| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385189 | A. BUILDING _____ B. WING _____ | 07/31/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| AVAMERE TRANSITIONAL CARE AT SUNNYSIDE | 4515 SUNNYSIDE ROAD SE SALEM, OR 97302 |

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 0684<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review it was determined the facility failed to assess, monitor and treat skin wounds and failed to follow physician orders [REDACTED].#s 1 and 3) reviewed for non-pressure skin conditions. Resident 1 experienced bilateral post-operative infection and dehisced (splitting or bursting open) wounds, hospitalization and surgery; and this placed residents at risk for unmet treatment needs. Findings include: 1. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 discharged from the facility to the hospital on [DATE]. a. The 12/2010 Facility Skin Program Guideline indicated actual skin areas would have weekly documentation which included measurements and how the wound progressed toward healing such as improvement, worsening or if the wound remained unchanged. The 7/9/20 Hospital admission orders [REDACTED]. No full skin assessment were completed for the two surgical incisions and the left inner thigh/groin wound and the left thigh wound was not documented to have drainage. On 7/28/20 at 9:29 AM Staff 3 indicated on admission both the left and right surgical incisions were open to air, the left incision had serous (thin, watery and clear substance) drainage and looked worse than the right incision. Staff 3 stated he documented the left inner thigh (groin) wound as a Stage two pressure ulcer (partial-thickness skin loss with exposed dermis - not be used to describe moisture associated skin damage including medical adhesive related skin injury) although he did not know much about the wound. Staff 3 stated the wound was scabbed over, not over a bony prominence and not a pressure ulcer. Review of Resident 1's medical record revealed no progress notes or wound assessments until a 7/16/20 progress note which indicated the lateral left thigh incision continued to drain with creamy slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) present and the wound edges were barely approximated (well approximated means the two edges are even with no puckering or gaps and the wound/incision is healing properly). Additionally, there was a large skin impairment to the left upper, inner thigh with firm slough present. There was no documentation to indicate treatment was provided. A 7/17/20 Progress Note indicated the bilateral thigh surgical wound incisions were dehiscing. The left thigh wound had slough and the right thigh wound was beefy red and the edges were not approximated. The Orthopedic Office was notified and Resident 1 was transferred to the Hospital Emergency Department. The July TARs revealed the staff were to Monitor thigh incisions every shift. All shifts except one had a checkmark documented which meant the thigh wounds was observed. There were no notes associated with the TAR to indicate the wounds had slough, drainage, dehisced or remained unchanged until 7/16/20. The 7/19/20 Transfer Discharge form indicated Resident 1 admitted to the facility with bilateral thigh surgical incisions. The left thigh incision drained serosanguinous (discharge containing both blood and a clear yellow liquid) drainage since admission. On 7/17/20 Resident 1's right thigh incision had dehisced and the two incisions on the left thigh had slough in both wounds and the edges were not well approximated. Resident 1 was transferred to the hospital. The current Kardex (CNA care plan) instructed staff to perform daily skin inspections and report any abnormalities to the nurse. A complete medical record review was completed the morning of 7/24/20. Resident 1's medical record did not include CNA documentation of daily skin inspections. The bilateral thigh surgical incisions did not have an admission or weekly skin assessments and the wound monitoring did not include the status of the bilateral thigh wounds so staff would be able to recognize if the surgical wounds worsened. Although the left thigh wound was draining on admission the lack of wound treatment was not clarified with the physician. There was no physician notification of the thigh wounds until 7/17/20. There was no documentation of assessment, monitoring or treatment of [REDACTED]. The physician was not notified of the left groin wound. The afternoon on 7/24/20 the following late-entry progress notes were documented into Resident 1's medical record: *7/14/20: The incisions were approximated well. The superior, lateral left leg continued to have moderate drainage. The left lower incision continued with moderate drainage. The drainage was