

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>385072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/25/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>CORVALLIS MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP <b>160 NE CONIFER BLVD CORVALLIS, OR 97330</b>	
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 0677  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide care and assistance to perform activities of daily living for any resident who is unable.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on interview and record review it was determined the facility failed to provide ADL assistance for dependent residents for 1 of 3 residents (#1) reviewed for bathing. This placed residents at risk for unmet needs. Findings include: Resident 1 readmitted to the facility 4/6/20 with [DIAGNOSES REDACTED]. The 4/2020 Shower Task Sheet indicated Resident 1 was to receive showers Sundays and Thursdays during day shift. Review of Shower Task Sheets from 4/6/20 through 5/12/20 indicated Resident 1 did not receive showers on her/his scheduled days for 4/23/20, 5/3/20 and 5/7/20. On 4/23/20 and 5/3/20 the sheet indicated Resident 1 did not receive a shower/bath and the reason was the resident was not available. On 5/7/20 the shower sheet indicated Resident 1 did not receive a shower/bath and the reason was listed as not applicable. The Shower Sheet further indicated Resident 1 received bed baths instead of showers during the days reviewed. Review of Progress Notes from 4/2020 through 5/2020 did not indicate reasons Resident 1 did not receive showers on the indicated dates nor that the resident was unavailable or out of the facility. On 9/22/20 at 1:41 PM Resident 1 stated there were multiple occasions showers were not completed by staff after the resident returned from the hospital after 4/6/20. Resident 1 stated she/he preferred showers and during 4/2020 the resident received bed baths instead. Resident 1 further stated staff would not complete showers on her/his scheduled shower days and staff stated to the resident they would get (her/him) next time. On 9/23/20 at 1:58 PM Staff 6 (CNA) stated there had been issues for staff to complete showers due to scheduling, as some days one aid would have five resident showers scheduled and then another day there would be zero showers scheduled. Staff 6 further stated there was no way one staff member could complete five showers in one day. On 9/23/20 at 2:15 PM Staff 7 (CNA) stated there were consistent issues for staff to complete showers for residents, including Resident 1, especially for day shift due to having more tasks during day shift, including more showers scheduled. On 9/23/20 at 3:08 PM Staff 8 (CNA) stated at times residents did not receive showers, including Resident 1, and there were issues providing showers on the correct shower day due to the staff's utilized shower schedules not matching the Task Sheet shower schedule. On 9/24/20 at 3:42 PM Staff 2 (DNS) acknowledged the three indicated dates Resident 1 was not bathed. Staff 2 stated the expectation was for staff to re-offer a shower if the resident was not available the first time and there was no indication the resident was re-offered a shower. Staff 2 stated she was unsure why the shower sheet was marked as not given and the reason being Not Applicable for 5/7/20 as that day was one of Resident 1's scheduled shower days. Staff 2 stated the facility was aware of issues with staff providing showers on the correct shower days for residents. Staff 2 further stated during 4/2020 the facility experienced a COVID-19 outbreak, so all residents received bed baths instead of showers to keep residents from sharing the shower room during that time.</p>		
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.