STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E075	A. Building B. Wing	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Rose Care Center	4254 Weathers Street NE Salem, OR 97301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40767 Based on interview and record review it was determined the facility failed to ensure Staff 13 (LPN) and Staff 39 (Registered Dietitian) adhered to professional standards related to skin treatments and nutrition for 2 of 8 residents reviewed for skin and nutrition. This placed residents at risk for worsening skin impairments, inaccurate documentation and weight loss. Findings include: 1. The Oregon Health Authority Health Licensing Office, Board of Licensed Dietitians - Chapter 834 Division 60 STANDARD OF PRACTICE AND PROFESSIONAL CONDUCT [DATE]. The board adopts the following standards of practice to establish and maintain a high standard of integrity and dignity in the profession of dietetic practice pursuant to ORS 691.405(1). A licensee must: (2) Use accurate and relevant data and information to perform nutrition assessment and identify nutrition-related problems; (5) Monitor and evaluate indicators and outcomes data directly related to the nutrition diagnosis, goals and intervention strategies to determine the progress made in achieving desired outcomes of nutrition care and whether planned interventions should be continued or revised; (8) Consider the health, safety, and welfare of the clients and public at all times. Resident 5 admitted to the facility [DATE] with diagnoses including a left knee amputation and diabetes. Resident 5's nutrition record indicated the following: *[DATE] the resident refused breakfast and lunch. *[DATE] the resident refused breakfast, lunch, and dinner. *[DATE] the resident refused breakfast, lunch, and dinner. *[DATE] the resident refused breakfast, lunch, and dinner. *[DATE] the resident refused breakfast, lunch, and dinner. Resident 5's weight records indicated she/he had the following weights: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[DATE] 290.6 lbs. *[DATE] 276.4 lbs. (indicating a 14.2 lb weight loss in 32 days and an overall 4% weight loss). *[DATE] 271.8 lbs. (indicating an additional 4.6 lb. weight loss in 8 days and an overall 6% weight loss since [DATE]). The resident was sent out to the hospital on [DATE] and was diagnosed with septic shock and renal failure. Resident 5 died at the hospital on [DATE]. There was no evidence in Resident 5's medical record to indicate Staff 39 (Registered Dietician) assessed the resident's weight loss or meal refusals. On [DATE] at 2:23 PM Staff 39 stated Resident 5 was on her list to review for Nutrition At Risk (NAR) in [DATE], but was not noted as a top priority. Staff 39 stated by the time she went to review Resident 5 she/he was already discharged to the hospital. Staff 39 worked two days a month for the facility offsite per preference, and had not been in the facility since prior to the COVID-19 pandemic [approximately February 2020] and therefore did not assess residents in person. Staff 39 last reviewed Resident 5 for nutrition and weights [DATE], but could not recall when she last assessed the resident in person. Refer to F692 34702 2. The Board of Nursing-Chapter 851 Division 45-Standards and scope of practice for the licensed practical nurse and registered nurse- [DATE] Conduct Derogatory to the Standards of Nursing Defined: (4) Conduct related to communication: (a) Failure to accurately document nursing interventions and nursing practice implementation; (c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to: (A) Documenting nursing practice implementation that did not occur; (B) Documenting the provision of services that were not provided; Resident 11 was admitted to the facility in ,d+[DATE] with diagnoses including quadriplegia. The [DATE] physician order indicated to cleanse the right gluteal fold with wound cleanser, pat dry, use calmoseptine (medication used to treat skin irritation) to peri wound (tissue surrounding wound). Apply daily and PRN. The [DATE] physician order indicated to check if catheter care was done. