

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Cascade Terrace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed for safe self-administration of medications for 1 of 1 sampled resident (#28) reviewed for self-administration of medications. This placed residents at risk for unsafe medication administration and adverse medication side effects. Findings include:</p> <p>Resident 28 was admitted to the facility in 2/2025 with diagnoses including dementia.</p> <p>Resident 28's 3/1/25 Admission MDS indicated the resident had no cognitive impairment.</p> <p>On 4/23/25 at 1:28 PM, Resident 28 had Aspercreme lidocaine gel (a topical pain reliever primarily used for muscle or joint pain) on her/his bedside table, within reach. Resident 28 stated the Aspercreme was used on her/his heels.</p> <p>Review of Resident 28's health record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer the Aspercreme lidocaine gel.</p> <p>On 4/23/25 at 1:28 PM, Staff 13 (CNA) stated residents should not have any medications at their bedside and if medications were found, the CNA should report it to the nurse.</p> <p>On 4/23/25 at 2:19 PM, Staff 30 (CNA) confirmed Resident 28 had Aspercreme lidocaine gel on her/his bedside table and was unsure how long it had been there. Staff 30 stated residents should not have medications at the bedside and medications are to be kept in the medication carts.</p> <p>On 4/23/25 at 2:24 PM, Staff 40 (LPN) confirmed Resident 28 had Aspercreme lidocaine gel at her/his bedside. Staff 40 stated the medication should not be at the resident's bedside, it was from the facility's supply room and she was unaware how long it had been there.</p> <p>On 4/24/25 at 4:19 PM, Staff 2 (Regional Clinical Support) confirmed the resident was not assessed to safely self-administer the medication and the medication should not be left in her/his room.</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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility to maintain the privacy and confidentiality of resident records for 3 of 3 sampled residents (#s 14, 28 and 48) reviewed for privacy. This placed residents at risk for loss of dignity and privacy. Findings include:</p> <p>The facility's 4/2014 Management and Protection of Protected Health Information (PHI) Policy indicated it was the responsibility of all personnel with access to resident and facility information to ensure that such information was managed and protected to prevent unauthorized release or disclosure.</p> <p>1a. Resident 48 was admitted to the facility in 3/2025 with diagnoses including cellulitis (a common bacterial infection of the skin).</p> <p>Observations on 4/24/25 from 12:08 PM to 12:13 PM revealed an unlocked computer screen on one of the facility's treatment carts in the south hallway. The computer screen displayed a picture of Resident 48 as well as the resident's name, gender, date of birth, age, allergies, code status, attending physician, vital signs and her/his scheduled treatments.</p> <p>On 4/24/25 at 12:14 PM Staff 45 (Agency LPN) stated the resident health information was not viewable when the computer's screen was locked. Staff 45 stated he was responsible for the treatment cart and he forgot to lock the computer screen.</p> <p>On 4/25/25 at 2:58 PM Staff 1 (Administrator) stated he expected computer screens to be locked when no staff were present in order to maintain resident confidentiality.</p> <p>51846</p> <p>1b. On 4/25/25 at 5:12 AM, four sheets of resident records were observed to be laid out on the counter of the central nurses station. CNAs were observed going in and out of resident rooms, away from the resident records. One of the sheets had Resident 48's room number, name, and information regarding the changing of her/his ostomy bag. Resident 417 was observed ambulating around the facility during this time, including passing by the central nurses station.</p> <p>On 4/25/25 at 5:21 AM, Staff 39 (LPN) confirmed the four sheets of resident records were from the evening shift and given to the night shift for review. Staff 39 stated evening shift ended around 10:30 PM and was not sure how long the papers were out on the counter. Staff 39 acknowledged the private and confidential information regarding Resident 48 observed on the papers and stated it should not be out in the open.</p> <p>On 4/25/25 at 2:58 PM, Staff 1 (Administrator) stated he expected staff to not leave shift change sheets unattended on the counter of the nurses station. Staff 1 stated private and confidential information should be under staff supervision or covered.</p> <p>2. Resident 14 was admitted to the facility in 8/2020 with diagnoses including Anxiety (episodes of fear, dread and uneasiness).</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 5:12 AM, four sheets of resident records were were observed to be laid out on the counter of the central nurses station. CNAs were observed going in and out of resident rooms, away from the resident records. One of the sheets had Resident 14's room number, name, and information regarding her/him being changed and constantly taking off her/his brief. Resident 417 was observed ambulating around the facility during this time, including passing by the central nurses station.</p> <p>On 4/25/25 at 5:21 AM, Staff 39 (LPN) confirmed the four sheets of resident records were from the evening shift and given to the night shift for review. Staff 39 stated evening shift ended around 10:30 PM and was not sure how long the papers were out on the counter. Staff 39 acknowledged the private and confidential information regarding Resident 14 observed on the papers and stated it should not be out in the open.</p> <p>On 4/25/25 at 2:58 PM, Staff 1 (Administrator) stated he expected staff to not leave shift change sheets unattended on the counter of the nurses station. Staff 1 stated private and confidential information should be under staff supervision or covered.</p> <p>3. Resident 28 was admitted to the facility in 2/2025 with diagnoses including unilateral primary osteoarthritis (a condition where the cartilage in the hip joint is worn down).</p> <p>On 4/25/25 at 5:12 AM, four sheets of resident records were observed to be laid out on the counter of the central nurses station. CNAs were observed going in and out of resident rooms, away from the resident records. One of the sheets had Resident 28's room number, name, and information regarding her/his catheter being emptied and changed. Resident 417 was seen ambulating around the facility during this time, including passing by the central nurse's station.</p> <p>On 4/25/25 at 5:21 AM, Staff 39 (LPN) confirmed the four sheets of resident records were from the evening shift and given to the night shift for review. Staff 39 stated evening shift ended around 10:30 PM and was not sure how long the papers were out on the counter. Staff 39 acknowledged the private and confidential information regarding Resident 28 observed on the papers and stated it should not be out in the open.</p> <p>On 4/25/25 at 2:58 PM, Staff 1 (Administrator) stated he expected staff to not leave shift change sheets unattended on the counter of the nurses station. Staff 1 stated private and confidential information should be under staff supervision or covered.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51311</p> <p>Based on interview and record review it was determined the facility failed to complete comprehensive assessments within 14 days of admission for 3 of 3 sampled residents (#s 318, 320, 468) reviewed for comprehensive admission assessments. This placed residents at risk for unmet care needs. Findings include:</p> <p>1. Resident 318 admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus and chronic kidney disease.</p> <p>On 4/23/25 (17 days after admission) a record review of Resident 318's Admission MDS dated [DATE] indicated the MDS was incomplete. The MDS did not include provider signatures in Section V: Care Area Assessment (CAA) Summary and Section Z: Assessment Administration to indicate the MDS was complete and care planning decisions were made.