STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385284	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crossings	6003 SE 136th Avenue Portland, OR 97236

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on observation and interview it was determined the facility failed to maintain a safe, clean and homelike environment on 1 of 1 facility and 1 of 2 resident dining rooms reviewed for environment. This placed residents at risk for tripping and living in an unkept and unhomelike environment. Findings include: 1. The facility's Homelike Environment Policy dated February 2021 outlined the following: - Residents are provided with a safe, clean, comfortable and homelike environment. Observations of the facility's dining rooms, hallways and resident rooms from 1/14/25 through 1/17/25 between the hours of 7:30 AM and 2:00 PM found the following issues: -The flooring in the ECU (Enhanced Care Unit) dining room had an irregular half-circular portion of linoleum, approximately 9 inches long, 4 inches wide and 1.5 inches deep, missing on the left side of the dining room near the exit door which was a tripping hazard. In addition, there was approximately 5 feet in length of flooring with missing pieces of linoleum in the middle of the dining room. Several residents were observed ambulating independently in the dining room at all hours. -The flooring immediately inside the ECU locked doors had an approximate 4 foot long, bubbled up and cracked section of linoleum. -The shared television room on the ECU had large scrapes across the left wall. -room [ROOM NUMBER] had several black marks on the flooring in the center of the room. -room [ROOM NUMBER] had numerous vertical scrapes approximately 3 feet in length, along the wall across from the bed, and the door on the sink's cabinet had several scrapes approximately 1 foot in length. -room [ROOM NUMBER] had multiple black marks and scrapes in front of the bed nearest the door. -The linoleum flooring in room [ROOM NUMBER] had an approximate 7 foot long crack down the center of the room. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The wall behind the bed in room [ROOM NUMBER] had numerous scrape marks. On 1/16/25 at 8:38 AM Staff 13 (CNA) stated the flooring in the ECU dining room was in the current condition for some time and was reported to maintenance in the past. On 1/16/25 at 11:11 AM Staff 10 (Maintenance Director), during a facility walk-through, stated residents frequently ambulated independently in the ECU dining room and confirmed the flooring was a tripping hazard. Staff 10 reported there was no warning in place to notify residents of the tripping hazard. Staff 10 acknowledged the needed repairs in the identified resident rooms and shared spaces and stated it was his expectation that the facility was homelike and kept safe for all residents. 46053 2. The facility's Homelike Environment Policy dated February 2021 outlined the following: - Residents are provided with a safe, clean, comfortable and homelike environment. Resident 68 was admitted to the facility in 11/2024 with a diagnosis of cerebral infarction (stroke). A review of Resident 68's care plan revealed she/he only slept in her/his chair and it was her/his goal to sleep comfortably. On 1/13/25 at 12:05 PM the temperature in Resident 68's room was cool and uncomfortably-cold air was felt blowing from the ceiling vent above her/his chair. On 1/13/25 at 12:09 PM Resident 68 was observed sitting in her/his room in the lounge chair where she/he slept and spent most of her/his time during the day. She/he stated, It's freezin' ass cold. And from midnight until 8:00 AM it gets even colder. The vent blows ice cold air. On 1/16/25 at 7:36 AM Resident 68 was observed in her/his room sitting in her/his chair. She/he had multiple blankets covering her/his chest and lap. She/he wore a jacket under the blankets. The temperature in the room was observed to be uncomfortably cold and cold air blew from the ceiling vent over Resident 68's chair where she/he was seated. She/he reported, It is always cold from midnight until about 8:00 AM. I put on extra blankets but it should be warmer in here. Resident 68 stated she/he told her/his caregivers the temperature in her/his room was too cold. On 1/16/25 at 7:52 AM Staff 26 (CNA) confirmed Resiedent 68's room was cold and stated she adjusted the thermostat when she/he told her the room was cold. She said when she adjusted the thermostat her/his room became too warm. She reported it was difficult to regulate the temperature and said, We try to fix it but it is hard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 12:30 PM Staff 10 (Maintenance Director) stated he checked the temperature in residents' rooms regularly. He reported Resident 68's room was a little cold and stated, At night it gets cooler. He stated he adjusted the temperature for Resident 68 several times in the past three months. Staff 10 stated he planned to install locked cages covering the thermostats to prevent unauthorized individuals from changing temperatures or schedules. He added, People try to be helpful but it can mess things up more if they change the temperature setting. Staff 10 stated, The temperature should be comfortable all the time. A review of Resident Grievance Forms revealed the residents in rooms near Resident 68's room also reported cold temperatures in their rooms. On 1/17/25 at 9:40 AM Staff 2 (DNS) acknowledged the difficulty in regulating comfortable temperatures in residents' room and stated she was aware residents reported issues with their room temperatures being cool. She stated she expected temperatures to be comfortable for residents.