

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure a resident's right to a dignified existence with use of a power mobility device for 1 of 1 resident (# 19) reviewed for choices. This placed residents at risk for diminished independence and freedom of socialization with other residents. Findings include: The facility's Resident Right Policy dated 7/2018 indicated the resident has a right to and the facility will promote and facilitate resident self-determination through support of resident choice. Resident 19 was admitted to the facility in 11/2022 with diagnoses including cerebral infarction (blockage of blood flow to the brain) and depression. A 5/8/25 Occupational Therapy Evaluation included a goal for Resident 19 to operate a power chair with standby assist in the facility to maximize socialization skills. Review of Occupational Therapy Encounter Notes from 5/8/25 through 7/21/25 revealed Resident 19 received therapy services from Staff 5 (Rehabilitation Director) focused on improving skills involved with operating a power wheelchair, but no assessment on the use of a power wheelchair was performed. The resident's plan of treatment included power wheelchair mobility training in therapy on 5/23/25, 5/27/25, and 5/28/25, however power wheelchair training did not occur on those dates. On 6/3/25, an Occupational Therapy Encounter Note stated the use of power wheelchair was trialed and discontinued, stating Resident 19 experienced tactile feedback and visual scanning deficiencies. A cognitive assessment dated [DATE] revealed Resident 19 had a BIMS score of 13 which indicated the resident had normal cognitive function. A 5/23/25 Quarterly MDS stated Resident 19 had adequate vision without corrective lenses. A 6/3/25 Therapy to Facility Communication note stated Resident 19 was unsafe to continue use of a power wheelchair due to her/his decreased tactile feedback in her/his hands and visual scanning. On 7/22/25 at 9:08 AM Resident 19 stated she/he wanted to use her/his power wheelchair to increase her/his freedom to move in the facility and community. Resident 19 stated therapy would assess her/him to determine if she/he was safe with using the power wheelchair, but no time was spent in a power wheelchair to determine Resident 19's abilities to use a power wheelchair safely. On 7/22/25 at 1:49 PM Staff 6 (CNA) stated Resident 19's functional use of her/his hands improved in the last month with Resident 19 demonstrating an ability to perform self-care tasks like brushing teeth, caring for dentures, face washing, upper body dressing and using a call button without assistance. On 7/22/25 at 1:56 PM Staff 5 stated Resident 19 had a goal to use a power wheelchair with standby assist, meaning a staff member was next to Resident 19. Skills related to power wheelchair use including sitting balance, fine motor skills and spatial reasoning were assessed, but no assessment which involved the use of a power wheelchair was performed with Resident 19. Staff 5 stated fine motor skills and spatial reasoning were impaired. When asked for a record of these assessments, no information related to operating a power wheelchair was provided. On 7/23/25 at 3:14 PM Resident 19 was observed independently participating in bingo which required fine motor and visual scanning techniques. The resident was also able to visually scan the bingo card and bin containing bingo markers, pick up a small bingo marker and place that marker on the correct number. On 7/23/25 at 3:33 PM Staff 7 (CNA) stated Resident 19 was not observed to have any difficulty with her/his vision or fine motor skills when participating in activities. Staff 7 stated Resident 19 previously had grasping problems when performing activities, but those impairments improved in the last month. On 7/24/25 at 10:14 AM Staff 2 (DNS) stated Resident 19 actively participated in occupational therapy which was focused on improving skills required to operate a power wheelchair and confirmed an assessment with Resident 19's use of a power wheelchair should have been performed to make a determination of Resident 19's independent use of a power wheelchair.</p>		

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>Based on interview and record review it was determined the facility failed to ensure an appropriate PASARR (Preadmission Screening for individuals with a mental disorder and/or individuals with intellectual disability) was completed for 2 of 3 sampled resident (#s 8 and 34) reviewed for PASARR. This placed residents at risk for not receiving specialized services. Findings include: An 8/2018 facility policy revealed, a PASARR will be completed for each resident prior to admission. The applicants are evaluated for a serious mental disorder. Specialized services will be offered to individuals with mental disorders.1. Resident 34 admitted in 2/2025 with diagnoses including schizophrenia and anxiety.A PASARR I assessment completed on 5/5/24 revealed Resident 34 should receive a PASARR-II due to her/his diagnoses of schizophrenia.A review of Resident 34's electronic health record revealed no PASARR II was completed for Resident 34.On 7/24/25 at 10:06 AM Staff 2 (DNS) confirmed a PASARR-II had not been completed for Resident 34 to address her/his schizophrenia diagnoses.2. Resident 8 was admitted in 11/2024 with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and PTSD (Post Traumatic Stress Disorder). A review of the resident's electronic health record (EHR) at the time of the survey revealed there was no PASARR I available in the record. In an interview on 7/23/25 at 3:26 PM Staff 14 (Admissions/Social Services) stated he reported the lack of PASARR I screenings to Staff 1 (Administrator).7/23/25 at 3:37 PM, Staff 4 (MDS Coordinator) acknowledged a PASARR 1 was not completed for Resident 8.On 7/23/25 at 3:48 PM Staff 1 stated Resident 8 should have had a PASARR I completed upon admission to the facility.</p>		

