STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E173	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Portland	12640 SE Bush Portland, OR 97236

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review, it was determined the facility failed to promote and facilitate resident self-determination to support a resident's preference for health care providers for 1 of 3 sampled residents reviewed for abuse. This placed residents at risk for lack of self-determination and autonomy. Findings include: The facility's Resident Rights: Right to Self-Determination Policy, dated 7/2018, indicated the following: -The facility would support each resident to have the opportunity to exercise his or her autonomy regarding those things that are important to his or her life. This included the resident's interests and preferences. -The resident had a right to, and the facility would promote and facilitate resident self-determination through support of resident choices, including but not limited to the rights specified in the regulation. -The resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments and plan of care. -The resident had a right to make choices about aspects of his or her life in the facility that are significant to the resident. Resident 1 was admitted to the facility in 5/2024 with diagnoses including Parkinson's Disease (a progressive neurological disorder) and anxiety. Resident 1's 5/30/25 revised Trauma Care Plan instructed staff to involve Resident 1 in her/his cares and daily decisions. Resident 1's 11/6/25 Modification Quarterly MDS and 2/4/26 Quarterly MDS indicated the resident had no cognitive impairment. On 4/6/26 at 9:39 AM, Resident 1 stated she/he spoke with several staff members and administration about not wanting Staff 3 in her/his room or providing care to her/him, on several occasions. Resident 1 stated she/he tried to get her to not work with me but Staff 3 continued to be assigned to her/him and was her/his CNA, today. Resident 1 stated she/he told them and told them she/he did not want Staff 3 as her/his CNA, but nothing changed. On 4/6/26 at 11:16 AM, Witness 1 (Complainant) stated Resident 1 did not want Staff 3 to be her/his CNA. Witness 1 stated we complained to the facility several times but it doesn't do anything. Witness 1 stated they had no idea why the facility continued to assign Staff 3 as Resident 1's CNA but was told the facility did not have anyone else. A review of the 3/24/26 through 4/6/26 staff assignment sheets indicated Staff 3 (CNA) was assigned to Resident 1 on the following days: -3/25/26, 3/26/26, 3/27/26, 3/28/26, 3/29/26, 3/31/26, 4/1/26, 4/2/26, 4/3/26, 4/5/26 and 4/6/26. Observations on 4/6/26 between the hours of 9:30 AM and 2:30 PM revealed Staff 3 provided care and services to Resident 1 during day shift. On 4/6/26 at 1:04 PM, Staff 3 stated Resident 1 did not like her as her/his CNA and the nursing staff and upper management were aware. Staff 3 stated they continued to assign her as Resident 1's CNA despite being aware Resident 1 doesn't want me. On 4/7/26 at 9:19 AM, Staff 8 (CNA) stated her and Staff 3 worked as partners in Resident 1's section and had been assigned to care for Resident 1 for awhile. Staff 8 stated Resident 1 did not want Staff 3 assisting her/him. On 4/7/26 at 10:04 AM, Staff 9 (Social Services) stated Resident 1 reported she/he did not want Staff 3 as her/his CNA, several times. Staff 9 stated the concern was talked about amongst us all for a while. Staff 9 stated Resident 1 mentioned it to him again on Monday (4/6/26) and he passed the information up the line to Staff 1 (Administrator) and Staff 2 (DNS). On 4/7/26 at 10:50 AM, Staff 10 (Staffing Coordinator/Human Resources) stated she was responsible for assigning CNAs to specific resident rooms in conjunction with Staff 2. Staff 10 confirmed Resident 1 (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbalized complaints regarding Staff 3 and stated changes in CNA assignments were made if a teammate asked to make a change and Staff 3 did not have any issues providing care to Resident 1. Staff 10 stated Staff 1 and Staff 2 were aware of Resident 1's request and had spoken to the resident and her/his sister. On 4/7/26 at 11:10 AM, Staff 2 stated she was aware Resident 1 did not want Staff 3 assigned to her/him. Staff 2 reviewed CNA assignment sheets for 3/24/26 through 4/6/26 and confirmed Staff 3 was assigned to Resident 1 on 3/25/26, 3/26/26, 3/27/26, 3/28/26, 3/29/26, 3/31/26, 4/1/26, 4/2/26, 4/3/26, 4/5/26 and 4/6/26. Staff 2 stated it was Resident 1's right to have a choice regarding who cared for her/him, but there were challenges with staffing and many considerations when it came to CNA assignments.