STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385264	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Secora Rehabilitation of Cascadia	10435 SE Cora Street Portland, OR 97266

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 42222 Based on interview and record review it was determined the facility failed to ensure residents were free from physical restraints for 1 of 3 sampled residents (#7) reviewed for restraints. This placed residents at risk for mistreatment. Findings include: On 6/8/23, the Past Noncompliance was corrected when the facility implemented a plan of correction, which included: -Residents on the same unit were interviewed and no other restraints were found to be improperly utilized; -Educated the staff responsible and placed on corrective discipline; -Provided in-service training to all nursing staff for abuse and neglect which included the use of restraints; and -Provided signature sheet verifying nursing staff had completed the training. Resident 7 was admitted to the facility in 5/2023, with diagnoses including stroke and repeated falls. Resident 7's care plan dated 5/4/23 revealed she/he was a high fall risk and had a history of falls. Staff were to encourage Resident 7 to transfer to her/his bed, wheelchair or ambulate when she/he was on the unit to prevent further falls. On 6/7/23 the facility submitted a report to the State Survey Agency (SSA) which stated Resident 7 had been placed in a device which limited her/his ability to stand. Staff 3 (RCM) assisted the resident to the bathroom and found the resident's gait belt was tied to the resident's wheelchair. Staff 11 (CNA) told Staff 3 he had tied the gait belt to the wheelchair to keep Resident 7 from falling while Staff 11 assisted other residents. The facility investigation revealed Staff 11 was suspended, the resident was placed on alert, a skin check was completed and staff education was initiated. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation included a handwritten statement from Staff 11 dated 6/7/23 which stated in part, Resident 7 was a super high fall risk. In order to keep a close watch on [the resident] and also be able to care for my other residents, I wheeled [the resident] along with me to rooms. I had a gait belt around [the resident's] waist and tied the extra length of the belt to part of [the resident's] wheelchair. If [the resident's] alarm chimed, I would have enough time to conclude whatever I am doing and still get to [the resident]. On 9/19/24 at 12:55 PM, Staff 3 confirmed on 6/7/23, Resident 7 was observed by her to have a gait belt tied to her/his wheelchair. She stated she completed a full skin check with no negative findings and Resident 7 did not report any pain or discomfort as a result of the restraint. On 9/19/24 at 1:20 PM, Staff 11 confirmed he had written the statement on 6/7/23 and had tied Resident 7's gait belt to her/his wheelchair to keep her/him from falling. On 9/19/24 at 1:30 PM, Staff 1 (Administrator) and Staff 2 (DNS) were advised of the investigative findings and provided no additional information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on interview and record review it was determined the facility failed to provide pain management to 1 of 3 sampled residents (#3) reviewed for abuse. This placed residents at increased risk of unmanaged pain. Findings include: The facility's pain management policy, revised 10/2022 recognized a resident's right to be free of pain and promoted pain relief utilizing a pain management plan during the resident's stay at the facility. Facility procedures included an initial pain assessment upon admission for all residents. Resident 3 admitted to the facility in 10/2023, with diagnoses including spinal fractures and chronic pain syndrome. Resident 3's physician orders dated 10/23/23 included a prescription for morphine tablets (15 mg), to be administered every 12 hours for pain. Resident 3's care plan dated 10/24/23 revealed she/he was at risk for acute pain related to her/his diagnoses following a spinal cord injury. Interventions were to administer medications as ordered, anticipate need for pain relief and respond immediately to any complaint of pain. Resident 3's initial pain assessment was completed on 10/24/23 at 5:46 PM by Staff 12 (RN). The assessment revealed Resident 3 reported a pain level of 10 and she/he was in severe pain. Resident 3's 10/2023 MAR revealed she/he was not administered morphine on 10/24/23 evening shift due to the medication being unavailable. Pharmacy delivery records revealed the morphine was delivered to the facility on [DATE] at 2:30 AM. The MAR revealed the resident received the first dose of morphine on 10/25/23 at 8:00 AM. A nursing note written on 10/25/23 at 9:20 AM by Staff 4 (RCM) revealed she gave Resident 3 her/his morning medications which included the morphine, the resident was upset and said she/he had asked for the medication earlier but had not received it. On 9/19/24 at 11:23 AM, Staff 5 (LPN) stated she completed resident assessments for new admissions to the facility. If a resident complained of pain during her/his assessment, the facility was expected to provide pain medication to the resident as ordered. If the resident's pain medication was not available, it was the responsibility of the admitting nurse to contact the pharmacy and get a code for the Cubix (a medication system that dispenses common medications for emergent care needs). Staff 5 stated pain medications typically found in the Cubix included morphine. Resident 3's clinical record did not reveal any efforts were made by nursing staff on 10/24/23 to dispense pain medications from the Cubix. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 11:40 AM, Staff 4 confirmed the morphine was not administered to Resident 3 on 10/24/23 and there were no progress notes to explain the delay of the medication's delivery to the facility. Resident 3 was not interviewed due to discharging from the facility. Staff 12 was not interviewed due to medical leave. On 9/19/24 at 1:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated it was an expectation that residents receive pain medication timely.