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41458 Based on interview and record review it was determined the facility failed to ensure transfer notices with appeal rights were provided in writing to residents and their representatives for 2 of 2 sampled residents (#s 80 and 81) reviewed for hospitalization s. This placed residents at risk for lack of information regarding their options and rights. Findings include: 1. Resident 80 was admitted to the facility in 2/2024 with diagnoses including a stroke and difficulty with swallowing. A review of Resident 80's health record revealed she/he was transferred to the hospital on 10/5/24. No evidence was found in Resident 80's health record to indicate a transfer notice with appeal rights was provided in writing to the resident or their representative upon transfer to the hospital. On 1/16/25 at 2:21 PM Staff 2 (DNS) stated transfer notifications with appeal rights were not being provided to residents or their representatives when they transferred to the hospital and it was her expectation that required notifications be provided to residents or their representatives when transferring to the hospital. 2. Resident 81 was admitted to the facility in 10/2024 with diagnoses including calculus (hard deposits) of the gallbladder and abdominal pain. A review of Resident 81's health record revealed she/he was transferred to the hospital on 10/31/24. No evidence was found in Resident 81's health record to indicate a transfer notice with appeal rights was provided in writing to the resident or their representative upon transfer to the hospital. On 1/16/25 at 2:21 PM Staff 2 (DNS) stated transfer notifications with appeal rights were not being provided to residents or their representatives when they transferred to the hospital and it was her expectation that required notifications be provided to residents or their representatives when transferring to the hospital.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41458 Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification, including reserved bed hold payment, at the time of transfer to the hospital for 2 of 2 sampled residents (#s 80 and 81) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 80 was admitted to the facility in 2/2024 with diagnoses including a stroke and difficulty with swallowing. A review of Resident 80's health record revealed she/he was discharged to the hospital on 10/5/24. No evidence was found in Resident 80's health record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital on 10/5/24. On 1/16/25 at 2:21 PM Staff 2 (DNS) confirmed a written bed hold policy including reserved payment was not provided to Resident 80 or their representative when the resident was transferred to the hospital on 10/5/24. 2. Resident 81 was admitted to the facility in 10/2024 with diagnoses including calculus (hard deposits) of the gallbladder and abdominal pain. No evidence was found in Resident 81's health record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital on 10/31/24. On 1/16/25 at 2:21 PM Staff 2 (DNS) confirmed a written bed hold policy including reserved payment was not provided to Resident 81 or their representative when the resident was transferred to the hospital on 10/31/24.

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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. 50926 Based on observation, interview, and record review it was determined the facility failed to provide care and treatment for 1 of 2 sampled residents (#56) reviewed for edema. This placed residents at risk for unmet needs. Findings include: Resident 56 was admitted to the facility in 11/2024 with diagnoses including deep vein thrombosis (a blood clot that may cause pain and swelling) in the lower left leg, atrial fibrillation (an irregular, often rapid heart rate), and high blood pressure. On 1/13/2025 at 10:37 AM, Resident 56 stated she/he had discomfort to her/his legs due to swelling. The resident was observed to have edema (swelling) in both feet. The resident stated a provider had ordered compression stockings for the edema about four weeks earlier but she/he did not receive the compression stockings. Compression stockings were not observed on her/his lower extremities. On 1/16/25 at 12:07 PM, Staff 20 (RN) stated she was not aware of an order for compression stockings for Resident 56; however, she was able to locate an order for Tubigrip (a form of compression dressing) in a progress note dated 12/6/24. On 1/16/25 at 1:30 PM, Staff 33 (LPN Resident Care Manager) stated the order for Tubigrip for compression had not been followed up on and was not implemented, due to an oversight. On 1/17/25 at 12:59 PM Staff 2 (DNS) stated she expected the provider orders to be processed and implemented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36494 Based on observation, interview and record review it was determined the facility failed to ensure staff completed timely smoking assessments and smoking materials were stored safely for 3 of 3 sampled residents (#s 22, 50, and 60) reviewed for accidents. This placed residents at risk for accidents and smoking hazards. Findings include: A Smoking Policy dated 8/2022 revealed the following: -Resident smoking status is evaluated upon admission to ensure all residents are safe to smoke. -A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. -No resident will be allowed to store any smoking materials in their room. All smoking material will be stored in a secured designated area (a lock box) accessible only to staff. If any smoking materials are seen on residents, please report to nurse or the social worker. -If it is believed that residents are not compliant with locking up smoking materials and have them in their possession the IDT (interdisciplinary team) will be notified. IDT members will work with the resident to determine if smoking materials are being stored inappropriately and what interventions can be put in place to promote compliance. 