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	06/03/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46053 Based on observation, interview and record review it was determined the facility failed to ensure resident needs and preferences related to lighting were accommodated for 1 of 3 sampled residents (# 13) reviewed for accommodation of needs. This placed residents at risk for lack of access to lighting and an unhomelike environment. Findings include: Resident 13 was admitted to the facility in 3/2024 with diagnoses including a non-pressure chronic ulcer and Type 2 Diabetes (a condition that happens as a result of the way the body regulates sugar as fuel). A review of Resident 13's 4/4/24 Admission MDS revealed her/his cognition was moderately impaired. On 5/29/24 at 9:34 AM Resident 13 stated her/his overbed light switch only had a short cord and she/he could not reach it to turn her/his light on or off. Resident 13 stated she/he reported it to staff but she/he was still waiting for it to be fixed. On 6/3/24 at 1:42 PM Staff 19 (Maintenance Director) stated he expected CNAs to report maintenance issues to him using the facility's work order system. He also stated he is notified of maintenance issues via word of mouth from staff members and residents. On 6/3/24 at 2:08 PM Staff 19 acknowledged the pull cord for Resident 13's overbed light was not long enough for her/him to use independently. Staff 19 stated the pull cord should be fixed. On 6/3/24 at 3:39 PM Staff 1 (Administrator) stated she expected residents to be able to turn their lights on and off and the broken pull cord needed to be repaired.

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: 38E173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46053 Based on interview and record review it was determined the facility failed to obtain copies of advance directives and inform residents of the right to formulate advance directives for 2 of 2 sampled residents (#s 8 and 13) reviewed for advance directives. This placed residents at risk of not having their health care decisions honored. Findings include: 1. Resident 8 was admitted to the facility in 8/2017 with diagnoses including Type 2 Diabetes (a condition that happens as a result of the way the body regulates sugar as fuel) and morbid (severe) obesity. Resident 8's 2/16/24 Quarterly MDS revealed she/he was cognitively intact. Resident 8's Care Plan revealed the following: -Focus: I have a Living Will or other Advance Directive: Health Care Agent. -Goal: I will have my desires and wishes followed according to my signed directive. -Interventions: Facility will place my Advance Directive in my medical record. Staff will review my healthcare directives with me at least quarterly to verify that my wishes have not changed. Staff will understand and follow my healthcare directives. (Date initiated: 6/8/23) No evidence was found in Resident 8's health record to indicate the facility obtained a copy of her/his advance directive or discussed it with her/him since the date the care plan intervention was initiated. On 5/30/24 at 9:33 AM Staff 1 (Administrator) stated she expect advance directives to be discussed with each resident at a minimum on a quarterly basis. She acknowledged the facility did not obtain a copy of Resident 8's advance directive and there was no documentation in her/his health record to indicate it was discussed with her/him since her/his care plan was initiated. 2. Resident 13 was admitted to the facility in 3/2024 with diagnoses including a non-pressure chronic ulcer and Type 2 Diabetes (a condition that happens as a result of the way the body regulates sugar as fuel). Resident 13's 4/4/24 Admission MDS revealed her/his cognition was moderately impaired. A review of Resident 13's health record revealed she/he was her/his own responsible party. No evidence was found in Resident 13's health record to indicate she/he had an advance directive or that staff discussed her/his wishes related to creating an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 9:33 AM Staff 1 (Administrator) stated she expect advance directives to be discussed with each resident at a minimum on a quarterly basis. She acknowledged there was no documentation in Resident 13's health record to indicate the facility discussed her/his wishes related to developing an advance directive.

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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. 46053 Based on interview and record review it was determined the facility failed to notify a resident's representative of an appointment out of the facility for 1 of 1 sampled resident (#289) reviewed for notification of change. This placed residents at risk of their representatives being uninformed. Findings include: Resident 289 was admitted to the facility in 12/2016 with diagnoses including chronic congestive heart failure (a long-term condition in which the heart cannot pump blood efficiently) and type 2 diabetes (a condition that happens as a result of the way the body regulates sugar as fuel). A review of Resident 289's 8/29/22 CAA related to cognition revealed she/he had severe cognitive decline including impaired memory and decision making. Resident 289's admission agreement indicated her/his representative/legal guardian was her/his daughter. A review of Resident 289's health record revealed she/he was sent out of the facility for an appointment on 11/10/2022. No evidence was found in Resident 289's health record to indicate her/his representative was notified she/he would be attending an appointment out of the facility. On 6/3/24 at 2:16 PM Staff 1 (Administrator) acknowledged Resident 289 was out of the facility for an appointment on 11/10/22 and she expected her/his representative to be notified of this.