</p> <p>Resident 318's Admission MDS Section V triggered the following care areas for further assessment: Functional Abilities, Urinary Incontinence, Nutritional Status, Pressure Ulcer, and Pain. The identified CAAs were incomplete and unsigned on 4/23/25 (17 days after admission).</p> <p>On 4/28/25 at approximately 1:35PM, Staff 2 (Regional Clinical Support) confirmed the facility had overdue admission assessments for residents, including Resident 318.</p> <p>46053</p> <p>2. Resident 320 was admitted to the facility in 4/2025 with diagnoses including stroke and Type 2 Diabetes (a chronic condition characterized by high blood sugar levels).</p> <p>A review of resident 320's health record revealed her/his Admission MDS assessment was in progress and overdue by five days on 4/28/25.</p> <p>On 4/28/25 at 1:31 PM Staff 33 (Assistant Regional Director of Clinical Services) acknowledged Resident 320's Admission MDS was not completed within her/his first 14 days in the facility. Staff 33 stated an accurate MDS assessment was necessary to initiate a person-centered care plan for Resident 320.</p> <p>52549</p> <p>3. Resident 468 admitted to the facility in 4/5/2025 with diagnoses including type 2 diabetes mellitus and below the knee amputation.</p> <p>On 4/23/2025 (18 days after admission) a record review of Resident 468's Admission MDS dated [DATE] indicated the MDS was incomplete. The MDS did not include provider signatures in Section V: Care Area Assessment (CAA) Summary and Section Z: Assessment Administration to indicate the MDS was complete and care planning decisions were made.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 468's Admission MDS Section V triggered the following care areas for further assessment: change in cognitive status, mood decline, nutritional status, pressure ulcers, mental errors, physical limitations, depression, contractures, and pain. The identified CAAs were incomplete and unsigned when reviewed on 4/23/2025 (18 days after admission).</p> <p>On 4/28/2025 at approximately 1:35 PM, Staff 2 confirmed the facility had overdue admission assessments for residents, including Resident 468.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure the MDS was coded accurately related to dental and hearing for 2 of 2 sampled residents (#s 3 and 16) reviewed for dental and communication. This placed residents at risk for inaccurate assessments. Findings include:</p> <p>The facility's 11/2019 Certifying Accuracy of the Resident Assessment Policy revealed any information captured on the MDS reflected the status of the resident during the observation period for that assessment.</p> <p>1. Resident 3 was admitted to the facility in 2/2012 with diagnoses including traumatic brain injury.</p> <p>A 6/3/24 Dental Treatment Record indicated Resident 3 was fully edentulous (lacking teeth).</p> <p>Resident 3's 12/24/24 Annual MDS revealed the resident was not edentulous.</p> <p>On 4/21/25 at 12:59 PM Resident 3 was observed in her/his room without any natural teeth.</p> <p>On 4/25/25 at 12:10 PM Staff 33 (Assistant Regional Director of Clinical Services) acknowledged Resident 3's Annual MDS was inaccurate and the resident should have been coded as edentulous.</p> <p>2. Resident 16 was admitted to the facility in 3/2025 with diagnoses including heart failure.</p> <p>Resident 16's 3/23/25 Nursing Admission Evaluation revealed the resident's hearing was poor in both ears.</p> <p>Resident 16's 3/30/25 Admission MDS indicated the resident was cognitively intact and her/his hearing was adequate.</p> <p>On 4/21/25 at 2:50 PM Resident 16 was observed in her/his room in her/his wheelchair. Resident 16 was only able to hear questions when asked at close range, with an elevated volume and a face-to-face approach. Resident 16 stated she/he can't hear anything and was in need of hearing aids.</p> <p>On 4/28/25 at 11:19 AM Staff 34 (CNA) and at 11:21 AM Staff 25 (CNA) stated staff needed to speak at a loud volume and close to the resident in order for her/him to hear.</p> <p>On 4/28/25 at 11:45 AM Staff 2 (Regional Clinical Support) acknowledged Resident 16's Admission MDS was inaccurate and the resident should have been coded as hearing impaired.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458</p> <p>Based on interview and record review it was determined the facility failed to ensure dependent residents received showers for 1 of 6 sampled residents (#28) reviewed for ADLs. This placed residents at risk for a lack of personal hygiene and loss of dignity. Findings include:</p> <p>Resident 28 was admitted to the facility on [DATE] with diagnoses including dementia.</p> <p>Resident 28's 2/23/25 Bowel and Bladder Care Plan indicated the resident had a catheter due to urine retention and was incontinent of bowel.</p> <p>Resident 28's 2/23/25 Kardex (a quick reference for CNAs to access a resident's care information) indicated the resident received bathing/showering on Monday and Thursday, day shift or per preference.</p> <p>Resident 28's 3/1/25 Admission MDS indicated the resident had intact cognition and was dependent with bathing/showering.</p> <p>Resident 28's 3/20/25 and 4/1/25 through 4/23/25 bathing task logs indicated the resident received bathing/showering on the following days:</p> <p>- 3/6, 3/20, 3/27, 3/31, 4/3, 4/10 and 4/23.</p> <p>A review of Resident 28's Progress Notes from 3/1/25 through 4/23/25 revealed no evidence the resident was provided with additional showering opportunities if showering was refused, or the resident's shower was not provided.</p> <p>On 4/21/25 at 11:33 AM, Resident 28 stated she/he was admitted to the facility in 2/2025 and was not showered until sometime in March. Resident 28 reported she/he was not showered frequently enough and she/he liked to receive showers at least twice a week.</p> <p>On 4/24/25 at 12:53 PM, Staff 35 (NA) stated Resident 28 was dependent on staff for showering, enjoyed taking long showers, and did not refuse showering.</p> <p>On 4/24/25 at 1:14 PM, Staff 30 (CNA) stated Resident 28 should receive showers twice a week and the resident did not refuse showering.</p> <p>On 4/25/25 at 11:29 AM, Staff 36 (CNA) stated if a resident missed a shower, it should be made up the next day unless the resident did not want it. Staff 36 stated if a resident refused a shower, a bed bath should be offered and if the resident refused a bed bath, the nurse would be notified.</p> <p>On 4/25/25 at 1:13 PM, Staff 37 (RN) stated if a resident refused bathing/showering the CNA notified the nurse and the nurse approached the resident. If the resident continued to refuse, the nurse documented the refusal and the resident was offered a shower the next day. Staff 37 reported if a resident's shower was missed, it should be made up later in the day or the next day.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 1:32 PM, Staff 2 (Regional Clinical Support) confirmed Resident 28 did not receive showers as scheduled. Staff 2 stated she expected Resident 28 to receive a minimum of two showers a week and showers refused or missed should be documented in the resident's progress notes.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458</p> <p>Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activity program for 2 of 3 sampled residents (#s 28 and 118) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include:</p> <p>The facility's Activity Programs policy, revised 6/2018, indicated the following:</p> <ul style="list-style-type: none"> -The activities program was provided to support the well-being of residents and to encourage both independence and community interaction. -Activities were based on the comprehensive resident-centered assessment and the preferences of each resident. -All activities were documented in the resident's medical record. -Individualized and group activities were provided that reflected the schedules, choices and rights of the residents. <p>1. Resident 28 was admitted to the facility in 2/2025 with diagnoses including dementia.