STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385258	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Post Acute	8643 NE Beech Street Portland, OR 97220

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. (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 3 sampled residents (#9) reviewed for falls. Findings include: Resident 9 admitted to the facility in 8/2025 with diagnoses including left femur fracture following a fall in previous living situation, dementia with psychotic disturbance, muscle weakness, difficulty walking, and unsteadiness on feet. A MORSE (Morse Fall Scale) Fall assessment dated [DATE] and 8/16/25 indicated Resident 9 was a high fall risk.The Occupational Therapy Evaluation and Plan dated 8/18/25 revealed Resident 9's problem solving was severely impaired and the resident required maximum assistance with transfers. The 8/22/25 admission MDS revealed Resident 9 had a BIMS score of three, which indicated the resident had severe cognitive impairment. The resident utilized a walker and wheelchair as mobility devices, required substantial to moderate assistance with transfers to and from the bed and for toileting. The resident had a history of falls with fracture.The Cognitive Loss/Dementia and Psychotropic Drug Use CAAs dated 8/22/25 indicated Resident 9 was alert, confused and forgetful at baseline, was unable to advocate for care needs, and had a history of falls at home resulting in a hip fracture. Staff were directed to complete frequent safety checks, comfort, and needs, as well as develop a care plan to decrease risks for falls. The resident was dependent on staff for all cares and that possible adverse consequences of psychotropic medication use included falls and short-term memory loss.A review of Resident 9's clinical record revealed the resident had two unwitnessed falls since admission to the facility, on 8/26/25 and 10/23/25. The second fall resulted in injury to Resident 9's head and face.According to the 9/4/25 Comprehensive Care Plan the resident was at risk for ADL/Mobility decline and required assistance related to left femur fracture, the resident was at risk for falls with or without injury related to history of falls, and the resident exhibited cognitive loss related to dementia. Interventions included assistance with locomotion, the use of a manual wheelchair and indicated the resident was dependent on assistance from staff for toileting. The care plan directed staff to use a gait belt for transfers, anticipate and meet needs promptly, fall mats on both sides of the bed, quarter bilateral enabler bars, keep call light within reach, toileting and incontinence care on rounds, upon request, and as needed, and encourage use of call light to promptly notify staff.A 10/23/25 an unwitnessed fall incident report revealed Resident 9 was found lying face down on her/his floor at the foot of her/his bed after walking unassisted. The resident was documented to have predisposing factors of impulsiveness, gait imbalance, recent room change, and non-compliance with cares. Call light within reach and footwear were not identified as being in place.Review of the 10/24/25 revised care plan showed no changes were made to the fall risk, ADL/mobility, or cognitive sections. On 11/9/25 the facility amended the care plan to include monitoring for irritability and restlessness related to depression and PTSD. None of the listed interventions reflected fall prevention. On 11/14/25 at 12:18 PM Resident 9 stated she/he did not need assistance walking in their room. Resident 9 stated she/he did not use the call light because their roommate would call staff or would go find someone. The resident was observed sitting at the edge of the bed without a call light within reach, no fall mats on either side of the resident's bed, no quarter bilateral enabler bars on the bed, or a wheelchair in the room. Observations throughout the day on 11/14/25 from 8:38 AM through 12:45 PM revealed the call light not within reach of Resident 9. The call light was observed to be stuck behind the bedside table and draped over her/his roommate's bed. On 11/14/25 at 10:37 AM and 3:15 PM Staff 30 (Agency CNA) stated they were given report during shift change from another CNA. Staff 30 stated they looked at the Kardex (a quick reference tool CNAs use to help care for residents) to know what Resident 9's care needs were. Staff 30 stated Resident 9 was independent with care but would let staff know if she/he needed assistance. Staff 30 accessed Resident 9's Kardex and confirmed Resident 9 required moderate assistance from one person with transfers and walking and should have had a wheelchair, floor mats on both sides of bed, and enabler bars attached to the bed. On 11/14/25 at 12:37 PM Staff 25 (CNA) stated Resident 9 got up on her/his own, did not ask for assistance, and, since moving rooms, was independent with walking with a walker. Staff 25 stated she did not know if Resident 9 was at risk for falls and recalled the resident had fall mats at the beginning of her/his admission but could not recall when they were removed. Staff 25 confirmed the call light was not within reach of Resident 9 and found the call light attached to the roommate's bed. On 11/14/25 at 2:47 PM Staff 31 (CNA) stated Resident 9's abilities fluctuated depending on the day, but she/he was mostly independent, if she/he needed to use

