

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2025
NAME OF PROVIDER OR SUPPLIER  Village Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3955 SE 182nd Avenue Gresham, OR 97030	

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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>42222</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (#3) reviewed for medications. As a result, Resident 3 experienced significant clinical symptoms (increased swelling of the extremities, lowered oxygen levels and shortness of breath) related to the medication error and had a 10-day hospitalization stay. Findings include:</p> <p>Resident 3 admitted to the facility in 1/2025 with diagnoses including chronic obstructive pulmonary disease (damage to the airways and air sacs in the lungs which make it difficult to breathe) and congestive heart failure (a weakened heart condition the causes fluid buildup in the feet, arms, lungs and other organs).</p> <p>Resident 3's 1/10/25 nursing notes indicated she/he was alert and oriented and was able to make her/his needs known.</p> <p>On 2/4/25, the facility submitted a report to the State Survey Agency which revealed Resident 3 did not receive her/his lasix (a diuretic which reduces fluid buildup), which resulted in her/his hospitalization and the facility had initiated an investigation. On 2/7/25, the facility sent additional information which confirmed Resident 3 did not receive lasix for four days due to a charting error on the resident's MAR.</p> <p>Physician orders dated 1/11/25 for Resident 3 revealed she/he was to be administered 40 mg of lasix once a day from 1/11/25 through 1/22/25.</p> <p>Resident 3's Nursing Note dated 1/22/25 revealed she/he had a new order for lasix to be administered two times a day for five days due to the resident's complaints of increased swelling in her/his lower extremities.</p> <p>Resident 3's 1/23/25 Nursing Note indicated for the resident's new order to be implemented, her/his original order needed to be stopped.</p> <p>Resident 3's 1/2025 MAR revealed she/he did not receive her/his lasix from 1/27/25 through 1/30/25.</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
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An MD provider note dated 1/31/25, indicated Resident 3 had reported shortness of breath and swelling in her/his legs. The note indicated the resident had not been administered lasix from 1/27/25 through 1/31/25 and was a medication error. Resident 3 was re-started on her/his medication on 1/31/25.</p> <p>Resident 3's 2/2/25 Nursing Note revealed she/he was observed to have continued shortness of breath, increased respiratory rate, lower than normal oxygen levels and swelling in her/his legs. The resident was sent to the ED at approximately 9:00 AM and diagnosed with acute hypoxemic respiratory failure (a serious condition where the lungs fail to deliver enough oxygen to the blood, leading to a deficiency of oxygen in the body).</p> <p>Hospital discharge records dated 2/12/25 revealed Resident 3 was admitted to the ED on 2/2/25, and was diagnosed with hypoxemic respiratory failure. Resident 3 was admitted to the ICU and received 5-6 liters of oxygen (baseline oxygen was 2 liters), prednisone (a steroid medication used to treat inflammation), and was volume overloaded on her/his physical exam. Resident 3's BNP (brain natriuretic peptide, a protein hormone produced by the heart's ventricles in response to stress and pressure, which rise when heart failure is experienced) was elevated above normal levels and the report concluded the heart failure was due to medication non-adherence.</p> <p>On 5/21/25 at 2:31 PM, Staff 5 confirmed she received new orders from the provider to start a lasix burst which consisted of taking the medication twice a day for five days. She attempted to hold the once per day lasix order from 1/22/25 through 1/26/25. She was unable to place the medication on hold due to a glitch in the computer system and had to discontinue the medication. She stated she was going to be off for several days, so she spoke to the facility provider and the care manager regarding the medication change, as she was concerned about the glitch in the medication system. Staff 5 stated she placed the resident on alert for the new medication regimen and assumed the previous nurse manager or DNS would address the issue in their clinical rounds.</p> <p>Resident 3 was not interviewed due to discharging from the facility.</p> <p>On 5/22/25 at 11:28 AM, Staff 4 (Nurse Practitioner) stated a resident missing four days of lasix would constitute a significant medication error and could have significant, serious medical outcomes for residents.</p> <p>On 5/22/25 at 12:05 PM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the investigative findings and provided no additional information.</p>		