</p> <p>Resident 28's 3/1/25 Admission MDS indicated the resident was cognitively intact. Resident 28 liked to participate in religious services/practices, go outside for fresh air during good weather, do her/his favorite activities, listen to music and have books/newspapers/magazines to read.</p> <p>A 3/6/25 Activity Assessment indicated Resident 28's important activities included having books/newspapers/magazines, listening to music, being around animals such as pets, keeping up with the news, doing favorite activities, going outside when the weather was good and participating in religious services or practices.</p> <p>Resident 28's Psychosocial-Well being Care plan, last revised 3/6/25, indicated the resident was at risk for psychosocial-well being concerns related to dementia and other behavioral conditions. Resident 28's Activities-Customary Routine Care plan included keeping up with the news, listening to music, participating in favorite activities, reading books/newspapers or magazines and spending time outdoors. Resident 28 was to be provided with activity materials like books, magazines, newspapers, TV, radio and arts and crafts in accordance with the resident's interests.</p> <p>The facility's Activity Calendar revealed the following scheduled activities:</p> <ul style="list-style-type: none"> -4/21/25 10:00 AM: [NAME] plays piano 1:30 PM: Bingo <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-4/22/25</p> <p>10:00 AM: Art and reminisce</p> <p>1:30 PM: Craft</p> <p>-4/23/25</p> <p>10:00 AM: Collages</p> <p>11:00 AM: Bible stories</p> <p>1:30 PM: Bingo</p> <p>-4/24/25</p> <p>10:00 AM: Spring sensory</p> <p>2:00 PM: Banana splits</p> <p>-4/25/25</p> <p>10:00 AM: Fun Friday</p> <p>1:30 PM: Bingo</p> <p>Resident 28's Activity Participation Logs for 4/1/25 through 4/24/24 indicated the resident had coffee/treats on 4/1/25 and 4/10/25 and a hair cut on 4/8/25. On 4/19/25, Resident 28 participated in an unknown group activity.</p> <p>Random observations of Resident 28 conducted from 4/21/25 through 4/24/25 between the hours of 8:26 AM and 2:27 PM, revealed Resident 28 was often in her/his room, either in bed or her/his wheelchair, frequently yelling, help. Resident 28 was not observed out of her/his room and was not observed in any group or one-to-one activities. No books, newspapers or magazines were available in the resident's room. There was no music or TV playing. The resident was not observed outside despite the sunny, warm weather. Resident 28 often scrolled on her/his phone without focus.</p> <p>On 4/23/25 at 1:28 PM, Resident 28 stated she/he did not like to lie around and did not like bingo or TV. Resident 28 stated she/he enjoyed going outside, going to the gym, riding stationary bikes and music. Resident 28 was talkative and appeared to enjoy visiting with others.</p> <p>On 4/24/25 at 12:53 AM, Staff 35 (NA) reported Resident 28 got up in her/his wheelchair and kind of read the menu. Staff 35 stated Resident 28 went to bingo last week but she/he did not like bingo. Staff 35 stated Resident 28 did not like to watch TV and he had never seen any books, newspapers or magazines in the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/25 at 1:06 PM, Staff 12 (CNA) stated Resident 28 liked attention or was lonely so if she/he was left in her/his room, alone, the resident would scream and yell. Staff 28 stated the resident went to the gym with therapy, otherwise, she did not see the resident in activities. Staff 12 stated Resident 28 used to play games on her/his phone but was no longer able to. Staff 12 stated Resident 28 was not seen in any activities in or out of her/his room. Staff 12 stated there were no books or magazines in the resident's room and she/he no longer received a newspaper since she/he changed rooms [4/19/25].</p> <p>On 4/25/25 at 11:48 AM, Staff 7 (Activities Director) stated it was her responsibility to complete the activities section on the MDS, complete an Activity Assessment, develop the residents' activity care plans and document all activities in the resident's electronic health records. Staff 12 stated Resident 28 did not like bingo but watched TV. Staff 12 stated she did not know too much about Resident 28 but the facility was supposed to have music channels though she had not taken the time to learn how the music channels worked. Staff 12 stated she had radios/CD players but not enough for the residents. On 4/25/25 at 12:14 PM, Staff 7 observed Resident 28's room and confirmed there were no books or newspapers in the the resident's room and Staff 7 found one magazine buried under multiple items in the resident's night stand, top drawer. Staff 12 stated there was no radio/CD player assigned to Resident 28.</p> <p>On 4/28/25 at 12:39 PM, Staff 1 (Administrator) stated the facility was expected to provide activities that met the residents' preferences and if the resident stayed in their room, activities should be provided to keep them entertained.</p> <p>51846</p> <p>2. Resident 118 was admitted to the facility in 4/2025 with diagnoses including necrotizing fasciitis (a serious bacterial infection that can cause rapid tissue damage).</p> <p>Resident 118's Activity Assessment revealed it was very important to listen to music she/he liked, keeping up with the news and to have materials to read.</p> <p>Resident 118's 4/18/25 Care Plan indicated for Resident 118 to be provided with materials such as books, magazines, newspapers, TV and radio in accordance with her/his interests.</p> <p>On 4/21/25 at 12:25 PM, Resident 118 expressed not knowing what activities were available and that it would be fun to listen to music, a podcast, or a book on tape. There were no activities observed in Resident 118's room.</p> <p>On 4/23/25 at 2:50 PM, after staff left Resident 118's room, there was no music or TV on.</p> <p>On 4/24/25 at 8:52AM, Resident 118 was sitting up while staff assisted her/him to eat. There was no music or TV on.</p> <p>On 4/24/25 At 12:04 PM, Resident 118 was observed in bed with no music or TV on.</p> <p>On 4/28/25 at 12:54 PM, Resident 118 stated she/he did not know how to use the TV and staff did not offer to turn it on.</p> <p>(continued on next page)</p>		

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

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/28/25 at 2:05 PM, Staff 25 (CNA) stated Resident 118 was invited to group activities, but she/he often declined. Staff 25 (CNA) stated she had not asked Resident 118 what she/he liked to do, but the information could be found on the Kardex. Staff 25 stated Resident 118 did not ask staff to turn on music or TV and Staff 25 had not suggested or offered to do it for her/him.</p> <p>On 4/25/25 at 11:50 AM, Staff 7 (Activities Director) acknowledged Resident 118 mainly stayed in her/his room and could not remember what Resident 118's preferences were. Staff 7 stated she had not taken the time to navigate music channels on the TV and she needed to procure more CD players or radios. Staff 7 stated she had not gotten anything for Resident 118.</p> <p>On 4/28/25 at 2:25 PM, Staff 1 (Administrator) expected CNAs to help Resident 118 with preferred activities. This included offering to help residents turn on music and TVs and not waiting for residents to request the service.</p>

