STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385272	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tigard Rehabilitation and Care	14145 SW 105th Avenue Tigard, OR 97224

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure non-pressure skin wounds were monitored for 1 of 3 sampled residents (#6) reviewed for non-pressure skin wounds. This placed residents at risk for worsening wounds and delays in treatment. Findings include:Resident 6 was admitted to the facility on [DATE] with diagnoses including heart failure and diabetes.A 4/17/25 Clinical admission Progress Note, completed by Staff 4 (LPN), indicated Resident 6 had some redness with a small healing blister to her/his front left knee that was present upon admission.The 4/18/25 care plan revealed Resident 6 had impaired skin integrity due to a current blister on the left thigh/shin and immobility.A review of Resident 6's medical record, including a review of the 4/2025 TAR, revealed no assessment of the wound and no monitoring of the wound. Resident 6 discharged to the hospital on 4/22/25 for an unrelated diagnosis.On 11/13/25 at 2:45 PM Staff 4 confirmed he completed Resident 6's clinical admission assessment that included a full body skin check. Staff 4 stated when skin impairments were identified he placed a note on the TAR to monitor them. Staff 4 confirmed Resident 6 had a blister on her/his left knee. Staff 4 reviewed the TAR and acknowledged he did not implement monitoring of Resident 6's blister.On 11/14/25 at 1:48 PM Staff 25 (LPN Resident Care Manager) confirmed there were no assessments completed for Resident 6's blister on the left knee.On 11/14/25 at 2:25 PM Staff 2 (DNS) stated if a skin impairment like a blister was noted upon admission it was expected to be documented in the admission progress note, added to the TAR, the resident placed on alert charting, and a risk management note started. Staff 2 acknowledged Resident 6's blister was not assessed or monitored during her/his stay at the facility.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review it was determined the facility failed to ensure newly identified pressure ulcer wounds were comprehensively assessed and wound care orders were obtained and implemented for 1 of 3 sampled residents (#7) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include:The facility's 4/2018 Pressure Ulcer/Skin Breakdown - Clinical Protocol - Assessment and Recognition specified the nurse shall describe and document/report the following:Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates (leaking fluid) or necrotic (dying/dead) tissue and pain assessment.The 2019 National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries Quick Reference Guide indicated the following recommendations regarding pressure ulcer assessment: - Assess the pressure ulcer initially and re-assess it at least weekly to monitor progress towards healing; - Document the results of all wound assessments; - Assess and document physical characteristics including: location, category/stage, size, tissue type(s), color, peri-wound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor.Resident 7 was admitted to the facility in 10/2025 with a diagnosis of osteomyelitis of vertebrae (bone infection).Resident 7's 10/29/25 admission MDS was not completed. A Progress Note dated 11/1/25 completed by Staff 26 (LPN) indicated she was informed by a CNA of an open sore on the upper part of Resident 7's buttock.A 11/1/25 Skin Integrity Report, initiated by Staff 26, indicated a new open sore on the upper part of the resident's buttock and indicated the Resident Care Manager and Physician was notified. A note added on 11/3/25 indicated a new pressure injury to the left buttock wound which measured 1.5 x 1.1 cm and a new pressure injury to the coccyx which measured 3.1 x 5 x 0.3 cm.There was no evidence in Resident 7's health record to indicate a comprehensive assessment of the wound including measurement, location, stage, and other characteristics was completed after the wound was identified on 11/1/25 and before 11/3/25.Resident 7's 11/3/25 Physician Orders included the following: wound treatment to coccyx and sacrum wound bed, wash, pat dry, apply hydrogel to the sacrum and medihoney to coccyx wound bed, place large sacral dressing to cover both wounds. every day and PRN.There was no evidence wound care orders were obtained prior to 11/3/25. Resident 7's TAR revealed wound care was not provided until 11/4/25.On 11/14/25 at 12:20 PM Staff 26 stated she remembered a CNA notified her on 11/1/25 that Resident 7 had a new open area. Staff 26 stated she looked at the open area on resident 7's left buttock, cleaned the wound, covered it, and initiated a Skin Integrity Report. Staff 26 stated she did not measure the wound, did not obtain orders from the provider, did not document any wound treatment, and did not initiate any house wound orders on the TAR.On 11/14/25 at 12:57 PM Staff 2 (DNS) stated when a new skin issue was discovered, a Skin Integrity Report was to be initiated. She expected the nurse on duty to assess and measure the wound right away, complete wound care, implement a treatment protocol on the TAR, and place the resident on alert charting. Staff 2 acknowledged Resident 7's wound was identified on 11/1/25 and was not comprehensively assessed and measured until 11/3/25. Staff 2 confirmed there was no evidence in Resident 7's health record to indicate wound care was provided from 11/1/25 through 11/3/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review it was determined the facility failed to ensure narcotic drug records were in order and an account of all controlled drugs was maintained for 1 of 3 narcotic books reviewed for medication administration. This placed residents at risk for drug diversion. Findings include:The facility's policy for reconciling controlled substances, revised 11/2022, stated the system for reconciling the receipt, dispensing and disposition of controlled substances included the following:-Records of personnel access and usage;-Medication administration records;-Declining inventory records; and-Destruction, waste and return to pharmacy records.-Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile and inventory the count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the DNS.A 3/27/25 FRI indicated narcotic medication for two residents was missing and unaccounted for.A 3/31/25 investigation report revealed the facility was unable to determine what happened to the missing narcotic medication.On 11/14/25 at 11:13 AM Staff 8 (CMA) stated she remembered hearing about missing narcotic medication and denied knowing any information related to the incident.On 11/14/25 at 1:03 PM Staff 6 (LPN) stated she remembered reports of two missing narcotic cards but denied knowledge of what happened to the medication.On 11/14/25 at 12:32 PM Staff 3 (Former DNS) stated during a review of one of the facility's narcotic books on 3/26/25 it was determined two narcotic cards were missing. Staff 3 stated as a result of the investigation completed on 3/31/25, an immediate audit of all narcotics was completed, and education was provided to all staff responsible for managing medication.The deficient practice was identified as Past Noncompliance based on the following:The deficient practice was identified by the facility and was corrected on 4/1/25 when the facility completed a root cause analysis of the incident and identified a system failure related to managing narcotic medication. The plan of correction included: A full audit of all narcotic books was completed; no additional discrepancies were found. Education was provided to staff to include the facility's updated protocol for counting narcotic medication which included to count the number of narcotics in each book and record the amount next to staff initials on the signature/sign off page upon each shift change. All narcotics were inputted into new narcotic books to reflect correct records of each narcotic medication.