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure activities were honored for 1 of 1 sampled resident (#9) reviewed for activities. This placed residents at risk for boredom, and loneliness. Findings include: Resident 9 was admitted to the facility in 12/2024 with diagnoses including dementia and PTSD (Post Traumatic Stress Disorder). The resident's admission MDS dated [DATE] indicated the resident had a BIMS score of six which indicated the resident had severe cognitive impairment. The MDS revealed it was very important for Resident 9 to be around animals such as pets, do her/his favorite activities, go outside when the weather was good, and listen to music she/he liked. The resident's care plan initiated on 12/20/24 revealed Resident 9 liked music. The resident was provided an activity calendar, invited to activities, and calling family/friends. The care plan did not include specific preferences for Resident 9 which included, pet visits, listening to music of her/his choice, doing things with groups of people, and going outside on nice days. Random observations from 7/21/25 through 7/24/25, revealed Resident 9 sitting alone either in the main dining room or in the halls with little to no staff interaction and no activities of interest provided to her/him. Group activities were observed to be occurring near Resident 9. On 7/22/25 at 2:25 PM Resident 9 was observed sitting in the main dining room at a table alone. Two activities were occurring in the dining room; the resident was not included in either one. Resident 9 told a staff member she/he was looking for a hiding place because no one wanted to hang out with her/him. On 7/23/25 from 2:15 PM to 3:20 PM Resident 9 was sitting in the hallway staring at the floor and no staff interacted with her/him and no activities were offered. During an interview on 7/21/25 at 2:05 PM and 7/24/25 at 10:30 AM Witness 1 (Resident Representative) stated, Resident 9 slept when she/he was bored, was usually in bed or out sitting in the hallway when Witness 1 came to visit. Witness 1 stated the resident enjoyed listening to country music and older rock music. On 7/24/25 at 10:10 AM Resident 9 stated she/he liked country music, going outside, and liked dogs. Resident 9 stated she/he would like to be invited to activities. During an interview on 7/24/25 at 1:07 PM and 7/25/25 at 9:05 AM Staff 9 (CNA) stated Resident 9 enjoyed visiting with dogs and would go to activities if she/he was invited. During an interview on 7/24/25 at 1:30 PM Staff 17 (CNA) stated Resident 9 would go to activities if she/he was invited but was unaware of activity preferences. During an interview on 7/25/25 at 9:18 AM Staff 12 (Activities Director) stated she completed one on one visits twice weekly, but Resident 9 was not on her list. Staff 12 confirmed three activities which were very important to Resident 9 were missing from the care plan and were not being offered to Resident 9. During an interview on 7/25/25 at 10:02 AM Staff 1 (Administrator) stated she expected activities to be offered to all residents and ensure preferences and activities were reflected on the care plan. Staff 1 acknowledged Resident 9's care plan was not reflective of her/his activities and was not being offered to participate in activities.</p>		

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, it was determined that the facility failed to implement care planned transfer interventions to prevent falls for 1 of 2 sample residents (#4) reviewed for accidents. This placed residents at risk for physical injury. Findings include: Resident 4 was admitted to the facility in 1/2025 with diagnoses including right leg amputation. Resident 4's 4/2025 and 6/2025 care plan revealed the resident required two-person assistance with a mechanical lift when moving from bed to a shower chair. A Fall Incident dated 5/21/25 revealed Resident 4 had a fall while being transferred out of bed into a shower chair. The resident was transferred by one CNA who did not utilize a mechanical lift. On 7/24/25 at 2:19 PM Staff 11 (CNA) stated she was told by Resident 4 she/he no longer used the mechanical lift and only needed one staff person to assist with her/his transfer status because the resident was working with therapy. On 7/24/25 at 3:00 PM Staff 13 (LPN) stated Resident 4's transfer status in 5/2025 (before the fall) was a two-person mechanical lift transfer. On 7/25/25 at 10:22 AM Staff 2 (DNS) stated Resident 4 told Staff 11 she/he did not need the mechanical lift anymore because the resident was working with therapy utilizing a slide board transferring. Staff 2 stated she was aware of the fall on 5/21/25 and acknowledged Staff 11 did not follow the care plan. Staff 2 indicated she expected all staff to review and follow the residents care plan. On 5/28/25, the Past Noncompliance was corrected by the facility with the following: 1. Staff 11 was educated and retrained in the moment regarding reviewing and following the care plan. 2. All CNAs were educated regarding reviewing and implementing the care plan. 3. All staff attended monthly CNA meetings to ensure they provided safety checks for those residents which were considered a high fall risk. 4. The QAPI team monitored/audited any kind of falls whether a resident was injured or not and ensured staff reviewed, implemented and followed the care plan.</p>