clear to tan in color to both sites. The left groin was scabbed over with minor redness to the surrounding skin. (This entry, written 10 days after Resident 1's discharge, revealed three wounds to the left leg. Resident 1 had two wounds on the left leg and one wound on the right leg.) *7/15/20: The incisions were approximated well. The superior, lateral left leg continued to have moderate drainage. The left lower incision continued with moderate drainage. The drainage was clear to tan in color to both sites. The left groin was scabbed over with minor redness to the surrounding skin. (This entry, written nine days after Resident 1's discharge using the same verbiage as the 7/14/20 entry, revealed three wounds to the left leg. Resident 1 had two wounds on the left leg and one wound on the right leg.) *7/16/20 at 2:22 PM: Bilateral incision sites were heavily scabbed over with dry blood. Telephone call out to physician (physician did not return phone call. This entry, written eight days after Resident 1's discharge did not indicate the left thigh incision was draining). *7/16/20 3:05 PM: Bilateral incision sites were intact. (This entry, written nine days after Resident 1's discharge and timed 43 minutes after the previous entry, contradicted how the bilateral incision sites presented on the previous shift. The 7/29/20 Hospital Records revealed Resident 1 was admitted to the hospital for bilateral wound infections and dehiscence. Resident 1 had surgery for [REDACTED]. The wounds were debrided (removal of dead or infected tissue from a wound in order to allow healthy new tissue to form) and negative pressure wound therapy devices were applied. During the debridement surgery the surgeon observed necrotic (dead) fat tissue in the right distal femoral wound. The surgeon noted the left femoral wound had a full-thickness necrosis (death) of the skin and during the process of debridement found the fascia (a band or sheet of connective tissue, primarily collagen, beneath the skin that attaches, stabilizes, encloses, and separates muscles) was disrupted and the (bone) plate visible. The debridement was completed down to the level of the bone. The surgeon noted the left wound was worse than the right wound and the left side fascia was repaired. On 7/22/20 at 4:32 PM Witness 1 (Complainant) stated Resident 1 presented to the Emergency Department with three open wounds. The left groin area, the left thigh surgical incision was open with slough and the right thigh surgical incision dehisced. The right thigh incision was red, bloody and fatty tissue was observed. Witness 1 stated no wound care was completed during Resident 1's stay at the facility. On 7/28/20 at 10:30 AM Staff 5 (LPN) stated the left thigh groin wound looked like a tape burn and the left surgical incision had drainage since admission. Staff 5 stated on 7/16/20 both wounds on the left thigh had slough present. On 7/27/20 at 2:00 PM Staff 7 (LPN) acknowledged she wrote a late entry progress for 7/16/20 seven days after Resident 1's discharge which indicated the incision sites were intact bilaterally. Staff 7 acknowledged the previous shift charted the incision sites were heavily scabbed over with dry blood, the physician was called and the information was passed onto the next shift but stated she did not remember receiving this information in report and did not talk to Resident 1's physician. Staff 7 stated she only cared for Resident 1 twice and was unable to express much in her charting documentation. On 7/29/20 at 5:43 AM Staff 4 (RN) verified he worked the night shift on 7/16/20 and stated he did not receive any untoward report regarding any wound. On 7/29/20 at 6:00 AM Staff 8 (LPN) stated he cared for Resident 1 on 7/14/20 and 7/15/20, did not know the resident well, reported to the RNCM the wounds were |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385189 | A. BUILDING _____ B. WING _____ | 07/31/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| AVAMERE TRANSITIONAL CARE AT SUNNYSIDE | 4515 SUNNYSIDE ROAD SE SALEM, OR 97302 |

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 0684<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>draining and was informed the wounds were supposed to be open to air. Staff 8 stated he was called on 7/24/20 and instructed by Staff 13 (SDC - Staff Development Coordinator) to come into the facility that day to complete late entry charting for 7/14/20 and 7/15/20 on Resident 1. On 7/29/20 at 7:50 AM Staff 6 (RNCM) verified she was summoned to Resident 1's room on 7/17/20. Staff 6 stated the right wound was split open showing beefy red tissue. The left wound had heavy scabbing around the edge with noticeable slough in the middle of the incision. Staff 6 stated this was a change of condition from when she last