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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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review it was determined the facility failed to provide appropriate dosing of opioid medication for 1 of 3 sampled residents (#3) reviewed for medications. This placed residents at risk for complications related to narcotic medications. Findings include:The facility's Medication Administration Policy dated 1/2023 indicated the following: -Medications are administered in accordance with written orders. If the dose seems excessive or unrelated to the resident's current condition, the nurse calls the pharmacy or prescriber for clarification. The clarification is documented in the resident's medication record. -Prior to administration, review and confirm medication orders for each individual resident on the MAR.-If the label and MAR were different or if there was any other reason to question the dosage or directions, the prescriber's orders were to be checked for the correct dosage schedule. Resident 3 was admitted to the facility in 9/2024 with diagnoses including opioid abuse. Resident 3's 12/20/24 physician order indicated the resident was prescribed methadone (a medication used to treat opioid abuse)1gm/1ml solution: Take 20 ml of methadone once a day. A 1/10/25 Medication Risk Management investigation revealed Staff 33 (Agency LPN) opened all six prefilled bottles of Resident 3's methadone (the remainder of Resident 3's one-week supply), which resulted in the methadone needing to be destroyed. Due to the medication error, Resident 3 was sent to the methadone clinic to receive her/his 1/10/25 dose and returned to the facility with her/his replacement supply for the remainder of the week. Later that morning, Staff 33 administered a second dose of methadone to Resident 3 despite the resident telling Staff 33 she/he already received a dose of methadone earlier at the methadone clinic. Resident 3 took the second dose of methadone. Resident 3's 1/10/25 narcotic page confirmed Staff 33 signed out one dose of methadone at 11:45 AM and the resident's 1/10/25 MAR indicated Staff 33 administered methadone to Resident 3 at 11:51 AM.On 11/13/25 at 11:43 AM, Staff 9 (Former LPN Care Manager) stated Staff 33 opened Resident 3's remaining bottles of methadone, located in the resident's methadone lock box, and poured the methadone into a cup. Staff 33 came to Staff 9 questioning why there was not enough methadone to administer to Resident 3. Staff 9 stated because of the medication error, the methadone had to be destroyed, so she called the methadone clinic to explain what happened and find out what needed to be done. Staff 9 stated she was instructed to send Resident 3 to the methadone clinic so clinic staff could administer the resident's 1/10/25 dose. Staff 9 stated Resident 3 returned from the methadone clinic with her/his replacement methadone which was documented on the resident's narcotic sheet in the narcotic book. Staff 9 reported later she looked at Resident 3's narcotic sheet and noted Staff 33 provided a second dose of methadone. Staff 9 interviewed Resident 3 who confirmed she/he took a second dose of methadone because Staff 33 was insistent the resident did not receive her/his methadone yet that day. In addition, Staff 33 confirmed she administered the dose. Staff 9 stated she called the methadone clinic who then revoked our certification which resulted in Resident 3 having to go each day to have her/his methadone administered by the methadone clinic staff. On 11/13/25 at 12:28 PM, Staff 7 (Former DNS) stated Resident 3 was supposed to be administered one prefilled bottle of methadone, daily, but Staff 33 thought she was supposed to pour all of the methadone into one cup. Staff 7 stated Staff 33 went to one of my nurses who told her she was not supposed to open every bottle and because of this medication error, the methadone had to be destroyed. Staff 7 reported Resident 3 was sent to the methadone clinic to receive her/his 1/10/25 dose of methadone and was provided a second dose later in the morning by Staff 33. Staff 7 stated Staff 33 was confused about Resident 3's physician order and Staff 33 had difficulty reading the labels on the methadone bottles. Staff 7 stated the facility lost their ability for weekly take-outs so Resident 3 had to go to the methadone clinic every day to receive her/his daily methadone. On 11/14/25 at 8:19 AM, Staff 38 (Respiratory Therapist) stated on 1/10/25, he saw Staff 9, Staff 33 and Resident 3 huddled near the entrance to his office. Staff 38 stated Staff 9 and Resident 3 were upset because Staff 33 opened all of Resident 3's bottles of methadone. Resident 3 was concerned she/he would not be able to get her/his dose of methadone that day and Staff 9 promised she would take care of it. Staff 38 reported he escorted Resident 3 to the methadone clinic and watched as the resident took her/his dose of methadone. Later that day, Resident 3 was provided a second dose of methadone. Staff 38 stated he provided a breathing treatment later in the day and there was no change from her/his baseline after the resident received the second dose. On 11/14/25 at 11:38 AM, Staff 5 (RN Consultant) confirmed on 1/10/25 at 11:51 AM, Resident 3 was provided with an extra dose of methadone after her/his return from the methadone clinic. Staff 5 verified the resident was prescribed 20 ml of methadone daily. On 11/17/25 at 8:28