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:55 PM the ,d+[DATE] TAR was reviewed and indicated Staff 13 (LPN) documented the treatment to Resident 11's gluteal fold was completed and the catheter was checked on [DATE]. On [DATE] at 3:59 PM Resident 11 stated staff had not treated the area to her/his gluteal fold and had not looked at her/his catheter today ([DATE]). Resident 11 stated she/he was up in her/his chair all day and had not been back to bed or received treatment. On [DATE] at 4:15 PM and 4:44 PM Staff 13 stated he documented and completed treatment to the gluteal wound at approximately 2:00 PM. Staff 13 was informed Resident 11 reported she/he was in her/his chair all day and had not received treatments to the gluteal fold. Staff 13 then stated I have not done [her/his] wound today, that must have been yesterday. Staff 13 further stated he documented catheter care was completed, but had not checked Resident 11's catheter. Staff 13 stated he documented catheter care was complete because CNA staff completed that care. Refer to F684.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34702 1. Based on interview and record review it was determined the facility failed to assess a change of condition for 1 of 3 sampled residents (#5) reviewed for change of condition. This resulted in Resident 5 experiencing weight loss, a change of condition and hospitalization . Findings include: Resident 5 was admitted to the facility in 2/2020 with diagnoses including diabetes and left lower leg amputation. The 5/24/20 BIMS indicated Resident 5 was cognitively intact. The 2/14/20 care plan indicated Resident 5 needed one person staff assistance for toileting and transfers. Resident 5 had bowel and bladder incontinence. The care plan indicated Resident 5 was to receive weekly skin assessments by nursing staff. Resident 5's nutrition record indicated the following: *8/10/20 the resident refused breakfast and lunch. *8/11/20 the resident refused breakfast, lunch, and dinner. *8/12/20 the resident refused breakfast, lunch, and dinner. *8/13/20 the resident refused breakfast, lunch, and dinner. *8/14/20 the resident refused breakfast, lunch, and dinner. Resident 5's supplement intake record indicated the following: *8/10/20 480 mls *8/11/20 refused *8/12/20 refused *8/13/20 refused *8/14/20 refused Resident 5's weight records indicated she/he had the following weights: *7/2/20 290.6 lbs. *8/3/20 276.4 lbs. (indicating a 14.2 lb weight loss in 32 days and a 4% weight loss). (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	*8/11/20 271.8 lbs. (indicating an additional 4.6 lb. weight loss in 8 days and an overall 6% weight loss since 7/2/20). An 8/4/20 physician progress note indicated Resident 5 had a current weight of 274.6 lbs and no weight loss. The previous physician note dated 6/11/20 indicated Resident 5's previous weight was 296.8 lbs. The note did not address the 22 lb. weight loss. The 8/4/20 physician note indicated Resident 5 had a left below the knee amputation and amputation of the right toes. The note did not indicate a head to toe skin assessment was completed for Resident 5. An 8/12/20 progress note indicated Resident 5 was on alert for starting Diflucan for yeast rash and was started on 8/11/20. Resident 5 was offered pain relief options multiple times but declined. An 8/13/20 progress note indicated Resident 5 was doing well with antibiotics and was complaining of pain in areas of the yeast infection but continued to go outside and sit in the sun for long periods of time. An 8/14/20 progress note indicated Resident 5 continued to refuse to eat and was no longer getting out of bed. Resident 5 was refusing to be changed. Resident 5 had yeast and open skin areas with foul smell and skin sloughing noted and nothing worked to treat the yeast and open skin areas. Resident 5 had been drinking supplements. The 8/14/20 skin assessment indicated the resident had a skin tear to the right ankle. There was no indication a head to toe skin assessment was completed The 8/13/20 Fall Assessment indicated Resident 5 had a fall at 9:20 PM and was found on the floor. The resident was unable to verbalize clearly the events that led to the fall. Resident 5 had two skin tears, one on the forearm and one on the right leg stump. The physician was notified by note in box. The note indicated the resident's last fall was on 5/8/20. An 8/14/20 progress note indicated Resident 5 became increasingly aggressive and had a recent fall on 8/13/20 and was almost on the floor x 2 thus far. [resident had near falls on two occasions]. On 8/14/20 The resident was noted to have altered mental status with hallucinations. The noted stated suspected illicit drug use and that the resident was coming down from being high. The resident complained of un-retractable