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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. 46053 Based on observation and interview it was determined the facility failed to maintain a homelike environment for 1 of 3 sampled residents (# 13) reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include: Resident 13 was admitted to the facility in 3/2024 with diagnoses including a non-pressure chronic ulcer and type 2 diabetes (a condition that happens as a result of the way the body regulates sugar as fuel). A review of Resident 13's 4/4/24 Admission MDS revealed her/his cognition was moderately impaired. On 5/29/24 at 9:40 AM a gouge approximately 16 inches in length and 36 inches above the floor was observed in the wall adjacent to the head of Resident 13's bed. On 6/3/24 at 1:42 PM 19 (Maintenance Director) acknowledged the gouge in the wall and stated it should have been fixed prior to the resident moving into the room. On 6/3/24 at 3:39 PM Staff 1 (Administrator) stated the gouge in Resident 13's wall was unacceptable and she expected residents' rooms to be painted and homelike before they move in.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41453 Based on observation, interview, and record review it was determined the facility failed to protect the resident's right to be free from physical and sexual abuse for 2 of 7 sampled residents (#s 3 and 12) reviewed for abuse. This placed residents at risk for physical and psychological harm. Findings include: 1. Resident 12 was admitted to the facility in 6/2023 with diagnoses including a communication deficit and dementia. Resident 12's behavioral care plan initiated on 6/7/23 indicated the following: -The resident had a behavior issue related to a lack of spatial awareness (Resident does not recognize when she/he is close to others personal space.) -[Staff] consistently check on whereabouts of resident if found in room other than her/his or attempting to enter other rooms . -Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident 12's 3/10/24 Quarterly MDS revealed the resident had short and long-term memory problems, no memory recall ability, and her/his decision making was severely impaired. Resident 17 was admitted to the facility in 1/2023 with two different types of dementia. Resident 17's 2/6/24 behavioral care plan indicated the following: - The resident had potential to be physically aggressive. - The resident's triggers for physical aggression were interactions with another resident invading her/his space. The resident's behavior was de-escalated by removing the other resident or this resident from the situation. Resident 17's 3/20/24 Quarterly MDS indicated the resident was moderately cognitively impaired. A Facility Reported Incident (FRI) dated 8/6/23 revealed Resident 12 was observed to be on her/his hands and knees on the floor next to Resident 17's bed. Resident 17 was observed to be holding a book in both hands and Resident 12 was noted to have multiple skin tears on both arms. A facility event report dated 8/11/23 revealed the following: - Resident 17 used to be homeless and had no space to call her/his own. - Resident 12 had behavioral issues related to other people's personal space. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 12's location was to be consistently checked on due to her/his tendency to wander into other resident rooms. - Resident 17 stated she/he struck Resident 12 and considered striking her/him again. - Resident 12 was unable to be interviewed due to cognitive status. On 5/27/24 and 5/28/24 Resident 12 and 17 were interviewed. Neither resident had any recollection of an altercation. On 6/3/24 at 12:13 PM Staff 18 (Housekeeper) stated she witnessed Resident 12 on the floor on her/his hands and knees. Staff 18 witnessed Resident 17 holding a book over Resident 12 and told Staff 18 to get her/him out of here before I hit her/him again. There were no other witnesses to this altercation. On 5/31/24 at 7:48 AM Staff 17 (CNA) stated Resident 12's skin was very very fragile something as simple as trying to help Resident 12 transfer, if not done properly, will cause a skin tear. Staff 17 confirmed physical contact with Resident 12's arms by Resident 17 could easily cause skin tears. 05/30/24 07:42 AM Staff 8 (CNA) stated knowledge of Resident 12's and Resident 17's behaviors. Staff 8 stated an altercation and physical contact occurred but was unsure of the exact specifics. 