

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/23/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Pearl at Kruse Way, The		STREET ADDRESS, CITY, STATE, ZIP CODE 4550 Carman Drive Lake Oswego, OR 97035	
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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders and implement bowel care for 1 of 3 sampled residents (#4) reviewed for constipation. This placed residents at risk for medical complications from constipation including bowel impaction. Findings include:</p> <p>The facility's 10/2020 Bowel Care Protocol indicated the following:</p> <p>-If a resident did not have a bowel movement for three consecutive days then evening shift was to run a report and administer Milk of Magnesia (MOM). If no results, then day shift was to administer a suppository and if no results then a Fleets enema was to be administered.</p> <p>Resident 4 admitted to the facility on [DATE] with diagnoses including femur fracture.</p> <p>The 1/6/24 physician order indicated Resident 4 was to receive the following:</p> <p>-Milk of Magnesia 30 ml every 24 hours PRN for bowel care and constipation.</p> <p>-Dulcolax suppository 10 mg insert rectally PRN for constipation, give for no bowel movement for four days for constipation if MOM was ineffective.</p> <p>-Fleet enema insert 1 application rectally as needed for constipation.</p> <p>Resident 4's 1/2024 bowel records revealed the following:</p> <p>-1/14/24-1/19/24 no bowel movement (six days).</p> <p>-1/21/24-1/25/24 no bowel movement (five days).</p> <p>There was no indication Resident 4 received or refused the ordered bowel medications on the identified dates.</p> <p>Interviews on 1/22/25 and 1/23/25 with Staff 10 (LPN Resident Care Manager), Staff 3 (Therapy Director), Staff 8 (LPN), Staff 7 (RNCM), Staff 11 (RN), Staff 12 (RN) and Staff 5 (SSD) revealed the staff did not remember Resident 4. Two unsuccessful attempts were made to contact Staff 9 (CNA) who was noted in the clinical record to often work with Resident 4.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 385271	Facility ID: 385271 If continuation sheet Page 1 of 3

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 2:30 PM Staff 2 (DNS) acknowledged Resident 4 did not have bowel movements on the identified dates. Staff 2 further acknowledged there was no evidence to indicate the resident was offered bowel medications on the identified dates.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702</p> <p>Based on interview and record review it was determined the facility failed to assess and monitor pressure ulcers for 1 of 3 sampled residents (#4) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include:</p> <p>Resident 4 admitted to the facility on [DATE] with diagnoses including femur fracture. Resident 4 discharged from the facility on 1/29/24.</p> <p>The 1/6/24 Admission Nursing Database indicated Resident 4 did not have skin issues.</p> <p>The 1/2024 TAR indicated weekly skin audits were completed on 1/13/24 and 1/20/24 and no new skin issues were identified.</p> <p>The 1/22/24 physician progress note indicated the following:</p> <p>-Bilateral pressure injuries on heels with no open areas or drainage. The heels were floated and in cushion boots.</p> <p>-Pressure ulcer of the left buttock Stage 2 (Partial thickness skin loss).</p> <p>There was no evidence in Resident 4's clinical record to indicate the pressure ulcers were assessed including staging and measuring the wounds.</p> <p>The 1/2024 care plan did not include information or interventions regarding the bilateral heel pressure ulcers and the left buttock Stage 2 pressure ulcer.</p> <p>The 1/2024 TAR indicated Resident 4 received treatments to the bilateral heels and buttocks pressure ulcers as ordered.</p> <p>There was no indication the pressure ulcers were investigated to determine the cause or interventions needed to avoid further skin decline until 4/19/24 (81 days after the residents discharged).</p> <p>Interviews on 1/22/25 and 1/23/25 with Staff 10 (LPN Resident Care Manager), Staff 3 (Therapy Director), Staff 8 (LPN), Staff 7 (RNCM), Staff 11 (RN), Staff 12 (RN) and Staff 5 (SSD) revealed the staff did not remember Resident 4. Two unsuccessful attempts were made to contact Staff 9 (CNA) who was noted in the clinical record to often work with Resident 4.</p> <p>On 1/22/25 at 11:46 AM and 1/23/25 at 2:30 PM Staff 2 (DNS) stated the expectation was for nursing staff to take pictures of pressure ulcers when they were identified and then weekly. Staff 2 stated staff were to also stage the wounds and update the care plan to reflect appropriate interventions. Staff 2 acknowledged no pictures were taken of the bilateral heel pressure ulcers or the Stage 2 pressure ulcer to the buttocks, no measurements were completed upon identification of the pressure ulcers on 1/22/24, the care plan was not updated with interventions and the investigation was not completed until 4/19/24 after the resident discharged .</p>		