abdominal pain. The resident was sent to the hospital for treatment on 8/14/20. An 8/14/20 email from the charge nurse to Staff 1 (Administrator) indicated Resident 5 was transported to the hospital by ambulance on 8/14/20 at 6:55 PM for uncontrolled pain and suspected illicit drug use. The 8/14/20 hospital record indicated the following: -Resident 5 admitted at 7:14 PM with diagnoses including sepsis with severe septic shock, rectal abscess and pressure ulcer to the right buttock that was draining feculent (fecal) material. -The resident was admitted to the Intensive Care Unit for sepsis. After the resident was stabilized Resident 5 told hospital staff she/he was sick for a number of days with poor appetite and did not have any desire to eat. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	There was no indication in the resident's clinical record to indicate the dietitian or physician were notified of the meal refusals from 8/10/20 through 8/14/20, the continued weight loss and change of condition. There was no indication a head to toe skin assessment was completed after 8/6/20. The physician no longer worked at the facility. On 6/15/21 at 1:19 PM and 6/24/21 at 2:15 PM Staff 41 (LPN) stated she noticed Resident 5 having a decline for about 3 weeks before she/he was hospitalized . She stated the resident went from frequently enjoying time out of the facility to staying in her/his room and was bedridden. Staff 41 stated she was aware of Resident 5's meal refusals for the day of 8/14/20, but was not aware of her/his past meal refusals. Staff 41 stated CNA staff reported Resident 5 did not eat on 8/14/20 and she was concerned because the resident had elevated blood sugars even though she/he was not eating. Staff 41 further stated she didn't notify the physician or RD of Resident 5's meal refusals, or the change in condition. Staff 41 stated she was working under a Resident Care Manager (RCM) at that time and due to her being supervised, she had to check with the the RCM before notifying the physician. Staff 41 further stated Resident 5 had undue suffering three weeks before she/he was sent to the hospital. Staff 41 stated Resident 5 was hospitalized after the end of her shift on 8/14/20. On 6/15/21 at 3:43 PM Staff 12 (RN) stated she believed she was the staff who sent Resident 5 to the hospital on 8/14/20 for unretractable pain. She stated the RCM staff felt like it was due to withdrawal from drugs, but she had no recollection of Resident 5 using drugs. On 6/18/21 at 2:17 PM Staff 24 (CNA) stated she was familiar with Resident 5 and she/he had a gradual decline, stayed in bed, and was not as hungry as usual. On 6/18/21 at 2:23 PM Staff 18 stated a skin event was completed on 8/14/20 for a skin tear on the right ankle and she did not complete a head to toe assessment. Staff 18 further stated at that time the Resident Care Managers were completing the weekly head to toe skin assessments. On 6/21/21 at 9:55 AM and 6/22/21 at 2:44 PM Staff 17 (LPN Resident Care Manager) stated the last head to toe skin assessment for Resident 5 was completed on 8/6/20. Staff 17 acknowledged a weekly skin assessment was due on 8/13/20 and was not completed. Staff 17 stated it was the care manager's job to identify residents' patterns of concern. Staff 17 stated the physician visited Resident 5 but did not complete comprehensive head to toe skin assessments. Staff 17 stated Resident 5 had an anal fissure and pressure ulcer upon admission to the hospital on 8/14/20. She stated she was not aware of anal fissure or pressure ulcer prior to the resident's admission to the hospital. Staff 17 stated the resident did not have feeling of her/his lower body and would not have been able feel a pressure ulcer or anal fissure. Staff 17 further stated Resident 5 had a fall on 8/13/20 and did not have a recent history of falls. Staff 17 stated Resident 5 was not assessed timely for meal refusals which was a change in the resident's condition. On 6/23/21 at 2:23 PM Staff 39 (RD) stated she worked two days a month at the facility and had not worked in the building since pre-Covid [approximately February 2020] and worked remotely. Staff 39 stated on 8/11/20 Resident 5 was added to the Nutrition At Risk (NAR) list. Staff 39 stated if nursing staff told her a resident needed a priority RD assessment she put a star next to the resident's name. Staff 39 further stated she reviewed her notes and Resident 5 did not have a star by her/his name and the