05/31/24 10:45 AM Staff 3 (LPN/RCM) and Staff 4 (RNCM) - confirmed the facility knew Resident 12 wandered and had a history of climbing into other resident's beds. Staff 3 and 4 confirmed the facility was aware Resident 17 had a history of being aggressive when people entered her/his personal space. Staff 3 and 4 confirmed Residents 12 and 17 had a physical altercation and Resident 12 was injured as a result. 48830 2. Resident 3 was admitted to the facility in 1/2020 with diagnoses including anxiety. The 6/16/23 Annual MDS indicated Resident 3 was cognitively intact. Resident 33 was admitted to the facility in 4/2023 with diagnoses including dementia. The 4/30/24 Annual MDS indicated Resident 33 was cognitively intact and was ambulatory using a walker. A facility investigation dated 4/29/24 indicated on 4/23/24 around 8:45 PM Resident 3 reported that Resident 33 touched her/his breast inappropriately. Resident 3 stated Resident 33 walked by her/his room, stopped, stated she/he looked good and grabbed her/his breast and left the room. Resident 3 reported she/he was in her/his wheelchair in between the door and the bed at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/24 at 12:32 PM Resident 3 stated she/he had arrived back to her/his room after breakfast on 4/23/24 and was in her/his wheelchair watching tv. Resident 3 stated Resident 33 entered the room, made a comment to her/him, then grabbed her/his breast inappropriately. Resident 3 stated she/he told Resident 33 to go away, and Resident 33 left the room. Resident 3 stated she/he did not report the incident until later that evening to the nurse. Resident 3 stated she/he does feel safe in her/his room and the facility. On 5/30/24 at 10:43 AM Witness 2 (Resident 3's roommate) stated she/he witnessed the incident on 4/23/24. Witness 2 stated she/he was laying in bed when Resident 3 arrived back to the room after breakfast and sat in her/his wheelchair watching tv and was in direct line of sight of her/him. Resident 33 entered the room, stood next to Resident 3 and Resident 3 told Resident 33 to leave which she/he did not. Resident 33 proceeded to approach Resident 3 and touched her/his breast inappropriately then left the room. Witness 2 stated she/he does feel safe in her/his room and the facility. On 6/3/24 at 10:02 AM Staff 20 (RN) stated Resident 3 reported the incident to her on 4/23/24 during the evening rounds. Resident 3 explained after breakfast that morning she/he went back to her/his room, watched tv while in her/his wheelchair and Resident 33 entered the room and touched her/his breast inappropriately. Staff 20 stated since the incident occurred Resident 3 did not have a change in mood or behavior. On 6/3/24 at 1:54 PM Resident 33 declined she/he ever touched a resident inappropriately and did not remember the incident. On 6/3/24 at 2:15 PM Staff 2 (DNS) stated she talked with Resident 3 frequently and since the incident occurred Resident 3 did not have a change in mood or behavior and her/his daily routine had not changed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 41453 Based on interview and record review it was determined the facility failed to ensure written summary of a baseline care plan was provided to residents within 48 hours of admission for 2 of 4 sampled residents (#s 7 and 241) reviewed for baseline care plans. This placed residents at risk for being uninformed about their plan of care. Findings include: 1. Resident 7 was admitted to the facility in 5/2024 with diagnoses including kidney failure and anxiety. On 5/31/24 Resident 7's clinical record was reviewed. No record was found to show Resident 7 had a baseline care plan reviewed or provided to her/him. On 5/31/24 at 7:40 AM Resident 7 stated she/he had not been provided a baseline care plan. On 5/31/24 at 10:39 AM Staff 3 (LPN/RCM) and Staff 4 (RNCM) stated they were not aware baseline care plans were to be provided to and reviewed with residents. 2. Resident 241 was admitted to the facility in 5/2024 with diagnoses including heart failure and high cholesterol. On 5/31/24 Resident 241's clinical record was reviewed. No record was found to show Resident 241 had a baseline care plan reviewed or provided to her/him. On 5/31/24 at 10:39 AM Staff 3 (LPN/RCM) and Staff 4 (RNCM) stated they were not aware baseline care plans were to be provided to and reviewed with residents.

