STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385155	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Grove Post Acute	3900 Pacific Avenue Forest Grove, OR 97116

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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to provide medication per the physician order for 1 of 3 sampled residents (#2) reviewed for medications. This placed residents at risk for lack of needed medication. Findings include:Resident 2 admitted to the facility in 4/2026 with diagnoses including hypothyroidism. The 4/17/26 physician orders indicated Resident 2 was to receive levothyroxine (thyroid medication) once daily. The 4/2026 MARs indicated Resident 2 did not receive levothyroxine on the following dates: 4/18/26; 4/19/26; 4/20/26 and 4/21/26.\ No information was found in the resident's clinical record related to the failure to administer the levothyroxine. On 6/11/26 at 2:53 PM Staff 2 (DNS) acknowledged Resident 2 did not receive levothyroxine on the identified dates.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to obtain orders related to unplanned removal of an indwelling catheter for 1 of 1 sampled resident (#1) reviewed for catheter care. This placed residents at risk for urinary retention. Findings include: Resident 1 admitted to the facility on [DATE] with diagnoses including dementia.A 4/2/26 physician order indicated the use of a foley (indwelling) catheter.The 4/2/26 Care Plan indicated Resident 1 had a foley catheter in place with interventions including changing the catheter per facility policy and physician order.Review of Resident 1's progress notes from 4/7/26 through 4/23/26 revealed the following:-On 4/7/26 Resident 1 pulled out the catheter during night shift. Nursing staff attempted to reinsert the catheter, but the resident refused. -On 4/20/26 during a care conference meeting Resident 1's family asked about the catheter and were informed by Staff 3 (LPN Resident Care Manager) the resident previously had a catheter and Staff 3 would follow up. -On 4/23/26 the provider reviewed the resident's bladder scan and indicated the foley did not need to be replaced.There was no indication in Resident 1's medical record the physician was notified of the resident pulling out the catheter, and there was no catheter in place, until 4/20/26 (13 days later).On 6/11/26 at 10:30 AM Staff 3 stated if a resident pulled out a catheter and refused to have it reinserted the provider was to be notified to get further direction on how to proceed. Staff 3 stated she notified the provider of Resident 1 not having a catheter in place when she asked for a post void scan (bladder scan) on 4/20/26. Staff 3 acknowledged the provider was not notified until 13 days after the resident pulled out the catheter and physician orders were not followed related to use of a catheter. On 6/11/26 at 2:31 PM Staff 2 (DNS) acknowledged Resident 1's physician orders were not followed related to having a catheter in place and the provider was not notified in a timely manner after the catheter was pulled out.