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<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>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to obtain an ordered Ankle Foot Orthosis (AFO, a brace worn on the lower leg to provide support and control to the ankle and foot), identify and assess a skin condition or follow physician orders for parameters for a cardiac medication for 3 of 9 sampled residents (#s 3, 13 and 18) reviewed for position and mobility, skin conditions and unnecessary medications. This placed residents at risk for injury, worsening skin conditions and adverse side effects related to uncontrolled hypertension. Findings include:</p> <p>1. Resident 3 was admitted to the facility in 2/2012 with diagnoses including hemiplegia (a condition characterized by paralysis on one side of the body).</p> <p>A 12/12/24 Progress Note revealed Resident 3 was not appropriate for a prefabricated AFO due to her/his left hemiplegia and required a custom orthosis instead.</p> <p>Resident 3's 12/24/24 Annual MDS revealed the resident was severely cognitively impaired and experienced lower extremity impairment on one side.</p> <p>Resident 3's 1/24/25 PT Evaluation revealed an AFO would help to stabilize the left ankle joint and enhance the resident's ability to perform ADLs.</p> <p>A 3/7/25 Progress Note written by Staff 38 (NP) revealed the resident required the support from a custom AFO due to the need for foot and ankle support in more than one plane.</p> <p>No evidence was found in Resident 3's clinical record to indicate the facility obtained a custom orthosis for her/him since 12/2024.</p> <p>On 4/21/25 at 11:36 AM Witness 1 (Family Member) stated Resident 3 was supposed to wear an AFO with transfers. Witness 1 stated it had been forever since the AFO was ordered and it had still not been received.</p> <p>On 4/24/25 at 11:32 AM Resident 3 was observed in her/his room in bed. The resident indicated she/he was supposed to wear a brace on her/his left leg but could not recall the last time she/he wore it.</p> <p>On 4/24/25 at 1:16 PM Staff 41 (LPN) stated Resident 3 was supposed to use a left leg brace during transfers to help with stabilization. Staff 41 stated he could not recall the last time he saw the resident's leg brace.</p> <p>On 4/24/25 at 1:45 PM Staff 42 (Director of Rehab) stated Resident 3 was evaluated on 1/24/25 by PT when it was determined she/he was appropriate for an AFO. Staff 42 stated nothing had been done to obtain an AFO for Resident 3 since this time.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 12:10 PM Staff 2 (Regional Clinical Support) and Staff 33 (Assistant Regional Director of Clinical Services) acknowledged the lack of follow up regarding Resident 3's AFO. Staff 2 stated staff should have contacted the company responsible for creating the resident's AFO in 12/2024 once it was determined a custom orthosis was needed and followed up again in 1/2025 following the resident's PT evaluation.</p> <p>2. The facility's 9/2024 Skin at Risk/Skin Breakdown Policy and Procedure directed the following:</p> <ul style="list-style-type: none"> -Upon admission, skin at risk and any actual skin impairment was to be identified on the comprehensive care plan with interventions based on risk level identified. -A full body skin evaluation was to be completed weekly by the licensed nurse. -Upon discovery of a newly identified skin impairment, the licensed nurse was to document the skin impairment, notify the physician and obtain a treatment order if needed. <p>Resident 18 was admitted to the facility in 3/2025 with diagnoses including spastic hemiplegia (a form of spastic cerebral palsy where one side of the body experiences muscle spasticity and weakness).</p> <p>Resident 18's 4/2/25 Admission MDS indicated the resident was cognitively intact and did not have any skin issues.</p> <p>A review of Resident 18's 3/2025 and 4/2025 TAR revealed the resident's skin was evaluated twice weekly and no new skin impairments had been identified since her/his admission to the facility.</p> <p>On 4/23/25 at 3:21 PM Resident 18 was observed in her/his room in bed. Red blotches and bumps were observed scattered across both of the resident's cheeks. Resident 18 stated the blotches and bumps on her/his cheeks were present prior to her/his admission to the facility, they caused her/him irritation and she/he used a disposable wipe to clean her/his face daily. Resident 18 stated she/he could get stuff out of the bumps on occasion and the bumps felt like infected nerves. Resident 18 stated a nurse told her/him shortly after her/his admission to the facility she/he needed a cream for the blotches and bumps but the nurse never came back. Resident 18 stated she/he wanted the facility to assess and treat her/his skin condition.</p> <p>On 4/28/25 at 9:24 AM Staff 25 (CNA) stated nurses completed a skin evaluation upon a resident's admission to the facility and CNAs were to report any new skin issues to the nurse, including open wounds, bruises, redness, scratches, bumps, rashes and boils. Staff 25 stated she did not think Resident 18 admitted to the facility with the blotches and bumps on her/his cheeks, did not report the skin issue to the nurse and did not know if the resident's skin was being treated.</p> <p>On 4/28/25 at 9:30 AM Staff 27 (LPN) stated nurses completed resident skin assessments when notified of a new resident skin condition or if the nurse observed a new skin impairment. Staff 27 stated skin assessments were completed for any skin impairment, including redness, bruises and marks. Staff 27 stated the nurse completed a progress note and notified the resident's provider once the assessment was completed. Staff 27 stated he had not noticed the blotches or bumps and they had not been reported to him.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/28/25 at 10:00 AM Staff 2 (Regional Clinical Support) stated nurses were to complete a skin evaluation for any resident skin impairment and notify the provider. Staff 2 confirmed neither had been completed for the blotches and bumps on Resident 18's face.</p> <p>47001</p> <p>3. Resident 13 was admitted to the facility in 10/2024 with diagnoses including hypertension (high blood pressure).</p> <p>A review of Physician Orders revealed an 10/26/24 order for hydralazine (a medication used to lower blood pressure) as need every six hours for a blood pressure greater than 160.</p> <p>A review of Resident 13's blood pressures revealed the following:</p> <p>-4/4/25 blood pressure of 172/90</p> <p>-4/7/25 blood pressure of 164/78</p> <p>-4/17/25 blood pressure of 161/70</p> <p>-4/18/25 blood pressure of 164/72</p> <p>-4/19/25 blood pressure of 164/72</p> <p>A review of Resident 13's MAR revealed no evidence she/he received hydralazine for blood pressures greater than 160.</p> <p>On 4/28/25 at 10:21 AM Staff 2 (Regional Clinical Support) stated Resident 13 should have received hydralazine when her/his blood pressure was greater than 160.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053</p> <p>Based on observation, interview, and record review it was determined the facility failed to keep residents free from hazards, provide appropriate monitoring and supervision for residents with known substance use disorder and a history of illicit drug use, ensure staff possessed adequate knowledge and training regarding substance use, and follow up on recommendations from a fall investigation for 2 of 8 sampled residents (#s 3 and 217) reviewed for accidents and positioning/mobility. This failure was determined to be an immediate jeopardy situation which resulted in a serious adverse outcome for Resident 217, and placed residents at risk for injury, drug overdose, and death. Findings include:</p> <p>The facility's February 2023 policy titled Resident Possession and Use of Illegal Substances indicated the following:</p> <ul style="list-style-type: none"> -The possession and use of illegal substances by residents will not be tolerated; and -Facility staff will have knowledge of signs, symptoms, and triggers of possible illegal substance use. <p>1. Resident 217 was admitted to the facility in ,d+[DATE] with diagnoses including encounter for surgical aftercare following surgery on the nervous system and lower back pain.</p> <p>A review of Resident 217's [DATE] Nursing Admission/Readmission Evaluation/Assessment revealed she/he was alert and oriented and had a history of polysubstance use but denied current use.</p> <p>No evidence was found in Resident 217's care plan to indicate her/his history of polysubstance use.</p> <p>A progress note dated [DATE] at 7:57 PM indicated Resident 217 was found unresponsive in the facility's parking lot. Facility staff administered an intramuscular dose of Narcan (a medication used to reverse the effects of an opioid overdose) to Resident 217 to reverse the effects of a suspected opioid overdose, called 911 and sent her/him to the hospital emergency department. Resident 217's physician was notified of this incident and placed Resident 217's order for Oxycodone on hold pending a face to face meeting with Resident 217 on [DATE].