observed the wounds for Resident 1's 72 hour huddle (care conference). Staff 6 verified there were no full skin assessments or wound treatments completed on the bilateral thigh surgical incisions and the left groin wound. Staff 6 acknowledged the Kardex instructed staff to perform daily skin inspections and report any abnormalities to the nurse and further acknowledged there was no documentation in Resident 1's medical record this was completed. On 7/29/20 at 11:26 AM Staff 2 (DNS) stated since the bilateral thigh wounds were surgical incisions they were not followed on wound rounds and wound status was not documented. Staff 2 acknowledged with multiple staff members documenting the bilateral thigh wounds were monitored on the July 2020 TARs with no additional information, the staff were not able to recognize a change in condition to the bilateral incisions. Staff 2 acknowledged no formal skin assessment or monitoring was in place for the left groin wound. Staff 2 was unsure why the left thigh surgical incision treatment orders were not clarified with the physician since the wound was draining on admission to the facility. Staff 2 stated on 7/24/20 she initiated an incident report related to Resident 1's skin issues, discovered Resident 1's skin issues were not documented and instructed the nursing and therapy staff to document late entries. On 7/28/20 at 8:17 AM Witness 2 (Orthopedic Medical Assistant) stated the office was not notified of any change of condition until 7/17/20 when the Nurse Practitioner was informed of the one wound dehiscence and told there were no signs of infection. Witness 2 stated the facility did not notify the office the left thigh incision was draining, request wound treatment orders, notify the office of the left groin wound or inform them the two wounds on the left thigh had slough in them. Witness 2 stated the facility should have called to inform the office of the drainage, slough and any change of condition they identified. Resident 1 admitted to the facility with two surgical incisions to her/his bilateral thighs and one wound on the upper left thigh/groin area. The facility failed to fully assess the surgical and groin wounds on admission, did not thoroughly monitor the wounds until 7/16/20, seven days after Resident 1's admission, did not clarify or request treatment orders and failed to identify and report the change of condition to the left thigh wounds which resulted in the subsequent hospitalization and surgery for [REDACTED]. b. The 7/9/20 Hospital admission orders [REDACTED]. There was no evidence in the medical record the daily weight checks were completed as ordered. On 7/29/20 at 7:50 AM Staff 6 (RNCM) acknowledged daily weights were not completed as ordered and the physician was not notified the order was not followed. 2. Resident 3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The 12/2010 Facility Skin Program Guideline indicated actual skin areas would have weekly documentation which included measurements and how the wound progressed toward healing such as improvement, worsening or if the wound remained unchanged. The 1/27/20 Admission Nursing Data Base revealed Resident 3 had four surgical incisions to the right lower extremity and a small fluid filled blister just below the proximal incision most likely from tape. Review of the medical record revealed no weekly skin assessments for the four surgical incisions and the blister. Review of the January 2020, February 2020 and March 2020 TARs revealed wound treatments were completed as ordered. Review of the progress notes indicated no signs of infection to the the surgical incisions. On 7/29/20 at 8:01 AM Staff 6 (RNCM) verified no skin assessments were completed for Resident 3's four surgical incisions and blister. |
| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review it was determined the facility failed to provide timely, complete and accurate documentation in the medical record for 1 of 3 sampled residents (#1) reviewed for non-pressure skin conditions. This placed residents at risk for lack of current assessments. Findings include: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 discharged from the facility to the hospital on [DATE]. a. A complete record review was completed the morning of 7/24/20. Resident 1's medical record did not have an admission or weekly skin assessments and the wound monitoring did not include the status of the bilateral thigh wounds. There was no assessment or monitoring of the left groin wound. On 7/24/20 in the afternoon, seven days after Resident 1 transferred to the hospital, facility staff documented on Resident 1's skin impairments. The following timeline revealed Resident 1's skin documentation: *The 7/9/20 Admission Nursing Database indicated Resident one