STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385166	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryville	14645 SW Farmington Road Beaverton, OR 97007

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 resident (#6) reviewed for medication administration. This placed residents at risk for adverse medication consequences. Findings include:Resident 6 was admitted to the facility in 2025 with diagnosis including orthostatic hypotension and implantation of a prosthetic heart value. Resident 6's 5/21/25 Care Plan indicated Resident 6 had impaired cardiovascular function and altered cardiovascular function due to the presence of a pacemaker. Resident 6's MDS identified the resident with a BIMS score of 12 out 15 indicating mild to moderate cognitive impairment. A 6/5/25 Facility Risk Management Report identified Staff 16 (LPN) wrongly administered a combination of the following medications to Resident 6: Levothyroxine 50mcg, Tylenol 500mg, Gabapentin 300mg, Bactrim 800-160, Amidarone 200mg, Baclofen 5mg, Calcium Citrate 315mg-5mcg, Vit D3 125 mcg, Clopidogrel 75mg, CoQ10 75 mg, Entresto 300mg, Finasteride 5mg, Multivitamin 1 tab, Torsemide 100mg and Ezetimibe 10mg. Staff 16 was noted to have immediately discover the medication error and reported the incident to facility administration. Per Staff 16, she asked Resident 16 if she/he was the identified resident and resident responded yes and took the medication. Staff 16 confirmed during the report that she did not check to see if the medications administered were for the correct resident. Upon discovery of the medication error, Resident 6 was monitored and upon experiencing a change of condition including a low blood pressure of 99/49 was sent to the emergency room for evaluation. Resident 16 later returned to the facility after the hospital administered IV fluids to the resident to flush the medications from her/his system. Resident 16 was noted to have experienced no long-term effects from the medication administration error. A 6/5/25 Nursing Progress Note revealed Resident 6's systolic pressure dropped below 100 reaching a total blood pressure range of 99/49 as a result of the medication administration error. Resident 6 was sent to the emergency room for evaluation. On 4/23/26 at 1:10 PM, Staff 4 (RCM) stated Resident 6 was sent to the hospital after Resident 6's blood pressure dropped to 99/49. Staff 4 stated Resident 6 safely returned to the facility after being administered IV fluids to flush the medications from her/his system. On 4/23/26 at 1:21 PM, Staff 16 (LPN) confirmed she committed the medication error and confirmed Resident 6 was sent to the hospital after experiencing a change of condition from the medication error. Staff 16 stated the failure was due to an unstructured medication system and failing to confirm the identity of the resident before administration. Staff 16 reported during the incident, Staff 16 was assigned to administer medications managing three different treatment carts during her shift. Staff 16 indicated that upon preparing Resident 6's medications, she failed to confirm if the medication she prepped and administered was for Resident 6. On 4/23/26 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and indicated Staff 16 failed to administer the correct medication to Resident 6.

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