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

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 07/25/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Portland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review it was determined the facility failed to ensure a resident's prophylactic use of an antibiotic was reviewed and a rationale for continued use was documented when duplicate antibiotic treatment occurred for 1 of 1 sampled resident (#12) reviewed for antibiotic usage. This placed residents at risk for adverse medication consequences and drug-resistant infections. Findings include: The facility's Infection and Control: Antibiotic Stewardship policy, last revised 3/2019, indicated the facility would validate antibiotics were prescribed for the correct indication, the correct dose, the correct route and the correct duration. Resident 12 was admitted to the facility in 5/2024 with diagnoses including acute kidney failure, dysuria (painful or uncomfortable urination) and urinary retention (inability to completely empty the bladder). A 10/15/24 physician order indicated Resident 12 was prescribed Bactrim (an antibiotic) one time a day for UTI prophylaxis (ongoing antibiotic administration not intended to treat an existing infection, but to reduce the risk of developing one). A 6/14/25 progress note written at 6:40 PM indicated Resident 12 reported complaints of a possible UTI including burning with urination, weakness and low back pain. Resident 12 was transported to the Emergency Department (ED) for evaluation. A 6/14/25 progress note written at 11:00 PM indicated Resident 12 returned to the facility from the ED. Resident 12 had no UTI and blood work revealed no infection. The resident was diagnosed with possible muscle pain. Resident 12 was to follow-up with her/his PCP (Primary Care Physician). A 6/14/25 ED After Visit Summary revealed Resident 12 was evaluated for a possible UTI, no infection was identified and the resident was diagnosed with flank pain (discomfort located in the side of the abdomen, between the lower ribs and hips). Resident 12's 6/15/25 through 6/19/25 progress notes indicated there were no further concerns of burning with urination, weakness or low back pain voiced by the resident. A 6/19/25 PCP After Visit Summary indicated Resident 12 was started on cefuroxime (an antibiotic) twice a day for seven days (6/19/25 through 6/25/25) due to trace leukocytes (a small amount of white blood cells) identified during a urine dipstick test (a quick way to access various aspects of urine). Resident 12's June 2025 MAR indicated the resident received prophylactic Bactrim in addition to, cefuroxime from 6/19/25 through 6/25/25. A 6/20/25 progress note written at 9:29 AM indicated nursing staff attempted to contact Resident 12's PCP to clarify the resident's Bactrim usage due to Resident 12 receiving Bactrim and cefuroxime at the same time for the same condition. A review of Resident 12's electronic health record indicated the resident's PCP did not respond. On 7/22/25 at 1:04 PM, Staff 8 (LPN) stated Resident 12 was prescribed Bactrim for UTI prophylaxis in 10/2024. She stated on 6/14/25, Resident 12 went to the ED for abdominal pain and a possible UTI. Staff 8 reported when Resident 12 returned from the ED, there was no UTI found. Staff 8 reported Resident 12 was prescribed cefuroxime on 6/19/25, after a visit to the resident's outside provider. Staff 8 reported she was unsure why Resident 12 received two antibiotics at the same time for the same condition, and if she noticed a resident being prescribed two different antibiotics for the same condition, she would contact the provider for clarification. On 7/22/25 at 1:22 PM and 7/24/25 at 12:24 PM, Staff 2 (DNS) reported Resident 12 was placed on Bactrim, prophylactically for a history of UTI's, in 10/2024. On 6/14/25, Resident 12 went to the ED with symptoms of a possible UTI and was found to have no UTI. In addition, Resident 12's bloodwork indicated no infection. Staff 2 stated on 6/19/25, Resident 12 had a follow-up appointment with her/his PCP and returned to the facility with orders for a second antibiotic. Staff 2 stated she attempted to contact Resident 12's PCP office for clarification and to have a conversation regarding the resident's antibiotic use, but the PCP office did not return her call. Staff 2 stated Staff 4 (Infection Control Preventionist/MDS Coordinator) should have reached out to the PCP office to discuss the ongoing need and appropriateness of Resident 12's antibiotics. Staff 2 stated her expectations were for staff to have a clear understanding of why Resident 12 was on two antibiotics, Resident 12's antibiotics were evaluated and assessed to be appropriate and there was a rationale for dual antibiotic use. On 7/22/24 at 3:16 PM, Staff 4 stated she was aware Resident 12 received two different antibiotics at the same time for UTI management. Staff 4 stated she wondered why Resident 12 had two antibiotics and an antibiotic time-out form was faxed to the resident's PCP. Staff 4 stated Resident 12's PCP was not responsive, and she was unable to get through to the PCP office thus no follow-up regarding Resident 12's dual antibiotic use was completed. Staff 4 stated she would not want to see a resident receive two antibiotics for the same condition without clarification and a rationale provided and confirmed there was no clarification or rationale for Resident 12's dual antibiotic use.</p>		