</p> <p>A review of Resident 217's [DATE] post visit hospital summary revealed she/he was seen in the emergency department for approximately two hours where she/he was monitored following an opioid overdose in the parking lot of the facility.</p> <p>A review of Resident 217's electronic health record revealed she/he returned to the facility on [DATE] at 11:44 PM. No evidence was found to indicate the facility initiated monitoring for opioid use after she/he returned from the hospital.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Social Services progress note written by Staff 16 (Social Services Director) dated [DATE] at 10:28 AM indicated Resident 217 was clearly upset and agitated about her/his medication being changed due to her/his opioid use. Resident 217 stated she/he may have to self-medicate and may blow out of here.</p> <p>A review of the facility reported incident investigation completed on [DATE] revealed Resident 217 was not in the facility during rounds on [DATE] at 4:30 AM and staff attempted to reach her/him by calling her/his cell phone. Resident 217 was found unresponsive on the floor of her/his bathroom on [DATE] at 6:30 AM.</p> <p>On [DATE] at 11:30 AM Staff 27 (LPN) stated Resident 217 left the facility with her/his friends almost daily. Staff 27 stated there were times when Resident 217 was barely rousable and the facility did not have a procedure to assess residents after being out of the facility. Staff 27 stated he attempted to resuscitate Resident 217 during the incident on [DATE] but was unsuccessful and Resident 217 was pronounced dead. Staff 27 stated he found drug paraphernalia including a lighter, burnt aluminum foil, a metal straw with a rubber tip and a powdery substance on the floor with Resident 217. Staff 27 further indicated he did not receive training related to SUD (substance use disorder).</p> <p>On [DATE] at 12:00 PM, Staff 10 (CNA) stated she was not aware of Resident 217's drug use and staff had not been asked to keep an eye on [her/him]. Staff 10 stated she did not receive any training regarding Resident 217's drug use.</p> <p>On [DATE] at 12:08 PM, and at 1:33 PM Staff 9 (CMA) stated she was unaware of any residents with polysubstance abuse or SUD. Staff 9 stated after the incident where Resident 217 overdosed in the facility parking lot, her/his oxy was discontinued. Staff 9 stated Resident 217 changed drastically after this and she/he began to refuse other medications. Staff 9 stated staff were not asked to monitor Resident 217 or do extra rounds or anything. Staff 9 stated on [DATE], Resident 217 was found deceased in her/his bathroom. Once the police left, the housekeeper was asked to clean the room and found drug paraphernalia hidden in Resident 217's bathroom. Staff 9 further stated she was not provided any education on identifying signs and symptoms related to the suspicion of drug use.</p> <p>On [DATE] at 12:09 PM Staff 20 (CMA) stated he was made aware of Resident 217's SUD on [DATE] by the emergency medical technicians who responded to incident. Staff 20 stated prior to the incident, he did not receive any training on how to identify signs and symptoms related to the suspicion of drug use or how and when to monitor a resident with a diagnosis of SUD if they spent time away from the facility.</p> <p>On [DATE] at 12:33 PM, Staff 8 (Housekeeper) stated he was tasked to clean Resident 217's room after she/he died but did not know about SUD precautions. Staff 8 stated he found a lighter, a piece of aluminum foil and bag of white powder in Resident 217's bathroom, which he picked up using a paper towel, placed in a plastic bag and handed to Staff 27.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:05 PM Staff 16 (Social Services Director) acknowledged Resident 217 was sent to the hospital emergency department following an opioid overdose in the facility's parking lot and she/he was upset that her/his Oxycodone was being held as a result. Staff 16 acknowledged Resident 217 talked about self-medicating and may blow out of here as she indicated in the [DATE] progress note. Staff 16 stated staff were uneducated related to interventions and monitoring for SUD residents. Staff 16 stated she participated in a Substance Use/Abuse Training on [DATE]. Staff 16 further stated she was instructed to provide training which included signs and symptoms of SUD and possible signs of an overdose to the licensed nursing staff only but did not include CNAs or any other staff.</p> <p>On [DATE] at 3:06 PM Staff 1 (Administrator) acknowledged Resident 217 passed away from the incident which occurred on [DATE]. Staff 1 stated it was a group decision to educate the nurses rather than the CNAs because the nurses would be doing the assessments.</p> <p>2. On [DATE] at 9:31 AM Staff 16 provided additional information to the survey team which revealed an additional five residents (#s 18, 37, 61, 119 and 417) who resided in the building that had SUD who did not have baseline care plans to address their history of SUD and potential relapse and reuse.</p> <p>On [DATE] at 11:26 AM, Staff 14 (CNA) stated the facility trained staff on different tasks, but could not recall a specific training for SUD. She stated there were monthly in-service meetings, but had not yet had one regarding SUD.</p> <p>On [DATE] at 11:30 AM Staff 15 (LPN) stated she was not aware of Resident 217 having issues with drug use. She stated she received training online, but could not recall if there was a training regarding signs and symptoms of drug use and monitoring for drug use. She stated she had not received education on how to provide information to residents related to the risk of drug use.</p> <p>On [DATE] at 11:30 AM, Staff 13 (CNA) reported she was aware Resident 217's overdose in her/his bathroom and passed away however the only training she recalled was a sign posted in the breakroom to be aware of different things.</p> <p>On [DATE] at 11:47 AM, Staff 11 (CNA) reported she was aware Resident 217's overdose in her/his bathroom and passed away but was unaware the resident used drugs before that day. Staff 11 stated the facility did not provide any trainings related to SUD after the incident related to Resident 217.</p> <p>On [DATE] at 12:28 PM, Staff 31 (Agency CNA) and at 1:36 PM Staff 32 (CNA) stated they did not receive any training regarding SUD or monitoring for signs and symptoms of SUD.</p> <p>On [DATE] at 1:38 PM Staff 12 (CNA) stated she had not received any information recently about monitoring for suspicious behavior or drug related materials for residents with SUD.</p> <p>On [DATE] at 1:50 PM Staff 51 (CNA) stated she was not aware any residents used recreational drugs prior to [DATE] when staff provided training.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:05 PM Staff 16 (Social Services Director) stated staff were uneducated related to interventions and monitoring for SUD residents. Staff 16 stated she participated in a Substance Use/Abuse Training on [DATE]. Staff 16 further stated she was instructed to provide training which included signs and symptoms of SUD and possible signs of an overdose to the licensed nursing staff only but did not include CNAs or any other staff.</p> <p>On [DATE] at 3:06 PM Staff 1 (Administrator) stated it was a group decision to educate the nurses rather than the CNAs because the nurses would be doing the assessments. Staff 1 acknowledged no other staff disciplines were provided education regarding residents with SUD.</p> <p>On [DATE] at 4:18 PM Staff 1 (Administrator) and Staff 50 (Regional [NAME] President) were informed of the failure to identify the need to initiate interventions related to SUD and to educate direct staff on how to identify and safely care for residents with SUD. The failure constituted a situation of immediate jeopardy to the health and welfare of residents. A plan of correction was requested to immediately ensure residents with SUD were identified, their care plans were revised to include interventions and monitoring related to SUD and staff were educated on how to identify and treat residents with SUD.