resident was not assessed for NAR on 8/11/20. Staff 39 stated by the time she went to complete Resident 5's NAR assessment the resident was discharged to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Based on observation, interview and record review it was determined the facility failed to provide treatments as ordered for 1 of 3 sampled residents (#11) reviewed for skin. This placed residents at risk for worsening skin conditions. Findings include: The 6/3/21 Resident Council Notes indicated multiple residents showed concerns regarding wound care not being completed as scheduled. Resident 11 was admitted to the facility in 1/2020 with diagnoses including quadriplegia. The 5/10/21 BIMS indicated Resident 11 was cognitively intact. a. The 11/12/20 physician order indicated to cleanse the right gluteal fold with wound cleanser, pat dry, use calmoseptine (medication used to treat skin irritation) to peri wound (tissue surrounding wound). Apply daily and PRN. The 1/31/20 physician order indicated to check if catheter care was done. On 6/15/21 at 3:55 PM the 6/2021 TAR was reviewed and indicated Staff 13 (LPN) documented the treatment to Resident 11's gluteal fold was completed and the catheter was checked on 6/15/21. On 6/15/21 at 3:59 PM Resident 11 stated staff had not treated the area to her/his gluteal fold and had not looked at her/his catheter today (6/15/21). Resident 11 stated she/he was up in her/his chair all day and had not been back to bed or received treatment. On 6/15/21 at 4:15 PM and 4:44 PM Staff 13 stated he documented and completed treatment to the gluteal wound at approximately 2:00 PM. Staff 13 was informed Resident 11 reported she/he was in her/his chair all day and had not received treatments to the gluteal fold. Staff 13 then stated I have not done [her/his] wound today, that must have been yesterday. Staff 13 further stated he documented catheter care was completed, but had not checked Resident 11's catheter. Staff 13 stated he documented catheter care was complete because CNA staff completed that care. On 6/15/21 at 5:07 PM Staff 2 (DNS) was informed Staff 13 did not complete treatments but documented it was done for Resident 11. Staff 2 stated Staff 13 was currently being coached due to not having a long term care background. b. The 4/10/21 nursing order indicated to cleanse the right heel wound every day shift and apply foam dressing, monitor for worsening. The 4/10/21 note to the physician indicated Resident 11 had an open area to her/his right heel measuring 0.5 cm x 1.5 cm. The note indicated ok to cleanse with wound cleanser and cover in foam dressing and discontinue when resolved? Please advise. The provider response on 4/14/21 indicated ok with treatment, resident refused to allow me to see it. The 4/21/21 note to the provider indicated there was a nursing order dated 4/11/21 for right heel wound to cleanse with wound cleanser and apply foam dressing and monitor for worsening? On 4/21/21 The provider indicated yes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 4/2020, 5/2020 and 6/2020 TARs indicated Resident 11 received a foam dressing to her/his right heel on 4/15/21. There was no indication Resident 11 received additional treatments. On 6/14/21 at 1:36 PM Resident 11 stated she/he had an area on her/his heel that has been there for six months and staff did not assess the heel, but would apply a Band-Aide if the resident directed them to. On 6/15/21 at 4:03 PM Staff 12 (RN) stated Resident 11's heel treatments were to be completed daily starting on 4/10/21. Staff 12 stated treatments have not been done due to the treatment not being added to the TAR. Staff 12 stated she added the daily heel treatments to the TAR on 6/15/21. On 6/15/21 at 4:21 PM Resident 11's heel was observed with Staff 13. Resident 11 had an open area (approximately the size of a pencil eraser) to the back of the right heel. On 6/22/21 at 10:15 AM Staff 17 (LPN Resident Care Manager) stated Resident 11's orders were entered incorrectly into the electronic health record for heel treatments. Staff 17 acknowledged treatments were not completed to Resident 11's heel as ordered from 4/10/21 through 6/15/21.