

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Secora Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46053</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 6 sampled residents (#35) reviewed for unnecessary medications. This placed residents at risk for adverse side effect of medications. Findings include:</p> <p>The facility's 8/1/23 Medication Errors policy outlined the following:</p> <ul style="list-style-type: none"> -A significant medication error is one which causes the resident discomfort or jeopardizes their health and safety. -In the event of a significant medication error, immediate action is taken as necessary to protect the resident's safety and welfare. -The prescriber is notified promptly of the error. -A medication error/adverse reaction report is completed. <p>Resident 35 was admitted to the facility in 3/2024 with diagnoses including vascular dementia (cognitive decline caused by damage to the blood vessels in the brain) and a stroke.</p> <p>A review of Resident 35's 4/4/24 Admission MDS revealed she/he was cognitively intact and received anticoagulant therapy.</p> <p>A review of Resident 35's health record revealed a 4/12/24 signed physician order for 20 mg tablet of Rivaroxaban to be administered one time a day for other cerebral infarction due to occlusion or stenosis of small artery.</p> <p>A review of Resident 35's medication administration record revealed her/his prescribed Rivaroxaban (an anticoagulant) was not administered on 4/14/24, 4/15/24 and 4/16/24.</p> <p>(continued on next page)</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility investigation completed by Staff 29 (Former Administrator) indicated Resident 35's Rivaroxaban was available but Staff 30 (LPN) failed to administer it to her/him on 4/14/24, 4/15/24, and 4/16/24. The investigation also indicated on 4/17/24 Resident 35 presented with strokelike symptoms including being unable to hold up her/his head, her/his right pupil was pinpoint and fixed, she/he had weakness on the right side of her/his body, and was unable to respond verbally to questions. As a result, Staff 31 (RN, Former DNS) sent Resident 35 to the hospital emergency department.</p> <p>On 3/27/25 at 11:43 AM Staff 4 (DNS) stated Resident 35 was not administered her/his medications as ordered and developed stroke-like symptoms for which she/he was sent to the hospital. Staff 4 stated Staff 30 did not notify staff, contact the provider or call the pharmacy. Staff 4 stated Staff 30 did not follow appropriate protocol or follow physician orders.</p> <p>On 3/27/25 at 5:23 PM Staff 31 acknowledged Staff 30 did not administer Resident 35's medication as ordered and did not notify nursing staff, call the provider, pharmacist, or write a progress note about the missed scheduled doses. Staff 31 stated Staff 30 was terminated due to the incident.</p> <p>On 3/28/25 at 1:56 PM Staff 30 stated she looked for Resident 35's Rivaroxaban but was unable to locate the medication. Staff 30 stated it was her mistake, she was overwhelmed by work and forgot to call the pharmacy as well as the doctor.</p>		