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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>385195 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY COMPLETED<br><br>12/19/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Beaverton Post Acute Care of Cascadia |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>11850 SW Allen Blvd.<br>Beaverton, OR 97005 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>Based on interview and record review it was determined that the facility failed to provide colostomy care according to professional standards for 1 of 2 sampled residents (# 8). This placed residents at risk for skin breakdown and infection. Findings include: Resident 8 admitted to the facility with diagnoses including renal failure. Resident 8's 8/27/25 Care Plan indicated the resident's colostomy bag was to be changed as needed per the resident's provider order. Resident 8's 9/22/25 Physician Orders indicated the resident used a colostomy bag. On 12/18/25 at 11:57 AM, Resident 8 stated she/he recalled not having a colostomy bag for about a day and stated staff covered up her/his stoma (a surgically created opening in the abdomen that allows bodily waste to be diverted out of the body) with a brief and other pads. Resident 8 stated she/he was irritated because she/he could not attend activities on that day. On 12/18/25 at 1:25 PM, Staff 16 (Activities Director) stated the vendor the facility had ordered colostomy bags from discontinued orders due to changes in Medicaid funding. Staff 16 stated supplies were ordered on the previous Thursday and expected the following Tuesday. Staff 16 stated Resident 8 was no longer going to be covered by Medicaid. On 12/18/25 at 2:30 PM, Staff 3 (RCM) stated the facility ordered supplies once a month for residents and acknowledged Resident 8 went without a colostomy bag for a while but could not recall how long. Staff 3 stated staff covered Resident 8's stoma with a brief. Staff 3 confirmed Resident 8's frustrations from the resident's inability to go to activities that day due to there being no colostomy bags. Staff 3 stated they express ordered colostomy bags for Resident 8 two days after the initial order did not arrive.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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