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 34702 Based on interview and record review it was determined the facility failed to maintain acceptable parameters of nutritional status for 2 of 3 sampled residents (#s 5 and 28) reviewed for nutrition. This placed residents at risk for weight loss. Findings include: 1. Resident 5 was admitted to the facility in 2/2020 with diagnoses including diabetes and left lower leg amputation. An 8/14/20 progress note indicated Resident 5 continued to refuse to eat and was no longer getting out of bed. Resident 5 had been drinking supplements. a. Resident 5's nutrition record indicated the following: *8/10/20 the resident refused breakfast and lunch. *8/11/20 the resident refused breakfast, lunch, and dinner. *8/12/20 the resident refused breakfast, lunch, and dinner. *8/13/20 the resident refused breakfast, lunch, and dinner. *8/14/20 the resident refused breakfast, lunch, and dinner. The 6/30/20 order indicated Resident 5 was to have 1 scoop of protein powder with meals for wound healing. The 6/30/20 progress note indicated to discontinue protein powder due to the resident disliking the taste and states [she/he] does not want it, will discontinue at this point in time per MD. Resident 5's supplement intake record indicated the following: *8/10/20 480 mls *8/11/20 refused *8/12/20 refused *8/13/20 refused *8/14/20 refused Resident 5's weight records indicated she/he had the following weights: *7/2/20 290.6 lbs. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*8/3/20 276.4 lbs. (indicating a 14.2 lb weight loss in 32 days and a 4% weight loss). *8/11/20 271.8 lbs. (indicating an additional 4.6 lb. weight loss in 8 days and an overall 6% weight loss since 7/2/20). An 8/4/20 physician progress note indicated Resident 5 had a current weight of 274.6 lbs and no weight loss. The previous physician note dated 6/11/20 indicated Resident 5's previous weight was 296.8 lbs. The note did not address the 22 lb. weight loss. There was no indication in the resident's clinical record to indicate the physician addressed the weight loss on 8/4/20 or the dietitian or physician was notified of the meal refusals from 8/10/20 through 8/14/20 and the continued weight loss and change of condition. The physician no longer worked at the facility. On 6/23/21 at 2:23 PM Staff 39 (RD) stated she worked two days a month at the facility and had not worked in the building since pre-Covid [approximately February 2020] and worked remotely. Staff 39 stated on 8/11/20 Resident 5 was added to the Nutrition At Risk (NAR) list. Staff 39 stated if nursing staff told her a resident needed a priority RD assessment she put a star next to the resident's name. Staff 39 further stated she reviewed her notes and Resident 5 did not have a star by her/his name and the resident was not assessed for NAR on 8/11/20. Staff 39 stated by the time she went to complete Resident 5's NAR assessment the resident was discharged to the hospital. 34324 2. Resident 28 admitted to the facility in 2020 with diagnoses including obesity and heart failure. The 4/5/21 MDS indicated the resident was cognitively intact. Resident 28's weight records indicated she/he had the following weights: *3/2/21 297 lbs *3/26/21 265.8 lbs (indicating a 31.2 lb weight loss in 24 days and an overall 10.5% weight loss). The 4/6/21 Nutrition Assessment indicated Resident 28 had a 7.6 lb weight loss since her/his last nutritional assessment on 10/22/20, which was reflected as desirable. The note further indicated Resident 28 was independent with meals and Staff 39 (Registered Dietitician) was working remotely, therefore Resident 28 was not visited. Resident 28 was noted to have a BMI of 48.2, indicating morbid obesity. On 5/7/21 Resident 28 weighed 274.2 lbs, indicating a 6.4 lb weight gain since 3/26/21. There was no indication in Resident 28's medical record to indicate she/he was on an ordered weight loss regime. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/21 at 9:52 AM Resident 28 stated she/he had lost approximately 40 lbs due to health issues. Resident 28 stated the weight loss was due to liver failure and was not intentional. Resident 28 stated she/he was not on a prescribed weight loss plan and did not recall ever discussing with the facility, including Staff 39, about a desired weight loss regime. On 6/25/21 at 11:14 AM Staff 17 (LPN Resident Care Manager) stated based on Resident 28's BMI, the resident's weight loss was considered desired. Staff 17 stated at some point Resident 28 had wanted to lose weight and this would have been discussed with the resident. Staff 17 stated Staff 39 (Registered Dietitian) had not been in the facility since before COVID. Staff 17 confirmed Resident 28's weight loss was not addressed.