STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385195	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaverton Post Acute Care of Cascadia	11850 SW Allen Blvd. 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review it was determined the facility failed to follow the resident's plan of care to prevent a fall for 1 of 3 sampled residents (#3) reviewed for accidents. This placed residents at risk for falls with injury. Findings include:Resident 3 admitted to the facility in 6/2021 with diagnoses including a stroke and dementia.A 3/13/26 Quarterly MDS indicated Resident 3 had severe cognitive impairment.A 3/31/26 care plan indicated Resident 3 required 1 one-person participation for mobility while in a wheelchair and to use a tilt back wheelchair or stretcher for all transportation.A 5/11/26 post fall note revealed Resident 3 was at a dental appointment on 5/7/26 and slipped out of her/his wheelchair onto the ground. The resident was taken to the emergency room to be assessed and no injury was found.On 6/15/26 at 11:17 AM Witness 1 (Dental Provider) stated Resident 3 struggled to stay upright in her/his wheelchair during the appointment and eventually slid out of her/his wheelchair onto the floor. Witness 1 stated staff at the dental clinic were unable to assist the resident back into her/his chair safely so emergency was called.On 6/15/26 at 11:43 AM Staff 6 (CNA) stated when residents needed to be up for an appointment the nurse would inform staff of any information needed to ensure the resident was ready for transportation.On 6/15/26 at 1:06 PM Staff 5 (CNA) stated when residents went out for appointments, the care plan advised staff on what the resident needed for the appointment which included mobility devices. Staff 5 stated Resident 3 used a normal wheelchair and could not speak to the resident's additional needs for being transported to appointments.On 6/15/26 at 1:48 PM Staff 4 (RN) stated when residents went out for an appointment, she would tell staff to put the resident in a wheelchair based upon the resident's size. Staff 4 stated Resident 3 was transported to appointments via stretcher transport and was unable to provide additional information related to the resident's care.On 6/15/26 at 2:11 PM Staff 3 (RNCM) confirmed Resident 3 did not have the appropriate mobility device or transportation services set up for her/his dental appointment on 5/7/26.

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents only received medication as ordered by a physician for 2 of 3 sampled residents (#s 7 and 8) reviewed for medication errors. This placed residents at risk for adverse side effects of unnecessary medications. Findings include:1. Resident 7 was admitted to the facility in 2022 with diagnoses including osteomyelitis (bone infection). Resident 7's 6/10/26 Physician's Orders included the following: -ferrous sulfate (iron medication) 65 mg one time a day every Monday, Wednesday, and Friday. -vitamin C 500 mg in the morning every Monday, Wednesday, and Friday. The 6/2026 MAR indicated Resident 7 was administered vitamin C and ferrous sulfate on Thursday, 6/10/26. On 6/17/26 at 10:22 AM, Staff 10 (RN) stated Resident 7's ferrous sulfate and vitamin C were entered into the resident's electronic medical record incorrectly. Staff 10 stated she entered the orders at the end of her shift on 6/10/26 and the next shift nurse, Staff 11 (LPN), was to verify all orders were entered correctly. On 6/17/26 at 10:55 AM, Staff 11 (LPN) stated she was unaware of any new resident orders that required verification on 6/10/26. On 6/17/26 at 12:07 PM, Staff 3 (LPN Resident Care Manager) stated Resident 7's ferrous sulfate and vitamin C were entered into Resident 7's electronic medical record incorrectly. Staff 3 acknowledged Resident 7 received one extra dose of ferrous sulfate and one extra dose of vitamin C. On 6/17/26 at 1:03 PM, Staff 2 (DNS) acknowledged Resident 7's 6/10/26 medication orders were entered into the electronic medical record system incorrectly. Staff 2 stated she expected all nurses to input physician orders as they arrived throughout their shift and a second nurse was to review the new orders to ensure accuracy. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses including heart failure. Resident 8's 4/22/26 discharged medication list included the following:-Losartan 25mg (high blood pressure medication), one half tablet by mouth every morning for heart failure and to hold if systolic blood pressure was below 100. -Spironolactone 25 mg (medication used to treat heart failure), one half tablet by mouth every morning for heart failure. Resident 8's 4/22/26 signed discharge order indicated Losartan and Spironolactone were to be discontinued prior to the resident's admission to the facility. The 4/2026 MAR indicated Resident 8 was administered one dose of Losartan and one dose of Spironolactone on 4/23/26. On 6/17/26 at 12:16 PM Staff 7 (LPN) stated when Resident 8 admitted to the facility the medication (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	list reviewed and uploaded into the resident's medical record was obtained from the resident's discharged medications list and not the discharge orders signed by the physician. On 6/17/26 at 12:25 PM Staff 9 (RNCM) stated she reviewed Resident 8's signed discharge orders and compared them to the orders put into the resident's chart and noticed a discrepancy. Staff 9 stated the resident received a dose of Losartan and Spironolactone in error, the resident was put on alert and had no negative outcome.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review it was determined that the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (#4) reviewed for medication. This placed residents at risk for blood clots and excessive bleeding. Findings include:Resident 4 was admitted to the facility in 4/2026 with diagnoses including sick sinus syndrome requiring pacemaker insertion (a heart rhythm disorder requiring a pacemaker to assist with the irregular heartbeat) and acute deep vein thrombosis (blood clots) to bilateral legs.Resident 4's 4/2/26 admission Orders included the following:-Warfarin (anti-coagulant - blood thinner) 3.75 mg every Thursday, Saturday and 2.5 mg every Friday until 4/21/26. -Start Dabigatran Etexilate Mesylate (Pradaxa) (anti-coagulant - blood thinner) 150 mg two times a day on 4/22/26. The 4/2026 MAR indicated Resident 4 was administered Warfarin on 4/10/26 and 4/12/26. Resident 4 received one dose of Pradaxa on 4/10/26, two doses on 4/11/26, 4/12/26, 4/13/26 and one dose on 4/14/26 even though the order indicated the medication to start on 4/22/26. On 4/11/26 Resident 4's Warfarin was held due to the resident's PT/INR (blood test that measures how long it takes blood to clot especially when on blood thinners such as Warfarin with a therapeutic range 2.0 to 3.0) was 4.2 and a re-check was ordered by the provider on 4/13/26. According to the resident's progress notes dated 4/13/26, the resident's PT/INR was 6.7 and a re-check was ordered by the provider for the next day. On 4/14/26 the resident's PT/INR was 7.2. The provider was notified, Vitamin K (used to lower a high INR by enabling the liver to produce active clotting factors) was ordered and the resident was monitored for changes. On 6/16/26 at 1:29 PM Staff 7 (LPN) stated she reviewed Resident 4's MAR with the provider and found the resident received two anti-coagulants by mistake and a medication error occurred. On 6/16/26 at 3:03 PM Staff 8 (Former RN) stated he did not recall exactly what happened and thought he missed the start date of the Pradaxa and did not get another nurse to double check the new orders. On 6/17/26 at 12:07 PM Staff 9 (RNCM) stated on 4/10/26 the provider re-entered the Warfarin order to end on 4/21/26 and start the Pradaxa on 4/22/26 in the electronic health record which appeared as a new order and was transcribed by Staff 8 incorrectly to start on 4/10/26. Staff 9 stated unfortunately the medication error was not caught before Resident 4 was given multiple doses of two anti-coagulants. On 6/17/26 at 1:07 PM Staff 2 (DNS) acknowledged Resident 4 was administered two anti-coagulants simultaneously outside the physician orders. Staff 2 stated she expected all nurses to input physician orders as they arrived throughout their shift and a second nurse to review the inputted orders to ensure accuracy.