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to notify a resident's representative of a hospital transfer for 1 of 3 sampled residents (#4) reviewed for notification of changes. This placed residents and responsible parties at risk for not being informed of transfers: Findings include:The facility's 7/2018 Notification of Changes of Condition Policy instructs the facility to promptly notify the resident representative when there was a decision to transfer a resident from the facility to the hospital.Resident 4 was admitted to the facility in 2/2025 with diagnoses including peripheral vascular disease (a condition that restricts blood flow usually with legs and feet).Resident 4's admission Profile indicated Witness 4 (Complainant) was the resident's responsible party and emergency contact.A review of Resident 4's clinical record revealed she/he was transferred to the hospital on [DATE] and 12/18/25. No evidence was found in Resident 4's clinical record to indicate the resident's representative was notified of the hospital transfers. On 4/7/26 at 8:56 AM Staff 17 (LPN) stated the emergency contact or representative listed on the face sheet was to be notified before or immediately after the resident left the facility and the information was to be documented in the resident's clinical record.On 4/7/26 at 9:34 AM Staff 4 (LPN) stated family were to be contacted when residents transferred out of the facility to the hospital by who was listed as emergency contact or responsible party on the face sheet and he documented who was contacted in the clinical record. On 4/7/26 at 1:06 PM Staff 2 (DNS) and Staff 1 (Administrator) confirmed Witness 4 was not notified on 12/18/25 when Resident 4 was transferred to the hospital and acknowledged nursing staff were not contacting resident representatives.The deficient practice was identified as Past Noncompliance based on the following:On 12/19/25, the deficient practice was identified by the facility and was corrected when the facility did a root cause analysis of the incident and determined the facility had not consistently notified required parties for condition changes including hospital transfers. 1. Nursing staff were educated on Notification of Changes and Best Practices for Nursing Documentation on 12/19/25, 2. One-to-one education was provided on 12/19/25 with Staff 18 (RN), the nurse on shift at time of the transfer, 3. Notification of Changes was added as a focus area for the facility's Quality Assurance Performance Improvement (QAPI) team on 12/19/25, 4. Ongoing audits and tracking were initiated on 1/2026. Staff 2 continued to complete audits and ongoing education was provided as needed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review it was determined the facility failed to ensure a resident was free from sexual abuse for 1 of 3 sampled residents (#2) reviewed for abuse. This placed residents at risk for a decrease in their quality of life and at risk for psychosocial difficulties. Findings include: The facility's 11/2017 Freedom from abuse, neglect, and exploitation policy defined sexual abuse as non-consensual sexual contact of any type with a resident who appears to want the contact to occur but lacks the cognitive ability to consent or a resident who does not want the contact. Resident 2 was admitted to the facility in 11/2017 with diagnoses including relapsing multiple sclerosis (a disease where the immune system attacks the lining of nerve cells in the brain and spinal cord) and mild cognitive impairment. Resident 2's 11/26/25 Quarterly MDS indicated she/he had severe cognitive impairment.Resident 2's 10/27/25 care plan identified the resident had past sexual assault trauma, preferred female staff, and had impaired cognition. Resident 3 was admitted to the facility in 8/2023 with diagnoses of alcohol-induced persisting dementia and high-risk heterosexual behavior. Resident 3's 4/30/25 Annual MDS indicated she/he had moderate cognitive impairment.Resident 3's 5/6/25 care plan identified the resident had a history of sexual behaviors towards female residents and instructed staff to ensure she/he was supervised when around female residents. Staff were to redirect Resident 3 when sexual behaviors were anticipated and place the resident on intermittent one to one supervision after incidents for safety of others. Review of Resident 3's clinical records revealed the resident had attempted to touch a female resident on 10/15/25, was found in a female resident's room twice and sexually touched female staff on 10/31/25, and, on 11/3/25, been having