STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385187	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascade Terrace Post Acute	5601 SE 122nd Avenue Portland, OR 97236

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42222 Based on interview and record review it was determined the facility failed to provide ADL care for 1 of 3 sampled residents (#4) reviewed for ADL care. This placed residents at risk for unmet needs. Findings include: Resident 4 was admitted to the facility in 8/2024, with diagnoses including stroke and cerebral edema (excess fluid in the brain, which causes swelling). Resident 4 was discharged in 9/2024. Resident 4's Admission Nursing Database form dated 8/9/24 revealed she/he was alert but not oriented to person, time, or place; she/he was nonverbal and unable to express understanding. Resident 4 was considered an extensive assist for all ADL's and was a one person total assist for bathing. Resident 4's care plan dated 8/10/24 revealed she/he was to be bathed or showered twice a week. On 1/16/25 at 9:40 AM, Witness 4 (Complainant) stated she visited the resident almost daily when she/he was at the facility and bathing just wasn't done. She noted Resident 4 was non verbal and could not refuse showers or baths and recalled family members washed the resident's hair because it would get funky. Witness 4 stated nursing staff were questioned by family members about the resident's lack of baths or showers and nobody had any information. Resident 4's 8/2024 bathing task sheet revealed no baths or showers were completed. On 1/16/25 at 10:25 AM, Staff 18 (CNA) stated she recalled the resident's spouse told staff the resident did not get her/his showers. Staff 18 stated the resident was scheduled for showers on evening shift but it wasn't getting done. On 1/22/24 at 10:46 AM, Staff 17 (Former CNA) stated staffing levels were down last August and Resident 4 was not always provided her/his baths or showers. On 1/23/25 at 4:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the findings of the investigation and provided no additional information.

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 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. 42222 Based on interview and record review it was determined the facility failed to ensure tube feeding was administered according to physician orders for 1 of 3 sampled residents (#4) reviewed for physician orders. This placed residents at risk for insufficient nutrition. Findings include: Resident 4 was admitted to the facility in 8/2024, with diagnoses including stroke and cerebral edema (excess fluid in the brain, which causes swelling). Resident 4 was discharged in 9/2024. Resident 4's Admission Nursing Database form dated 8/9/24 revealed she/he was alert but not oriented to person, time, or place; was nonverbal and unable to express understanding. Resident 4 was found to have a nutritional problem or potential nutritional problem due to her/his NPO (nothing by mouth) and impaired swallowing status. Resident 4's care plan dated 8/10/24 revealed she/he was NPO and received her/his nutrition via a PEG tube. Resident 4's initial physician orders for tube feeding were as followed: -PEG Tube feeding: Standard formula with fiber - Jevity 1/2 (or equivalent) 290 ml 5x/day (0700, 1100, 1500, 1900, 2100) five times a day. On 1/16/25 at 9:40 AM, Witness 4 (Complainant) stated the resident's tube feed was scheduled every 4 hours or so but the tube feeds either didn't get done or were an hour or two late. She stated she told staff the feeds had not been done and would be told they had been administered. Witness 1 stated she was with the resident the entire time, knew it didn't occur and when she told staff, nobody had answers why it wasn't completed. Review of the 8/2024 MAR Audit Report revealed the following dates and times the resident's tube feeding was administered late: 8/10/24 at 7:00 AM; administered at 8:51 AM 8/10/24 at 11:00 AM; administered at 1:44 PM; 8/10/24 at 3:00 PM; administered at 4:32 PM; 8/13/24 at 7:00 AM; administered at 8:37 AM; 8/13/24 at 11:00 AM; administered at 1:31 PM; 8/13/24 at 3:00 PM; administered at 6:02 PM; 8/14/24 at 7:00 AM; administered at 9:39 AM; 8/14/24 at 11:00 AM; administered at 12:37 PM; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/14/24 at 3:00 PM; administered at 6:12 PM; 8/15/24 at 11:00 AM; administered at 1:10 PM; 8/15/24 at 3:00 PM; administered at 5:31 PM; 8/15/24 at 7:00 PM; administered at 9:19 PM; 8/16/24 at 11:00 AM; administered at 1:30 PM (no other tube feeding was administered or documented on this date); 8/17/24 at 9:00 PM; administered at 10:30 PM; 8/18/24 at 9:00 PM; administered at 10:31 PM; 8/20/24 at 7:00 AM; administered at 2:31 PM; 8/20/24 at 11:00 AM; administered at 2:31 PM; 8/20/24 at 7:00 PM; administered 8/21/24 at 1:22 AM; 8/20/24 at 9:00 PM; administered 8/21/24 at 1:22 AM; 8/21/24 at 7:00 AM; administered 3:43 PM; 8/21/24 at 11:00 AM; administered at 3:43 PM; 8/22/24 at 7:00 AM; administered at 3:31 PM; 8/22/24 at 11:00 AM; administered at 3:31 PM; 8/22/24 at 9:00 PM; administered at 11:25 PM; 8/23/24 at 9:00 PM; administered at 11:32 PM; 8/25/24 at 11:00 AM; administered at 1:27 PM; 8/27/24 at 7:00 AM; administered at 10:36 AM; 8/27/24 at 3:00 PM; administered at 6:15 PM; 8/27/24 at 7:00 PM; administered at 9:37 PM; 8/27/24 at 9:00 PM; administered at 10:42 PM; 8/28/24 at 7:00 AM; administered at 12:09 PM; 8/29/24 at 11:00 AM; administered at 1:06 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed Resident 4's initial tube feeding formula was 290 ml five times per day. On 8/15/24, the formula was increased to 340 ml five times per day; on 8/27/24 the formula was increased to 350 ml five times per day, on 8/29/24 decreased to 340 ml five times per day until the resident discharged . On 1/16/25 at 3:00 PM, Staff 9 (Registered Dietitian) stated he did not recall speaking with Resident 4's family during her/his stay at the facility and stated he would be notified of a resident's weight loss by the resident's Resident Care Manager (RCM) but did not recall any notifications of Resident 4's weight loss. On 1/22/25 and 1/23/25 between 11:00 AM and 3:30 PM, Staff 3 (Assistant Director of Nursing), Staff 10 (LPN), Staff 11 (LPN), and Staff 12 (Medication Aide) stated all medications and tube feeding should be administered within an hour before or after times ordered. On 1/23/25 at 3:20 PM, Staff 6 (LPN) was shown the 8/2024 medication audit results and confirmed he was the day shift nurse for most of the Resident 4's 8/2024 stay at the facility. He confirmed the times of the tube feeds on the audit were not within the time frames as ordered by the physician.