| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385271 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl at Kruse Way, The | 4550 Carman Drive<br>Lake Oswego, OR 97035 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>33179<br><br>Based on interview and record review it was determined the facility failed to administer medications at the prescribed dose for 1 of 3 sampled residents (#3) reviewed for physician orders. This placed residents at risk to receive a sub-therapeutic dose of medication. Findings include:<br><br>Resident 3 was admitted to the facility in 12/2023, with diagnoses including high blood pressure.<br><br>Resident 3's 12/15/23 Physician Orders included an order for metoprolol (a high blood pressure medication) 50 mg every evening.<br><br>Review of Resident 3's 12/2023 and 1/2024 MARs revealed the resident received 25 mg of metoprolol instead of 50 mg from 12/15/23 through 1/8/24.<br><br>On 6/27/24 at 8:39 AM, Staff 4 (Regional RN) verified Resident 3 was administered 25 mg of metoprolol instead of the 50 mg as ordered from 12/15/23 through 1/8/24. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Pearl at Kruse Way, The | 4550 Carman Drive<br>Lake Oswego, OR 97035 |

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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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>33179<br><br>Based on interview and record review it was determined the facility failed to follow the resident's plan of care for 1 of 3 sampled residents (#5) reviewed for accidents. This placed residents at risk for falls and injury. Findings include:<br><br>Resident 5 was admitted to the facility in 12/2023, with diagnoses including stroke and attention and concentration deficit.<br><br>Resident 5's 12/21/23 ADL Care Plan instructed staff to not leave the resident alone when she/he was up in the wheelchair.<br><br>Resident 5's 1/31/23 Progress Note indicated Resident 5 was left alone in her/his room while in a wheelchair. The resident attempted to self-transfer and fell to the floor.<br><br>On 6/25/24 at 12:20 PM, Staff 4 (Regional RN) verified Resident 5 was left alone in her/his wheelchair, the resident attempted to self-transfer and fell . Staff 4 acknowledged Resident 5's care plan was not followed. |