STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385276	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascade Manor	65 West 30th Avenue Eugene, OR 97405

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. Based on interview and record review it was determined the facility failed to notify the provider of abnormal vitals for 1 of 5 sampled residents (#2) reviewed for unnecessary medications. This placed residents at risk for adverse side effects to a low pulse. Findings include:Resident 2 was admitted to the facility in 3/2026 with diagnoses including heart failure and arterial fibrillation (an irregular heartbeat).A review of Resident 2's orders revealed a 3/7/26 order for amiodarone (a medication used to treat irregular heartbeat) 200 mg daily.A review of Resident 2's vital record revealed the following pulses:-3/7/26 59 beats per minute (BPM)-3/8/26 56 BPM-3/9/26 44 BPM and 55 BPM-3/10/26 47 BPM-3/11/26 59 BPM and 51 BPM-3/12/26 52 BPM-3/13/26 39 BPM-4/1/26 44 BPM-4/7/26 40 BPMA review of Resident 2's medical record revealed no evidence the provider was notified of the low pulses.On 4/14/26 Resident 2 had a pulse of 42 beats per minute and a blood pressure reading at 108/47, and an order was received to decrease the dose of amiodarone from 200 mg to 100 mg.On 4/22/26 at 2:28 PM Staff 2 (DNS) provided a CNA Assignment sheet with the normal vital parameters listed. The CNA Assignment sheet indicated the normal pulse would be 60-100 beats per minute. On 4/23/26 at 9:15 AM Staff 2 (DNS) stated staff were expected to notify the provider if the pulse was below 60 BPM per orders. Staff 2 acknowledged there was no evidence Resident 2's provider was notified of the pulses below 60 BPM.

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 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. Based on interview and record review it was determined the facility failed to ensure residents did not receive unnecessary medications for 1 of 5 sampled residents (#2) reviewed for unnecessary medications. This placed residents at risk for adverse side effects to receiving medications unnecessarily. Findings include:Resident 2 was admitted to the facility in 3/2026 with diagnoses including heart failure and arterial fibrillation (an irregular heartbeat).A review of orders revealed a 3/8/26 order for spironolactone (a medication that helps remove excess water and salt from the body) hold if the systolic blood pressure (SBP, the top number in a blood pressure reading) was less than 100.A 3/27/26 progress note indicated Resident 2's provider recommended checking Resident 2's orthostatic blood pressure (checking the blood pressure after changing positions).A review of Resident 2's medical record revealed no evidence of orthostatic blood pressures being completed.A review of Resident 2's blood pressures revealed Resident 2 received spironolactone when her/his blood pressure was 98/58 on 3/23/26 and 98/52 on 4/15/26.A review of Resident 2's medical record revealed no blood pressure readings on 3/25/26, 3/28/26-3/30/26, 4/2/26-4/6/26, 4/8/26-4/13/26, and 4/16/26-4/18/26.On 4/22/26 at 11:47 AM, Staff 2 (DNS) stated Resident 2 had orders to hold spironolactone when her/his SBP was less than 100. Staff 2 acknowledged on 3/23/26 and 4/15/26 Resident 2's SBP was less than 100 and she/he received spironolactone. Staff 2 acknowledged Resident 2's blood pressure was not checked daily. Staff 2 stated staff were expected to check Resident 2's blood pressure daily prior to giving the spironolactone and to hold the medication if Resident 2's blood pressure was less than 100.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review it was determined the facility failed to track infection organisms for 1 of 5 sampled residents (#2) reviewed for unnecessary medications. This placed residents at risk for antibiotic resistance. Finding include: Resident 2 was admitted to the facility in 3/2026 with diagnoses including a urinary tract infection (UTI) and heart failure.A 3/19/26 progress note indicated Resident 2 had three UTIs this year.A 3/27/26 progress note indicated Resident 2 had frequent UTIs.A 4/3/26 progress note indicated Resident 2 had increased confusion, frequent urination, and pelvic pain. An order for a urinary analysis with culture and sensitivity was received, and Resident 2 was started on antibiotics.A 4/5/26 urinary culture indicated skin flora (harmless bacteria on the skin).A 4/8/26 progress note indicated Resident 2's provider was requesting the final urinary culture and sensitivity.A 4/9/26 progress note indicated Resident 2's provider was requesting the final urinary culture and sensitivity.A review of Resident 2's medical record revealed no evidence of Resident 2's provider reviewing the urinary culture and sensitivity results.On 4/22/26 at 11:47 AM, Staff 2 stated Resident 2's urinary culture and sensitivity results were not received until 4/20/26. Staff 2 stated staff called the lab on 4/8/26 and requested results. Staff 2 acknowledged the urinary culture and sensitivity results indicated the lab was completed on 4/5/26. Staff 2 stated staff were expected to follow up on antibiotics 72 hours after the antibiotic starts to ensure the culture results are received and the right antibiotics are being used. Staff 2 acknowledged this process was not completed for Resident 2.