her/his legs and was unable to wiggle her/his toes.On 10/16/25 at 1:20 PM, Staff 7 (CNA) stated a turning/repositioning program indicated staff turned residents in bed to the left and right side and onto their backs with pillow support every two hours. Staff 7 stated she was informed by the CNA lead staff and/or the nurses when a resident was on a turning/repositioning program. Staff 7 stated Resident 5 was bed bound and had limited ROM to her/his left and right arm. Staff 7 stated Resident 5 required repositioning when she/he slid down in bed. Staff 7 stated she noticed a small sore on Resident 5's bottom and notified nursing. Staff 7 stated she applied barrier cream to her/his bottom and she notified staff when the dressing was soiled. Staff 7 stated Resident 5 was not on a turning/repositioning program.On 10/16/25 at 1:46 PM, Staff 8 (CNA) stated a turning/repositioning program indicated staff turned residents in bed to the left and right side with pillow support every one to two hours. Staff 8 stated there no residents on a turning/repositioning program. Staff 8 stated Resident 5 had dementia, was bed bound, slept most of the time and refused to get out of bed. Staff 8 stated Resident 5 did not have any skin issues and was not on a turning/repositioning program. Staff 8 stated she was informed about residents on a turning/repositioning program during shift change and/or the resident's care plan. On 10/16/25 at 1:52 PM, Staff 9 stated all residents who had wound care treatment orders were on a turning/reposition program. Staff 9 stated Resident 5 required maximum assistance when turned to the side. Staff 9 stated Resident 5 was on a turning/repositioning program and expected staff repositioned Resident 5 to the right, left and on her/his back every one to two hours. Staff 9 stated she ensure staff implemented repositioning interventions by listening on the radios used by floor staff and observed the residents throughout the day and indicated, But I have three halls. On 10/17/25 at 8:50 AM, Staff 11 (RN) was observed performing wound care on Resident 5. Resident 5 was lying flat and Staff 10 (CNA) turned her/him to the right side. The wound was observed to be open, with a pink wound bed and non-blanchable on the resident's coccyx. Staff 11 acknowledged the open, (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-blanchable, pink wound. Resident 5 verbalized pain when the wound was touched and during the wound care dressing change. Staff 11 placed a new dressing, positioned Resident 5 onto her/his back and placed pillows under her/his knees.On 10/17/25 at 9:04 AM, Staff 11 stated residents on a turning/repositioning program were repositioned every two hours and she was unsure if Resident 5 had repositioning orders. Staff 11 returned to the surveyor a few minutes later and said Resident 5 was on a turning/repositioning program. On 10/17/25 at 9:09 AM, Staff 10 (CNA) stated Resident 5 was not on a turning/repositioning program. On 10/17/25 at 10:25 AM, Staff 6 (LPN Resident Care Manager) stated Resident 5 was bed bound. Staff 6 stated Resident 5 had one wound that was classified as MASD and stated the pictures taken by staff showed a closed wound. Staff 6 stated Resident 5 received incontinence care several times per shift and had scheduled wound care treatment. Staff 6 stated she expected staff to reposition Resident 5 every one to two hours with pillow support. Staff 6 stated she considered Resident 5's wound to be unavoidable due to Resident 5's lack of memory and the inability for Resident 5 to communicate needs. Staff 6 acknowledged Resident 5 did not use the call light and depended on staff to reposition her/him in bed. On 10/17/25 at 10:41 AM, Staff 3 (LPN, Assistant DNS) stated there was no specific program that required using pillow support when staff repositioned residents. Staff 3 stated she expected staff to check residents regularly for skin breakdown. Staff 3 acknowledged using pressure relieving devices to offload Resident 5's coccyx was beneficial for wound healing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to follow infection control procedures for hand hygiene and PPE use for 1 of 1 facility reviewed for infection control. This placed residents at risk for exposure to infection and cross contamination. Findings include: 1. The CDC's 6/24/24 Infection Control Guidance: SAS-CoV-2 indicated staff who provided care to residents with confirmed COVID-19 were to wear a respirator with N95 filters and a barrier face covering. Resident 39 was admitted to the facility in 9/2/25 with a diagnosis of Parkinson's disease. A review of Resident 39's Progress Notes revealed she/he tested positive for COVID-19 on 10/14/25 at 10:23 AM. On 10/14/25 at 12:25 PM Resident 39's room was observed to have contact and droplet precaution signage on the door. On 10/14/25 at 12:25 PM Staff 12 (CNA) donned a gown, gloves, and surgical mask, but did not don eye protection and a N95 respirator before entering Resident 39's room. Staff 12 stated Resident 39 was on transmission-based precautions for COVID-19. Staff 12 stated he used contact precautions without eye protection because he did not provide direct care to Resident 39. On 10/15/25 at 11:48 AM Staff 13 (CNA) donned a gown, gloves, surgical mask, and a face shield hanging on the wall next to the doorway inside room [ROOM NUMBER]. Staff 13 was observed to enter room [ROOM NUMBER] to deliver a meal tray, proceeded to doff her PPE at the doorway, hung the face shield on the wall next to the doorway inside the resident's room and did not disinfect the face shield prior to exit. On 10/15/25 at 12:14 PM Staff 14 (CNA) stated a face shield was stored inside the room of a resident with COVID-19 and she used it when she provided care. On 10/15/25 at 1:58 PM Staff 2 (DNS) and Staff 3 (Assistant DNS) confirmed re-usable face shields should not be stored inside resident rooms and staff needed to wear both N95 respirators and eye protection when they entered the rooms of residents with COVID-19. 2. On 10/13/25 at 12:05 PM during the lunch meal service on the South Unit Hallway, Staff 15 was observed to place his hands inside a garbage bag to dispose of trash then prepared and delivered a cup of coffee to room [ROOM NUMBER] without completing hand hygiene. On 10/13/25 at 12:19 PM Staff 15 acknowledged he did not perform the needed hand hygiene. In a concurrent interview on 10/15/25 at 1:58 PM Staff 2 and Staff 3 confirmed staff were expected to complete hand hygiene as needed.