

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Fairlawn Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3457 NE Division Street 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43691</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for medication administration for 1 of 3 residents (# 501) reviewed for medication administration timeliness. This placed residents at risk for reduced medication efficacy and adverse medication side effects. Findings include:</p> <p>Resident 501 was admitted to the facility in 9/2023 with diagnoses including a urinary tract infection (UTI).</p> <p>Physician Orders from 10/2023 included orders for the following medications to be administered at 7:15 AM:</p> <ul style="list-style-type: none"> <li>- Polyethylene Glycol Power - Give 17 grams in the morning for bowel care.</li> <li>- Potassium Chloride ER - Give half a tablet by mouth in the morning for supplement.</li> <li>- Torsemide 100 mg - Give one tablet by mouth in the morning for heart health.</li> <li>- Cipro 500 mg - Give one tablet by mouth twice a day for UTI for 10 days. (Started 10/10/23).</li> <li>- Nitrofurantoin Macrocrystal 100 mg - Give one capsule by mouth in the morning for UTI prevention. (Started 10/20/23).</li> </ul> <p>Review of a 10/2023 Medication Admin Audit Report revealed the following delays in medication administration:</p> <ul style="list-style-type: none"> <li>- 10/5/23 - Administered at 9:48 AM</li> <li>- 10/7/23 - Administered at 10:54 AM</li> <li>- 10/13/23 - Administered at 9:18 AM</li> <li>- 10/20/23 - Administered at 11:03 AM</li> <li>- 10/21/23 - Administered at 10:11 AM</li> </ul> <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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NAME OF PROVIDER OR SUPPLIER  Fairlawn Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE  3457 NE Division Street Gresham, OR 97030	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 10/27/23 - Administered at 9:52 AM</p> <p>- 10/28/23 - Administered at 8:51 AM</p> <p>On 5/23/34 at 2:35 PM Staff 1 (Administrator) stated the administration for medications had a two hour window, which meant medications ordered to be administered at 7:15 AM could be administered between 6:15 AM and 8:15 AM. Staff 1 confirmed Resident 501 received her/his medications outside of this timeframe on the dates listed above.</p>		