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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. 48830 Based on interview and record review it was determined the facility failed to develop a person-centered comprehensive care plan for 1 of 4 residents (#16) reviewed for mood and behavior. This placed residents at risk for lack of care planning. Findings include: Resident 16 was admitted to the facility in 1/2024 with diagnoses including post-traumatic stress disorder (PTSD). The Mood State CAA from Resident 16's 2/6/24 Admission MDS noted Resident 16 had a diagnosis of PTSD and the care plan addressed the PTSD symptoms with interventions to assist with mood. A review of Resident 16's comprehensive care plan (last revised 4/14/24) revealed no focus, goals or interventions for Resident 16's PTSD symptoms. On 6/3/24 at 9:30 AM Staff 16 (Social Services Director) stated he completed a PTSD evaluation for Resident 16, and thought he completed the comprehensive care plan. Staff 16 confirmed Resident 16's comprehensive care plan related to PTSD symptoms with interventions to assist with mood was not completed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43691 Based on observation, interview and record review it was determined the facility failed to follow physician orders regarding wound care for 1 of 1 resident (# 241) reviewed for wound care. This placed residents at risk of unmet care needs. Findings include: Resident 241 was admitted to the facility in 1/2018 with diagnoses including lymphedemia (swelling of the extremities) and erythmia (skin redness caused by swelling or irritation). A cognitive assessment from 1/18/24 indicated Resident 241 had normal cognitive function. A Physician Order from 4/3/24 instructed staff to apply ACE wraps to both lower extremities in the morning before Resident 241 got out of bed and take them off at night. Review of the 5/2024 TAR revealed the ACE wraps were documented as not applied to Resident 241's lower extremities on the following dates: - 5/20/24, - 5/21/24, - 5/22/24, - 5/23/24, - 5/24/24, - 5/25/24, - 5/26/24, - 5/28/24, - 5/29/24, - 5/30/24 and - 5/31/24. On 5/28/24 at 1:13 PM Resident 241 was observed wearing ACE wraps which appeared ragged and nearly falling off. Resident 241 stated she/he had worn the same ACE wraps for a week with the wraps never being taken off during the night. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 11:08 AM Staff 3 (LPN RCM) reviewed Resident 241's active orders and stated ACE wraps were to be applied to Resident 241's lower extremities in the morning and removed in the evening. Staff 3 was requested to determine if these orders were being followed. Upon observation of Resident 241 legs, Staff 3 confirmed Resident 241 was not wearing ACE wraps as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43691 Based on observation, interview and record review it was determined the facility failed to provide adequate care and hazard removal for 2 of 2 residents (#s 239 and 240) reviewed for accidents. This placed residents at risk of injury. Findings include: 1. Resident 239 was admitted to the facility in 5/2022 with diagnoses including obesity and dementia. A Care Plan from 3/16/23 included instructions for two staff members to be present when providing all care. An 8/18/23 Progress Note stated Resident 239 rolled out of bed onto the floor when care was provided. On 5/30/24 at 1:13 PM Staff 10 (CNA) stated she recalled Resident 239 falling out of bed. Staff 10 stated care was provided by only one staff member when Resident 239 experienced the fall out of bed when care was being provided. On 5/31/24 at 2:37 PM Staff 1 (Administrator) confirmed Resident 239 was ordered to receive care from two staff members but care was only provided by one staff member when the fall occurred. 2. Resident 240 was admitted to the facility in 5/2024 with diagnoses including dementia. A cognitive assessment from 5/2024 indicated Resident 240 had severe cognitive impairment. On 5/31/24 at 12:39 PM two electric burners were observed unplugged on the floor of Resident 240's room. Resident 240 stated she/he has not used the electric burners but intended to use them. On 5/31/23 at 1:19 PM Staff 21 (CNA) stated she/he was unaware of the burners. On 5/31/23 at 1:25 PM Staff 1 (Administrator) confirmed the electric burners were unsafe and immediately removed them from Resident 240's room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43690 Based on observation, interview and record review it was determined the facility failed to maintain oxygen equipment and ensure oxygen was administered as ordered for 2 of 3 sampled residents (#s 4 and 21) reviewed for oxygen