admitted with R thigh 6cm surgical incision x3 0.5cm surgical incisions, L thigh 6cm surgical incision x3 0.5cm surgical incisions, L inner thigh stg (sic) 2. (A full skin assessment was not completed of the bilateral thigh surgical incisions and the left inner thigh groin wound.) * 7/10/20 - 7/13/20 - no skin documentation * 7/14/20 - late entry progress note documented on 7/24/20, 10 days after the assessment, revealed incisions were approximated well. Superior lateral site to left leg continued with moderate drainage. Left leg lower incision continued with moderate drainage. Drainage to both sites was clear to tan in color. Area to inner left thigh at groin scabbed over with minor redness surrounding area. (The right surgical incision was not documented on. The left thigh had one surgical incision and one groin wound.) * 7/15/20 - late entry progress note documented on 7/24/20, nine days after the assessment, revealed incisions were approximated well. Superior lateral site to left leg continued with moderate drainage. Left leg lower incision continued with moderate drainage. Drainage to both sites was clear to tan in color. Area to inner left thigh at groin scabbed over with minor redness surrounding area. (The right surgical incision was not documented on. The left thigh had one surgical incision and one groin wound.) * 7/16/20 - late entry progress note documented on 7/24/20, eight days after the assessment for 7/16/20 2:22 PM: Bilateral incision sites were heavily scabbed over with dry blood * 7/16/20 - late entry progress note documented on 7/24/20, eight days after the assessment, for 7/16/20 3:05 PM: Bilateral incision sites were intact. * 7/16/20 6:33 PM progress note: the lateral left thigh incision continued to drain and had creamy slough present and the wound edges were barely approximated (well approximated means the two edges are even with no puckering or gaps and the wound/incision is healing properly). There was also a large skin impairment to the left upper, inner thigh with firm slough present. * 7/17/20 - late entry progress note documented on 7/24/20, seven days after the assessment, for 7/17/20 3:20 PM: revealed Resident 1's bilateral wounds to hips were intact and no signs or symptoms of infection were seen. * 7/17/20 5:25 PM progress note: the bilateral thigh surgical wound incisions were dehiscing. The left thigh wound had slough and the right thigh wound was beefy red and the edges not approximated. * 7/19/20 Transfer Discharge form indicated Resident 1 admitted to the facility with bilateral thigh surgical incisions. The left thigh incision drained serosanguinous (discharge containing both blood and a clear yellow liquid known as blood serum) drainage since admission. On 7/17/20 Resident 1's right thigh incision had dehisced and the two incisions on the left thigh had slough in both wounds and the edges were not well approximated. On 7/28/20 at 9:29 AM Staff 3 (LPN) stated he documented the left inner thigh (groin) wound as a Stage two pressure ulcer (partial-thickness skin loss with exposed dermis. This stage should not be used to describe moisture associated skin damage including medical adhesive related skin injury) although he did not know much about the wound. Staff 3 stated the wound was scabbed over, not over a bony prominence and not a pressure ulcer. On 7/29/20 at 7:50 AM Staff 6 (RNCM) acknowledged Resident 1's medical record did not include admission or weekly skin assessments for Resident 1's two surgical incisions and the left groin wound. Staff 6 acknowledged the skin charting was incomplete. On 7/29/20 at 11:26 AM Staff 2 (DNS) acknowledged on the morning of 7/24/20 Resident 1's medical record was not complete related to skin assessments and monitoring and instructed staff to document late entries. b. The 7/9/20 Hospital Records indicated Resident 1 had a right nephrostomy tube (a catheter which is inserted through the skin and into the kidney to drain urine). The 7/9/20 Hospital admission orders [REDACTED]. The 7/9/20 Admission Nursing Data Base indicated Resident 1 had a Foley catheter but not a nephrostomy tube. On 7/29/20 at 7:50 AM Staff 6 (RNCM) acknowledged the Admission Nursing Data Base did not include Resident 1's nephrostomy tube, stated this was an oversight of the admitting nurse and was a documentation error. |
| F 0865<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Have a plan that describes the process for conducting QAPI and QAA activities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review it was determined the facility failed to monitor and evaluate previous corrective action activities to ensure corrections remained in place for 1 of 1 QA (Quality Assurance) activities reviewed. This caused residents to have unassessed skin conditions and a decline in skin conditions. Findings include: The 12/2010 Skin Program guideline indicated the Resident Care Manager or designee would evaluate any new impaired skin integrity and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385189 | A. BUILDING _____ B. WING _____ | 07/31/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| AVAMERE TRANSITIONAL CARE AT SUNNYSIDE | 4515 SUNNYSIDE ROAD SE SALEM, OR 97302 |