</p> <p>On [DATE] at 7:42 PM an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> -All residents' records would be reviewed to identify other residents with history of or active substance use disorder. -Residents identified with active, suspected or history of substance use will be identified and listed in a binder found at the nursing stations. The residents name plates outside their room will have a sticker placed to alert staff of potential hazards associated with active substance use disorder. -Residents identified with history of, or active substance use disorder will be offered substance use treatment services. -Residents identified with history of, or active substance use disorder will be assessed upon return from independent offsite outing for suspected substance use. -Residents who are assessed upon return from independent offsite outing or identified as active substance use will have an incident report generated and law enforcement notification if required. -Staff, including temporary or agency staff, will be educated to location of binder with residents identified with suspected or history of substance use disorder. -Staff, including temporary or agency staff, will be in-serviced to substance use disorder and signs of abuse related to drug use, what to do if suspected active use, and reporting suspected drug paraphernalia, as well as facility policy on resident possession and use of illegal substances. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Residents that are identified with drug paraphernalia or signs/symptoms of active drug use will be placed on alert monitoring, MD notification, POC task will be placed to alert CNA for increased monitoring for drug paraphernalia, law enforcement notification if required. In addition an incident report will be generated and resident assessment completed.</p> <p>On [DATE] at 10:51 AM it was determined the immediacy was removed after verification of completion of the IJ removal plan.</p> <p>47000</p> <p>3. Resident 3 was admitted to the facility in ,d+[DATE] with diagnoses including hemiplegia (a condition characterized by paralysis on one side of the body).</p> <p>Resident 3's [DATE] Care Plan revealed the following:</p> <p>-The resident required extensive assistance from two or more people to transfer into a car.</p> <p>-The resident was cleared to go out of the facility with Witness 1 (Family Member), and she had received car transfer training.</p> <p>Resident 3's [DATE] Annual MDS revealed the resident was severely cognitively impaired and experienced upper and lower extremity impairment on one side.</p> <p>A [DATE] Witnessed Fall Investigation revealed the following:</p> <p>-Resident 3 was lowered to the ground during an attempted transfer to the car with Witness 1.</p> <p>-The resident did not sustain any injuries.</p> <p>-A PT referral was placed for transfer training.</p> <p>A [DATE] PT Discharge Summary indicated Resident 3 was not tested for car transfers.</p> <p>On [DATE] at 11:36 AM Witness 1 stated she took Resident 3 out of the facility for an outing on [DATE]. Witness 1 stated it was getting harder and harder to transfer the resident and she could not recall the last time she received any training or education on how to safely transfer the resident into her car.</p> <p>On [DATE] at 11:32 AM Resident 3 was observed in her/his room in bed. Resident 3 stated she/he loved activities, including going outside and visits with Witness 1.</p> <p>On [DATE] at 11:55 AM Staff 30 (CNA) stated Resident 3 went out of the facility every Saturday with Witness 1. Staff 30 stated the resident went out most recently on [DATE] with Witness 1, and Witness 1 transferred the resident into the car independently.</p> <p>(continued on next page)</p>		

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

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:45 PM Staff 42 (Director of Rehab) stated Resident 3 received PT following her/his fall in , d+[DATE] but the resident and Witness 1 did not receive any education or training regarding car transfers. Staff 42 further stated he was unaware the resident continued to go out of the facility with Witness 1 following her/his fall in ,d+[DATE].</p> <p>On [DATE] at 12:12 PM Staff 2 (Regional Clinical Support) stated Witness 1 should have received car transfer training following Resident 3's fall on [DATE] and did not.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure dialysis services were in place including monitoring and communication with the dialysis provider for 1 of 1 sampled resident (#28) reviewed for dialysis. This placed residents at risk for dialysis complications and delayed treatment. Findings include:</p> <p>The facility's Hemodialysis (a medical treatment that removes waste products from the blood when the kidneys are not working properly) Care Policy and Procedure, dated 9/1/24 indicated the following:</p> <ul style="list-style-type: none"> -The licensed nurse completed the dialysis center communication information prior to the resident leaving for dialysis. -Upon the resident's return, the post-dialysis assessment portion of the form was to be completed and attached to the resident's medical record. -Residents who required hemodialysis were provided ongoing assessment and monitoring before and after dialysis treatments including monitoring for complications, issues were documented by the licensed nurse and the medical providers were notified. <p>Resident 6 was admitted to the facility in 2/2025 with diagnoses including diabetes, end-stage renal disease and dementia.</p> <p>Resident 6's 2/28/25 Hemodialysis Care Plan indicated the resident received dialysis on Monday, Wednesday and Friday.</p> <p>Resident 6's 3/6/25 Admission MDS indicated the resident had severe cognitive impairment.</p> <p>From 4/1/25 through 4/22/25, Resident 6 received nine dialysis treatments.</p> <p>A review of Resident 6's Hemodialysis Communication Observation/Assessment forms from 4/1/25 through 4/22/25 revealed the following days when the facility did not have pre-dialysis, post-dialysis or dialysis center communication:</p> <ul style="list-style-type: none"> -4/2: no pre-dialysis or dialysis center communication was completed; -4/4: no hemodialysis communication form was completed; -4/7: no pre-dialysis communication form was completed; -4/9: no hemodialysis communication form was completed; -4/11: no pre-dialysis or post-dialysis communication form was completed; -4/14: no hemodialysis communication form was completed; <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-4/18: no hemodialysis communication form was completed;</p> <p>-4/21: no hemodialysis communication form was completed.</p> <p>A review of Resident 6's health record revealed no evidence nursing staff contacted the dialysis center to obtain a verbal or electronic report on 4/2/25, 4/4/25, 4/9/25, 4/14/25, 4/18/25 or 4/21/25.</p> <p>On 4/23/25 at 1:25 PM, Resident 6 was out of the facility for dialysis and at 4:03 PM, she/he was observed returning to the facility from her/his appointment.</p> <p>On 4/22/24 at 8:35 AM, Witness 2 (Private Caregiver) stated Resident 6 went to dialysis on Monday, Wednesday and Friday and she accompanied the resident to her/his appointment. Witness 2 stated when Resident 6 returned from dialysis, usually the CNA obtained the resident's vitals but the licensed nurse did not complete an assessment upon the resident's return.</p> <p>On 4/24/25 at 9:49 AM, Staff 40 (LPN) stated licensed nurses were supposed to complete the pre-dialysis and post-dialysis communication form and place the completed form in the resident care manager's box. Staff 40 stated the dialysis center should complete the middle section of the Hemodialysis Communication Observation/Assessment form and if the dialysis center did not complete their section, the facility nurse was to call the dialysis center. Staff 40 reported, upon the resident's return from dialysis, a licensed nurse should assess the resident within 30 to 60 minutes. Staff 40 stated sometimes the nursing staff got busy and it was hard to keep up with everything.