therapy. This placed residents at increased risk for respiratory failure. Findings include: 1. Resident 4 was admitted to the facility in 8/2023 with diagnoses including multiple sclerosis and chronic obstructive pulmonary disease (COPD). The 4/25/24 Quarterly MDS indicated Resident 4 was cognitively intact. On 5/28/24 at 1:28 PM Resident 4 was observed to use an oxygen concentrator. The external filter on the oxygen concentrator was observed to have a thick layer of dust. On 5/29/24 at 8:44 AM Staff 7 (LPN) observed the resident's equipment and acknowledged the external filter of the oxygen concentrator was not clean. On 5/29/24 at 8:56 AM Staff 2 (DNS) stated it was her expectation the external filters were cleaned once a month. 2. Resident 21 was admitted to the facility in 10/2023 with diagnoses including congestive heart failure and chronic respiratory failure. The 5/2/24 Quarterly MDS indicated Resident 21 had moderate cognitive impairment. The 5/6/24 physician order for Resident 21 revealed the resident used continuous oxygen with a flow rate of 1.5 liters. On 5/29/24 at 8:03 AM Resident 21 was observed to use an oxygen concentrator with a flow rate of 2.5 liters. The external filter on the oxygen concentrator was also observed to have a thick layer of dust. On 5/29/24 at 8:21 AM Staff 7 (LPN) observed the resident and her/his equipment. Staff 7 acknowledged the physician's order was not followed regarding the oxygen flow rate and the external filter of the oxygen concentrator was not clean. On 5/29/24 at 8:56 AM Staff 2 (DNS) stated it was her expectation the oxygen levels were checked at the beginning of each shift and external filters were cleaned once a month.

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

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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 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. 43690 Based on observation and interview it was determined the facility failed to store and handle food in a sanitary manner for 1 of 2 facility kitchens (dining room kitchenette) reviewed for sanitary food storage and handling. This placed residents at risk for food-borne illness and contamination. Findings include: On 5/28/24 at 11:34 AM during the initial tour of the dining room kitchenette, the following was observed: Refrigerator: -One piece of cake with whipping cream not covered, labeled or dated. -One small plastic container of an unknown substance not labeled or dated. -One covered plate with a pork chop, baked potato and corn not labeled or dated. -One tray with multiple covered juice drinks not labeled or dated. -One opened container of prune juice on the top shelf that spilled to the lower shelves and out onto the floor. Freezer: -Seven small plastic containers with unknown substances not labeled or dated. -Two individual strawberry yogurt containers with a use by date of 5/20/24. -Two opened one pint ice cream containers with resident names not dated. -One opened gallon of chocolate ice cream without a secure lid and not dated. -Three small plastic containers of fish snack crackers on top of the refrigerator not labeled or dated. On 5/28/24 at 11:43 AM Staff 1 (Administrator) confirmed the identified items were not appropriately stored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43691 Based on observation, interview and record review it was determined the facility failed to accurately document wound care being provided which followed physician's orders for 1 of 1 resident (# 241) reviewed for wound care. This placed residents at risk of unmet care needs. Findings include: Resident 241 was initially admitted to the facility in 1/2018 with diagnoses including lymphedemia (swelling of the extremities) and erythmia (skin redness caused by swelling or irritation). A cognitive assessment from 1/18/24 indicated Resident 241 had normal cognitive function. A Physician Order from 4/3/24 instructed staff to apply ACE wraps to both lower extremities in the morning before Resident 241 got out of bed and to take them off at night. Review of the 5/2024 TAR revealed ACE wraps were documented as being off of Resident 241's lower extremities on the following dates: - 5/20/24, - 5/21/24, - 5/22/24, - 5/23/24, - 5/24/24, - 5/25/24, - 5/26/24, - 5/28/24, - 5/29/24, - 5/30/24 and - 5/31/24. On 5/28/24 at 1:13 PM Resident 241 was observed wearing ACE wraps which appeared ragged and nearly falling off. Resident 241 stated she/he had worn the same ACE wraps for a week with the wraps never being taken off during the night. On 5/31/24 at 11:08 AM Staff 3 (LPN RCM) confirmed Resident 241's records regarding ACE wraps being on or off were not accurately documented.