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	02/18/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review the facility failed to ensure a resident was treated with respect and dignity for 2 of 3 sampled residents (#s 1 and 5) reviewed for dignity. This placed residents at risk for undignified care. Findings include:Resident 1 was admitted to the facility in 7/2025 with diagnoses including type 2 diabetes and depression. Resident 1's 7/25/25 Care Plan identified Resident 1 was at risk for decreased psychosocial well-being and adjustment issues, including emotional distress and ineffective coping. The resident's care plan directed staff to use appropriate and effective communication, encourage personal preference and honor quality of life choices to ensure dignity and respect. Resident 5 was admitted to the facility 1/2026 with diagnoses including cellulitis and agoraphobia. Resident 5's 1/23/26 Care Plan identified Resident 5 was at risk for her/his psychosocial well-being, including increased agitation and tearfulness. The resident's care plan directed staff to honor the resident's preferences and choices to promote dignity and decrease anxiety. A 2/7/26 Facility Reported Event documented on 2/6/26, Resident 1 during a routine skin assessment reported inappropriate and undignified care from Staff 6 (RN) when performing a routine skin assessment. Staff 6 reportedly stated to Resident 1 to not fart on him while assessing the resident's peri-area. The report revealed this made Resident 1 feel both uncomfortable and undignified as the comment was inappropriate and unrelated to the cares being performed. On 2/17/26 at 10:19 AM, Resident 1 stated during the skin assessment, Staff 6 stated don't' fart on me, a lot of people fart on me, while examining the areas near the resident's anus. Resident 1 reported feeling disrespected and undignified and stated Staff 6's comment was unnecessary. Resident 1 stated she/he did not want Staff 6 to provide care in the future.On 2/17/26 at 11:15 AM, Staff 6 (RN) confirmed using the following statement with all residents during care: I am the registered nurse today. I have a couple of rules, don't fall on me, don't fart on me. Staff 6 stated he used the comment as a formal tool to establish rapport and reported he believed the comment was humorous rather than inappropriate.On 2/17/26 at 11:54 AM, Resident 5 indicated Staff 6 made unprofessional comments during cares, including weird jokes, and asked Resident 5 to not fart on him while performing routine catheter care. Resident 5 reported these comments made her/him feel awkward and uncomfortable during the time the care was provided. On 2/17/26 at 12:09 PM, Staff 7 CNA reported concerns about Staff 6's behavior. Staff 7 confirmed hearing Staff 6 told Resident 1 not to fart in [his/her] face during the skin assessment near her/his peri-area and rectum.On 2/17/26 at 3:26 PM, Staff 1 (Administrator) stated Staff 6's behavior and comments, including the phrase don't fart on me, did not honor resident dignity and were inappropriate when providing resident care.

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review it was determined the facility failed to report an allegation of physical abuse to the State Agency within the required 2 hours for 1 of 3 sampled residents (#9) reviewed for abuse. This failure placed residents at risk of unreported physical abuse. Findings include:Resident 9 was admitted to the facility in 10/2024 with diagnoses including metabolic encephalopathy and atrial fibrillation. Resident 9's 11/4/24 Care Plan identified Resident 9 with cognitive loss affecting decision-making ability.A 2/7/26 Facility Incident Report documented on 2/15/26, that Resident 9 placed a pillow over Resident's 8 face and was witnessed throwing heat packs at Resident 8 while the resident was sleeping.On 2/17/26 at 1:44 PM, Staff 11 (RNCM) stated she reported the incident to Staff 1 (Administrator). Staff 11 stated Staff 1 informed her the incident would be investigated but not reported to the State Agency. Staff 11 stated she did not know why the incident was not reported and believed the investigation was handled by facility administration. On 2/17/26 at 2:41 PM, Staff 14 (RN) stated she did not witness the event and reported the incident based on information received from care staff. Staff 14 stated the incident was not reported to the State Agency because administration determined it was not reportable.On 2/18/26 at 4:15 PM, Staff 1 (Administrator) stated he was notified of the incident by care staff and did not report the incident to the State Agency because he did not believe the incident to be abuse. Staff 1 acknowledged that all allegations of abuse need to be reported to the State Agency within two hours of the reported allegation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to implement care according to the resident's care plan for 1 of 3 sampled residents (#1) reviewed for care plans. This placed residents at risk for unmet personalized care needs. Findings Include:Resident 1 was admitted to the facility in 7/2025 with diagnoses including type 2 diabetes and depression.Resident 1's 7/7/25 Cognitive Assessment revealed the resident with a 15 out 15 BIMS score indicating no cognitive impairment.Resident 1's 7/25/25 Care Plan identified Resident 1 preferred individualized preference for female caregivers to ensure and promote a level of comfort when receiving care. The resident's care plan directed staff to ensure female caregivers were available when providing care.On 2/17/26 at 10:19 AM, Resident 1 stated during a routine skin assessment, Staff 6 (RN) did not have an additional female caregiver present in the room as preferred. Resident 1 stated the facility's practice when male nurses performed skin assessments was to have at least on female caregiver present to perform additional peri-care services to ensure the resident's comfortability and preferences. On 2/17/26 at 11:07 AM, Staff 5 (LPN) stated the standard protocol based on Resident 1's care plan was to ensure that at least one female caregiver was in the room when performing routine assessments including skin assessments. Staff 5 stated he was aware of Resident 1's caregiver preference and stated staff were expected to honor the resident's preference to maintain her/his comfort.On 2/17/26 at 11:15 AM, Staff 6 (RN) stated he provided care to Resident 1 but refused to answer when asked whether a female caregiver was present when he provided nursing services.On 2/17/26 at 12:04 PM, Staff 8 (CNA) stated Resident 1's preference was for female caregivers only and stated Staff 6 provided nursing services without a female caregiver present in the room.On 2/17/26 at 3:26 PM, Staff 1 (Administrator) stated Staff 6 failed to honor Resident 1's needs and preferences by performing nursing services without ensuring female caregivers were present.