</p> <p>On 4/24/25 at 10:00 AM, Staff 4 (LPN-Care Manager) reviewed Resident 6's Hemodialysis Communication Observation/Assessment forms and stated it was important the nursing staff completed the top portion of the form, which was sent with the resident to dialysis, because the dialysis center did not have access to the facility's electronic health record system. Staff 4 stated upon the resident's return, the dialysis center should have completed the mid-portion of the form, the nurse was to assess the resident and then complete the last section of the form. Staff 4 confirmed the facility did not have pre-dialysis and post-dialysis information for Resident 6 on the identified dates and he expected communication between the facility and dialysis to be completed with each dialysis visit.</p> <p>On 4/25/25 at 1:38 PM, Staff 2 (Regional Clinical Support) stated she reviewed Resident 6's Hemodialysis Communication Observation/Assessment forms and confirmed there were missing and incomplete forms.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>51846</p> <p>Based on interview and record review it was determined the facility failed to ensure RN coverage for eight consecutive hours seven days per week for 4 of 33 days reviewed for staffing. This placed residents at risk for lack of care. Findings include:</p> <p>Review of the Direct Care Staff Daily Reports (DCSDR) on 7/20/24, 8/3/24, and from 3/21/25 through 4/21/25 revealed no RN coverage for eight consecutive hours for the following Saturdays: 7/20/24, 8/3/24, 3/22/25 and 4/12/25.</p> <p>On 4/24/25 at 1:14 PM, Staff 6 (Payroll/Human Resources) acknowledged the facility lacked RN coverage on 7/20/24 and 8/3/24. She stated it was very difficult to find RN coverage on weekends.</p> <p>On 4/24/25 at 1:26 PM, Staff 6 acknowledged the facility lacked RN coverage on the DCSDR for 3/22/25 and 4/12/25.</p> <p>On 4/28/25 at 2:25 PM Staff 1 (Administrator) was not aware that there was no RN coverage on the identified days.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>51846</p> <p>Based on observation, interview, and record review it was determined the facility failed to post accurate and complete staffing information for 14 of 34 days reviewed for staffing. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include:</p> <p>A review of the Direct Care Staff Daily Report from 3/21/25 through 4/24/25 revealed incorrect information listed on the following dates: 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, 4/17/25, 4/18/25, 4/20/25, 4/21/25 and 4/24/25.</p> <p>A review of the DCSDR on 4/10/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, 4/17/25, 4/18/25, 4/20/25 and 4/21/25 revealed Sitter entered with hours worked for staff count.</p> <p>On 4/24/25 at 8:41 AM, the DCSDR for 4/24/25 was prefilled with morning, evening, and night shift information. The morning shift was signed and had no entries for Nursing Assistants. At 9:02 AM, Staff 35 was observed wearing a badge with CNA under his name and confirmed he was not a CNA. Staff 35 stated he did not have a CNA license in Oregon or any other state. At 1:45 PM, the DCSDR for 4/24/25 continued to reflect no entries for Nursing Assistants on the morning shift.</p> <p>On 4/24/25 at 1:14 PM, Staff 6 (Payroll/Human Resources) stated Sitter was a CNA who was assigned to perform one-on-one duties to a resident and should have been added to the CNA count. Staff 6 acknowledged the general public would not understand the role of Sitter and the DCSDR did not correctly identify the number of CNAs and hours worked for the identified dates. Staff 6 also confirmed Staff 35 was not a CNA and should have been listed as a Nursing Assistant on the DCSDR for 4/24/25.</p> <p>On 4/28/25 at 12:07 PM, Staff 6 confirmed Staff 35 worked with residents on 4/8/25, 4/11/25, 4/12/25, 4/13/25 and 4/14/25 and should have been counted as a Nursing Assistant.</p> <p>On 4/28/25 at 2:25 PM, Staff 1 (Administrator) stated he was not aware of the DCSDR having incorrect information.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52549</p> <p>Based on interview and record review it was determined the facility failed to monitor for adverse side effects (ASE) of medications for 1 of 1 sampled resident (#468) reviewed for Anticoagulant medication. This placed residents at risk for medication complications. Findings include:</p> <p>Resident 468 was admitted to the facility on ,d+[DATE] with the diagnosis including Peripheral vascular disease.</p> <p>The April 2025 MAR identified Clopidogrel Bisulfate (anticoagulant medication) 75mg one tablet PO QD at bedtime for clot prevention. There was no evidence that adverse side effects were monitored.</p> <p>Side effects for the medication included according to the Mayo clinic website, Collection of blood under the skin, deep, dark purple bruise.</p> <p>On 4/21/25 at 1:34 PM the resident showed her/his arms which had multiple bruises covering both arms.</p> <p>On 4/21/25 at 1:34 PM Resident 468 stated she/he did not know where she/he got the bruises.</p> <p>In a 04/24/25 interview at 12:23 PM with Staff 36 (CNA) stated that skin checks were completed once a week, and no bruising had been noted. Staff 3 had noted a new skin tear on the left wrist.</p> <p>On 4/25/25 at 11:25 AM Staff 40 (LPN) stated there was no notation of bruising for Resident 468 and it should be in his/her chart. Staff 40 stated she was unable to find any orders for monitoring the resident while on anticoagulant medication. Staff 4 (LPN/care manager) stated he was unable to locate documentation for anticoagulant medication in Resident 468's chart.</p> <p>Staff 4 (LPN/care manager) looked at resident 468's skin at 1:30 pm on 4/25/25 and confirmed Resident 468 had bruising. Staff 4 did stated monitoring of side effects for anticoagulant medication should be conducted.</p> <p>On 4/28/25 at 12:34 PM Staff 2 (Regional clinical support)and Staff 3 (DNS) stated there was no monitoring in Resident 468's medical record for the use of anticoagulant medication. Staff 2 stated staff were expected to document each shift for adverse side effects of anticoagulant medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001</p> <p>Based on observation and interview it was determined the facility failed to ensure medications and biologicals were stored securely and not accessible to unauthorized individuals and failed to ensure medications were not expired for 2 of 7 medication carts and 1 of 1 medication storage room. This placed residents at risk for diminished treatment efficiency and unauthorized access to medications and biologicals. Findings include:</p> <p>1. On [DATE] at 8:31 AM a medication cart was observed to be unlocked in the hallway near room eight. Staff and residents were observed walking past the unlocked medication cart.</p> <p>On ,d+[DATE]//25 at 8:32 AM the medication cart was observed with Staff 20 (CMA) to have over the counter medications and prescription medications inside.</p> <p>On [DATE] at 4:45 AM a medication cart was observed to be unlocked in the hallway near room [ROOM NUMBER]. The medication cart was observed to have ceftriaxone (an antibiotic) inside.</p> <p>On [DATE] at 8:50 AM a medication cart was observed to be unlocked in the hallway near room [ROOM NUMBER].</p> <p>On [DATE] at 8:59 AM Staff 21 (Agency RN) returned to the unlocked medication cart. The medication cart was observed with Staff 21 to have insulin inside.</p> <p>On [DATE] at 9:42 AM a medication cart was observed to be unlocked in the hallway near room [ROOM NUMBER]. Staff 22 (RN) was observed sitting at the nurses station near room [ROOM NUMBER] within eyesight of the medication cart, and staff and residents were observed in the hallway.