

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Maryville		STREET ADDRESS, CITY, STATE, ZIP CODE 14645 SW Farmington Road Beaverton, OR 97007	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</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 dependent residents received required assistance with ADLs for 1 of 3 sampled residents (#36) reviewed for ADLs. This placed residents at risk for lack of personal hygiene. Findings include:</p> <p>Resident 36 was admitted to the facility in 8/2024 with diagnoses including cerebral atherosclerosis (hardening of arteries in the brain) and dementia.</p> <p>Resident 36's Significant Change MDS dated [DATE] indicated the resident was dependent on staff for personal hygiene and grooming.</p> <p>Resident 36 was observed on 4/8/25 at 10:24 AM, and on 4/9/25 at 8:24 AM with a significant amount of chin hair visible.</p> <p>On 4/8/25 at 10:24 AM, Resident 36 stated she/he did not want to have facial hair and would like for staff to take care of it for her/him. Resident 36 stated she/he relied on staff to shave unwanted facial hair.</p> <p>On 4/9/25 at 2:13 PM, Staff 6 (CNA) stated she obtained information to care for Resident 36 from the [NAME] (bedside care plan) and acknowledged Resident 36 had long chin hairs.</p> <p>On 4/9/25 at 2:18 PM, Staff 2 (DNS) observed and acknowledged Resident 36's facial hair and stated the resident was in need of a shave.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1. Based on observation, interview and record review it was determined the facility failed to ensure proper hand hygiene was completed during meals for 1 of 6 halls reviewed for dining. This placed residents at risk for cross contamination. Findings include:</p> <p>The 8/2019 Handwashing/Hand Hygiene Policy indicated hand hygiene was the primary means to prevent the spread of infections. The policy indicated:</p> <p>7. Use of an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <ul style="list-style-type: none"> a. before and after direct contact with residents; l. after contact with objects in the immediate vicinity of the resident; o. before and after eating or handling food; p. before and after assisting a resident with meals; <p>On 4/7/25 during the lunch meal in the west hall and dining room the following observations were made:</p> <p>-12:05 PM Staff 10 (NA) removed three dirty breakfast trays from a two-tier serving cart and loaded the cart with three lunch trays. Staff 10 did not sanitize the cart prior to loading the cart with the lunch trays.</p> <p>- 12:07 PM Staff 10 delivered lunch trays to three residents in the dining room, donned clothing protectors and set-up each tray for the three residents. Staff 10 did not sanitize her hands between each resident or after leaving the dining room.</p> <p>-12:10 PM Staff 10 loaded the two-tier cart with three lunch trays and delivered the lunch tray to room [ROOM NUMBER] and exited the room without sanitizing her hands. Staff 10 delivered a lunch tray to room [ROOM NUMBER].1, assisted the resident with repositioning, adjusted the head of the bed and moved the bedside table. Staff 10 delivered a lunch tray to room [ROOM NUMBER].2, assisted the resident with repositioning in the bed, cleared and adjusted the bedside table.</p> <p>On 4/7/25 at 12:14 PM Staff 10 acknowledged she did not sanitize her hands in between delivering the lunch trays and touching each resident in the dining room and in the rooms. Staff 10 stated she should have sanitized the cart after removing the dirty breakfast trays and before using it for the lunch trays.</p> <p>On 4/7/25 at 12:20 PM Staff 2 (DNS) stated she expected all staff to complete hand hygiene after they passed out each resident tray and went in and out of resident rooms. Staff 2 stated she expected staff to sanitize the meal cart before each use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Based on interview and record review it was determined the facility failed to develop and implement a water management program and conduct a risk analysis assessment for potential areas of growth and spread of water-borne pathogens and illness. This placed all residents at risk for exposure to water-borne pathogens. Findings include:</p> <p>The Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality/Safety and Oversight Group letter 17-30, revised on 7/6/18, on Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease stated, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water.</p> <p>A review of the facility's 9/2022 Legionella Water Management Policy revealed the following:</p> <ul style="list-style-type: none"> -The water management program is reviewed annually by the facility water management team. -The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. -The water management program includes a detailed description and diagram of the water system in the facility and areas identified in the water system that could encourage the growth and spread of Legionella or other water-borne bacteria. <p>A review of the 2/2025 Facility Assessment revealed no evidence a risk assessment was completed to prevent the growth and spread of water-borne pathogens in the facility's main water system.</p> <p>On 4/11/25 at 10:05 AM Staff 1 (Administrator) stated the facility did not have a water management program and did not have a prevention plan or system in place for the prevention of the spread of water-borne pathogens, such as Legionella, in the facility's main water system.</p>		