increased sexual behaviors. No evidence was found in the resident's clinical record to indicate Resident 3 had been placed on 1:1s after these incidents. Review of the facility's 11/5/25 incident report revealed on 11/5/25 at 3:50 PM Staff 10 (Staffing Coordinator/Human Resources) saw Resident 3 with her/his hand under Resident 2's shirt while in the dining room. The report did not list any other witnesses but did identify that Resident 3 had been involved in similar incidents in the past. On 4/6/26 at 11:12 AM Staff 13 (CNA), 4/6/26 at 1:56 PM Staff 14 (CNA), 4/7/26 at 9:23 AM Staff 15 (CNA), and 4/7/26 at 9:45 AM Staff 16 (CNA) reported Resident 3 was not supposed to be alone with female residents due to a known history of sexually inappropriate behaviors towards female residents and when Resident 3 was not on 1:1s, staff were to redirect Resident 3 from entering resident rooms or when she/he demonstrated sexual behaviors. On 4/7/26 at 10:32 AM Staff 10 (Human Resources/Staffing Coordinator) stated on 11/5/25 she walked to the nursing station and observed Resident 3 fondling Resident 2's breast from under Resident 2's shirt. Staff 10 stated Resident 2 was trying to push Resident 3's hands away at the time of the incident. Staff 10 reported no other staff were in the area and confirmed Resident 3 was not supposed to be alone with female residents. On 4/7/26 at 1:34 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 3 had a known history of sexual behaviors towards others and acknowledged the incident between Resident 2 and Resident 3 on 11/5/25 was considered abuse.

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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 ensure residents were informed in writing of the facility's bed-hold policy and notice of transfer at the time of hospital transfer for 3 of 3 residents (#s 4, 7 and 8) reviewed for notification. This placed residents and responsible parties at risk for not being informed of transfer and bed-hold policy fees. Findings include: The facility's 7/2018 Notification of Changes of Condition Policy instructs the facility to promptly notify the resident representative when there was a decision to transfer a resident from the facility to the hospital.a. Resident 7 was admitted in 6/2024 with diagnoses including urinary tract infections (UTIs) and sepsis (an infection that enters the bloodstream).Resident 7's admission Profile indicated she/he was responsible for themselves.Review of Resident 7's clinical record revealed she/he was transferred to the hospital on 2/12/26 but no evidence was found in Resident 7's clinical record to indicate the resident was provided with the notice of transfer and facility bed-hold policy.b. Resident 4 was admitted to the facility in 2/2025 with diagnoses including peripheral vascular disease (a condition that restricts blood flow usually with legs and feet).Resident 4's admission Profile indicated Witness 4 (Resident 4's Daughter) was the resident's responsible party.A review of Resident 4's clinical record revealed she/he was transferred to the hospital on [DATE] and 12/18/25. No evidence was found in Resident 4's clinical record to indicate the resident's representative was notified of the hospital transfers. c. Resident 8 was admitted to the facility in 4/2025 with diagnoses including chronic heart failure.Resident 8's admission Profile indicated she/he was responsible for themselves.A review of Resident 8's clinical record revealed she/he was transferred to the hospital on 2/12/26 but no evidence was found in Resident 8's clinical record to indicate the written notice of transfer and facility's bed-hold policy were provided to the resident.On 4/7/26 at 8:56 AM Staff 17 (LPN) stated she did not document which documents she sent with residents transferring to the hospital and the facility did not have written transfer notices to provide to residents or resident representatives.On 4/7/26 at 9:34 AM Staff 4 (LPN) stated he was unaware he needed to provide a bed hold policy or a transfer notice when residents were transferred to the hospital. On 4/7/26 at 1:06 PM Staff 2 (DNS) was unable to locate documentation confirming the bed hold policy or written notification of transfer were provided to Resident 4, Resident 7, Resident 8, or their representatives. Staff 2 stated she was unaware a written transfer notification was required when transferring a resident out of the facility, but Staff 1 (Administrator) acknowledged a written notification of transfer and the facility bed-hold were supposed to be provided to residents or residents' representatives when transferred out of the facility.