</p> <p>On [DATE] at 9:51 AM Staff 22 was observed leaving the nurses station, the medication cart was observed to be unlocked, and staff and residents were observed in the hallway.</p> <p>On [DATE] at 9:56 AM Staff 22 was observed returning to the nurses station. The medication cart was observed with Staff 22 to be unlocked with insulin, prescription medications, and over the counter medications inside.</p> <p>On [DATE] at 11:48 AM Staff 2 (Regional Clinical Support) stated her expectation was the medication carts must be locked when not in use.</p> <p>2. On [DATE] at 12:08 PM the medication storage room was observed with Staff 9 (CMA). The medication storage room was observed to have a bottle of Vitamin A which expired in ,d+[DATE], a bottle of Complete Women 50+ multi-vitamin with minerals which expired in ,d+[DATE], two bottles of L-Argine (an amino acid supplement) which expired in ,d+[DATE], and a vial of Tubersol (a testing solution for tuberculosis) which was opened and had no open date on it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 12:33 PM Staff 2 (Regional Clinical Support) acknowledged the above medications were expired. Staff 2 stated Tubersol was only good for 30 days after opening and she acknowledged the bottle of Tubersol did not have an open date on it.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52549</p> <p>F800</p> <p>Based on observation, and interview, it was determined the facility failed to meet dietary preferences for 1 of 3 Residents (#468) sampled residents reviewed for food preferences. This placed residents at risk for limited food choices and potential weight loss. Findings include:</p> <p>Resident 468 was admitted to the facility in 4/2025 with diagnoses including diabetes and below the knee amputation.</p> <p>Resident 468's most recent MDS dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact.</p> <p>In an 04/21/25 interview at 1:30 PM Resident 468 stated, she/he would like more food. Resident 468 stated he/she asked staff for bigger portions but did not receive them. Resident 468 stated she/he did not get enough food.</p> <p>On 4/ 24/25 at 12:14 PM Resident 468's meal tray was observed to have an order card for double portions and a hamburger on the side. Resident 468 received small portions and no hamburger.</p> <p>On 04/24/25 at 12:23 PM Staff 36 (CNA), stated there is not a good system in place to meet resident preferences and cultural preferences for food.</p> <p>On 4/25/25 at 10:30 AM in an interview Staff 43 (dinning manager) stated he had spoken to Resident 468 about her/his preference for more food and the resident did request double portions per her/his preference on 4/12/25.</p> <p>On 4/25/25 at 11:32 AM Staff stated 46 (dietary) stated Resident 468 requested double portions and a hamburger on the side, all the time but she/he was upgraded to double portions on 4/25/25.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46053</p> <p>Based on observation, interview and record review it was determined the facility failed ensure food was labeled and stored in a manner to avoid spoilage in 1 of 1 kitchen and 2 of 3 nurses stations reviewed for sanitary food storage. The facility also failed to ensure the ice machine was plumbed correctly to prevent backflow of contaminated matter into the ice machine for 1 of 1 kitchen reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include:</p> <p>The facility's undated Key Food Safety Practices policy indicated:</p> <ul style="list-style-type: none"> -All food must be labeled and dated when opened; and -Raw ingredients will be free from contamination. <p>1. On 4/21/25 at 9:22 AM the following items were observed in the unit refrigerator located behind Nurses Station One:</p> <ul style="list-style-type: none"> -Two unlabeled, undated covered plastic ramekins of peanut butter; -One unlabeled, undated covered plastic coffee mug containing a clear liquid and ice; -One previously opened, unlabeled and undated 32 fluid ounce container of Med Pass 2.0+ Vanilla Fortified Nutritional Shake. <p>On 4/21/25 at 9:22 AM Staff 27 (LPN) acknowledged the unlabeled and undated items and stated they need to be labeled with the date they were opened so the nursing staff would know when they were opened.</p> <p>On 4/21/25 at 9:35 AM the following items were observed in the unit refrigerator located behind Nurses Station Three:</p> <ul style="list-style-type: none"> -One opened, undated and partially used 32 fluid ounce Sysco butter pecan flavored Med Plus 2.0 nutritional shake; -One unlabeled 16 fluid ounce can of Monster Energy drink. <p>On 4/21/25 9:35 AM Staff 44 (LPN) acknowledged the undated shake and stated it should be thrown out because there was no way to know when it was opened. Staff 44 stated the Monster Energy drink belonged to an employee.</p> <p>On 4/28/25 at 2:16 PM Staff 1 (Administrator) stated he expected items in the nurses station refrigerators to be labeled with the date they were opened so staff will know when to discard them. Staff 1 also stated these refrigerators were not to be used by employees to store their personal items.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 4/28/25 11:32 AM the facility's ice machine was observed to drain through a white plastic pipe into the wall behind the machine. No air gap was observed under the machine or connected to the drain pipe. The drain pipe exited the wall on the facility's north side and drained directly into the garden adjacent to the smoking gazebo. Staff 43 (Dietary Manager) stated this was the facility's only ice machine and the ice was used for preparing residents' beverages.</p> <p>On 4/28/25 at 11:45 AM Staff 1 (Administrator) acknowledged the ice machine drained unabated through a hole in the wall. Staff 1 stated he expected the ice machine to produce clean ice for residents' use and the current drain system involved the risk of contamination from the outside.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>51846</p> <p>Based on interview and record review it was determined the facility failed to submit mandatory staffing information based on the payroll data journal and other verifiable and auditable data as required. This placed residents at risk for inaccurate staffing information. Findings include:</p> <ul style="list-style-type: none"> - The facility's Reporting Direct Care Staffing Information (Payroll-Based Journal) policy, dated 8/2022, indicated complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal system. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates included Fiscal Quarter 4 with a date range of 7/1 through 9/30 to be submitted by 11/14. <p>Review of the Payroll Based Journal Staffing Data for fiscal year 2024, quarter four (7/1/24 through 9/30/24), revealed the facility failed to submit required data for the quarter.</p> <p>On 4/28/25 at 12:07 PM, Staff 6 (Payroll/Human Resources) was unaware the data was not submitted and stated the corporate office was responsible for submitting the information.</p> <p>On 4/28/25 at 2:25PM, Staff 1 (Administrator) was unaware the data was not submitted.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Cascade Terrace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to train staff of the elements and goals of the facility QAPI program for 1 of 1 facility reviewed for QAPI training. This placed residents at risk for lack of safety and quality of care. Findings include:</p> <p>On 4/24/25 at 4:42 PM, Staff 6 (Payroll/Human Resources) provided a list of new hire and annual trainings offered by the facility. There was no QAPI training.</p> <p>On 4/25/25 between the hours of 8:15 AM and 8:36 AM, Staff 12 (CNA), Staff 35 (NA), Staff 41 (LPN) and Staff 42 (CNA) reported they were unaware of the facility's QAPI program and had not received any training related to QAPI.</p> <p>On 4/25/25 at 2:05 PM, Staff 1 reviewed the list of new hire and annual trainings provided by the facility and confirmed the facility did not offer QAPI training to staff. Staff 1 stated he expected the facility to provide staff required trainings.</p>