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 0865<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>document the findings. The policy further indicated actual skin areas including open surgical wounds and ulcers would have weekly documentation which included measurements and how the wound progressed toward healing. The policy indicated the facility would maintain a weekly non-pressure log which when completed would be distributed to multiple staff including the DNS and Administrator. The policy revealed a monthly QA analysis based on the QI (Quality Indicator) reporting would be performed by the DNS to assess progress towards healing new wounds in the facility as well as the Interdisciplinary team would meet weekly to review and discuss the non-pressure logs. The facility was previously cited on the 3/13/19 complaint health survey for not completing weekly wound assessments. Resident 1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 readmitted to the hospital on [DATE] with bilateral wound infection and bilateral wound dehiscence. No admission or weekly skin assessments were completed for Resident 1's bilateral thigh surgical incisions and left upper groin wound. Resident 3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 3 had four right lower extremity surgical incisions and a blister to the right lower extremity. No weekly skin assessments were completed during Resident 3's stay at the facility. On 7/24/20 at 10:35 AM and 7/31/20 at 10:21 AM Staff 2 (DNS) stated the Nurse Practitioner and RNCM completed the weekly wound rounds and saw residents with Stage 3 and higher pressure ulcers. Staff 2 acknowledged non-pressure wounds were not assessed weekly and unsure when the facility stopped this practice. On 7/31/20 at 10:21 AM Staff 1 (Administrator) acknowledged the facility was previously cited on the 3/13/19 complaint health survey for not completing weekly wound assessments. Staff 1 acknowledged the QAPI program failed to recognize the facility staff stopped assessing and monitoring non-pressure wounds and the facility did not maintain the correction to the 3/13/19 complaint health survey. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br><br>Based on observation and interview it was determined the facility failed to appropriately screen essential visitors prior to entering the facility for 2 of 2 days reviewed for infection control screening. This placed residents at risk for COVID-19 infection. Findings include: a. On 7/24/20 at 8:25 AM the State Surveyor entered the facility. Staff 12 (LPN), who stood near the nurses station, called out to the surveyor she would locate Staff 11 (Human Resources/Payroll) to screen the surveyor into the building. At 8:28 AM Staff 10 (CNA) approached the surveyor and inquired if screening was completed. Upon hearing the surveyor was not yet screened Staff 10 proceeded to check the surveyor's temperature and asked the the surveyor to fill out the screening form. Staff 10 did not review the screening form. Staff 10 proceeded to screen in the next essential visitor. A third staff member approached the screening area and took over for Staff 10. The State Surveyor screening form was not reviewed. On 7/24/20 Staff 2 (DNS) was informed of the incomplete screening process of the State Surveyor. b. On 7/29/20 at 5:42 AM facility staff let the State Surveyor into the facility but did not screen the Surveyor for COVID-19 exposure or symptoms. The surveyor wore appropriate PPE (personal protective equipment) and was without COVID-19 symptoms. Staff 4 (RN) approached the Surveyor and Staff 4 was informed of the reason for the visit. Staff 4 allowed the Surveyor to pass the screening area and enter the resident areas of the facility. The surveyor walked between both the first floor and second floor nursing stations and to the end of the first floor north hall to interview both the night shift and day shift nursing staff but distanced herself from all residents. On 7/29/20 at 6:16 AM the Surveyor was approached by Staff 11 and asked if the screening was completed upon entrance to the facility. Staff 11 was told the screening was not completed. Staff 11 asked Staff 4 why he did not complete the screening and Staff 4 shook his head. Staff 11 acknowledged the Surveyor was not screened and proceeded to screen the Surveyor with a successful outcome. |