1. Resident 22 was admitted to the facility in 10/2024 with diagnoses including chronic heart failure and diabetes. A 10/23/24 Admission MDS revealed Resident 22 had a BIMS score of 13, which indicated the resident had moderate cognitive impairment. A smoking assessment was completed on 10/25/24 and 1/13/25 which revealed Resident 22 was safe to smoke independently. A care plan dated 6/27/24, and revised on 1/13/25, revealed Resident 22 was an independent smoker. No evidence was found indicating Resident 22's smoking materials needed to be locked up and stored safely. Random observations from 1/13/25 through 1/17/25, revealed Resident 22 kept her/his lighter and cigarettes in her/his upper right jacket pocket, which was visible. Resident 22 was observed self-propelling in and out of the designated smoking area independently and her/his smoking materials were with her/him. On 1/13/25 at 1:04 PM, Resident 22 stated she/he was allowed to smoke on her/his own, never turned in or locked up her/his smoking materials, and always kept them in her/his pocket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 10:37 AM, Staff 27 (CNA) and at 6:07 PM, Staff 28 (CNA) both stated Resident 22 was independent to smoke and did not need supervision. Staff 27 and Staff 28 stated Resident 22 did not turn in her/his smoking materials and kept them on her/him at all times. Staff 27 stated Resident 22 was supposed to keep her/his smoking materials locked up. On 1/16/25 at 12:25 PM, Staff 2 (DNS) stated all residents who smoked were assessed upon admission, quarterly, and if a resident had a change of condition. Staff 2 stated all residents, whether supervised or unsupervised, were to keep smoking materials locked up when not out smoking. On 1/17/25 at 1:40 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 1 stated residents who smoked were required to keep smoking materials locked up, but it was a bit challenging, and not all residents complied. Staff 1 stated that was something they continued to work on. 2. Resident 50 was admitted to the facility in 6/2024 with diagnoses including end stage kidney disease and diabetes. A 11/24/24, Quarterly MDS revealed Resident 50 had a BIMS score of 15, which indicated the resident was cognitively intact. A smoking assessment was completed on 9/27/24 and 1/13/25, which revealed Resident 50 was safe to smoke independently. No records were found to indicated Resident 22 had a smoking assessment upon her/his admission and the 1/13/25 quarterly smoking assessment was late. A care plan dated 6/28/24, and revised on 12/26/24, revealed Resident 50 was an independent smoker. Resident 50 was to secure her/his smoking materials in a secure storage box. Random observations from 1/13/25 through 1/17/25, revealed Resident 50 kept her/his lighter and cigarettes with her/him. Resident 50 was observed ambulating in and out of the designated smoking area independently and had her/his smoking materials with her/him. On 1/13/25 at 1:04 PM, Resident 50 stated she/he was allowed to smoke on her/his own, she/he always kept her/his smoking materials with her/him, and she/he never secured them in a storage box. On 1/14/25 at 2:40 PM, Staff 28 (CNA) stated Resident 50 was independent to smoke and the smoking materials were to be locked up. Staff 28 stated she was unsure if Resident 50 turned in her/his smoking materials. On 1/15/25 at 5:42 AM, Staff 29 (CNA) and at 5:09 PM, Staff 30 (CMA) both stated Resident 50 was independent to smoke. Staff 29 stated she was unaware if smoking materials were to be locked up or kept with the resident. Staff 30 stated Resident 50 was supposed to keep her/his smoking materials locked up at the nurses station. On 1/15/25 at 5:15 AM, Staff 25 (LPN) stated Resident 50 was an independent smoker, but all residents needed to be supervised. Staff 25 stated Resident 50 was supposed to keep her/his smoking materials at the nurses station, but was non-compliant. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 12:25 PM, Staff 2 (DNS) stated all residents who smoked were assessed upon admission, quarterly, and if a resident had a change of condition. Staff 2 acknowledged Resident 50's smoking assessment was not timely. Staff 2 stated all residents, whether supervised or unsupervised, were to keep smoking materials locked up when not out smoking. On 1/17/25 at 1:40 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 1 stated residents who smoked were required to keep smoking materials locked up, but it was a bit challenging, and not all residents complied. Staff 1 stated that was something they continued to work on. 3. Resident 60 was admitted to the facility in 8/2024 with diagnoses including schizoaffective (causing individuals to have hallucinations, embrace false beliefs, and experience depression or mania) disorder and kidney disease. A 11/10/24 Quarterly MDS revealed Resident 60 had a BIMS score of 15, which indicated the resident was cognitively intact. A smoking assessment was completed on 1/13/25, which revealed Resident 60 was safe to smoke independently. A review of Resident 60's medical records revealed no care plan was initiated related to resident 60's smoking, and no initial smoking assessment was found or completed until 1/13/25. On 1/14/25 at 2:40 PM, Staff 28 (CNA) stated Resident 60 was independent to smoke and the smoking materials were to be locked up. Staff 28 stated she was unsure if Resident 60 turned in her/his smoking materials. On 1/14/25 at 2:33 PM, Resident 60 stated she/he was able to smoke on her/his own and family brought in her/his smoking materials. Resident 60 stated she/he did not secure any smoking materials in a secure lock box. On 1/15/25 at 5:42 AM, Staff 29 (CNA) and at 5:09 PM, Staff 30 (CMA) both stated Resident 60 was independent to smoke. Staff 29 stated she was unaware if smoking materials were to be locked up or kept with the resident. Staff 30 stated Resident 60 was supposed to keep her/his smoking materials locked up at the nurses station. On 1/16/25 at 8:39 AM, Staff 31 (LPN) stated Resident 60 was an independent smoker but could not speak to the current smoking policy because it was complicated and the smoking policy kept changing. On 1/16/25 at 12:25 PM, Staff 2 (DNS) stated all residents who smoked were assessed upon admission, quarterly, and if a resident had a change of condition. Staff 2 acknowledged Resident 60's smoking assessment was not timely and there was nothing on Resident 60's care plan related to smoking. Staff 2 stated all residents, whether supervised or unsupervised, were to keep smoking materials locked up when not out smoking. On 1/17/25 at 1:40 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 1 stated residents who smoked were required to keep smoking materials locked up, but it was a bit challenging, and not all residents complied. Staff 1 stated that was something they continued to work on.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 36494 Based on observation, interview and record review it was determined the facility failed to ensure resident respiratory services were in place and equipment was maintained for 1 of 2 sampled residents (#54) reviewed for respiratory care. This placed residents at risk for breathing complications. Findings include: Resident 54 was admitted to the facility in 5/2024 with diagnoses including anxiety and depression. A care plan dated 5/24/24, revealed Resident 54 had sleep apnea and utilized a CPAP/BIPAP machine. The device was to be cleaned, including the mask, tubing and head gear. Random observations from 1/13/25 through 1/17/25 revealed Resident 54 utilized a BIPAP (a ventilator that helps people breathe by delivering pressurized air through a mask) machine adjacent to her/his bed on a nightstand. The BIPAP machine was dusty, and the tubing and mask were in a drawer covered with magazines and under a saltine cracker box. On 1/13/25 at 8:08 AM, and 11:38 AM, and on 1/17/25 at 8:17 AM, Resident 54 stated she/he utilized a BIPAP machine at night. Resident 54 stated staff did not clean the device or ensure the BIPAP had distilled water in the machine for her/him to utilize. A review of Resident 54's clinical record revealed no evidence of a physician's order for the use of the BIPAP machine. No evidence was found the facility staff were assisting the resident with placement or cleaning of Resident 54's BIPAP machine. On 1/16/25 at 5:13 AM, Staff 32 (CNA), and at 7:32 AM, Staff 23 (LPN), and at 8:39 AM, Staff 31 (LPN) all stated Resident 54 had a BIPAP machine and the resident wore the device at night. Staff 31 stated night shift was responsible for cleaning the BIPAP machine. Staff 32 stated Resident 54 refused to wear the machine at times. On 1/16/25 at 9:31 AM, Staff 3 (RNCM) entered the room and acknowledged Resident 54 had a BIPAP machine. The BIPAP device was on the nightstand, and the dispenser piece, which held the distilled water, was placed next to the BIPAP machine. Staff 3 stated it appeared the BIPAP machine seemed to have been cleaned. The tubing and mask was inside the drawer, while the machine itself was dusty, with no distilled water in the device or room. Staff 3 acknowledged she could not locate any orders for the BIPAP machine, and there was no indication the BIPAP was being cleaned appropriately.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 36494 Based on observation, interview and record review it was determined the facility failed to administer medications and ensure communication forms were completed accurately for 1 of 1 sampled resident (#50) reviewed for dialysis (a procedure which removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). This placed residents at risk for lack of care and services, and potential medication side effects. Findings include: Resident 50 was admitted in 6/2024 with diagnoses including end stage renal disease and diabetes. a. A care plan dated 8/12/24 and revised on 1/17/25 revealed Resident 50 received dialysis related to renal failure. Resident 50 went out for dialysis at 5:00 AM on Tuesday, Thursday, and Saturday and returned at 2:00 PM. A review of Resident 50's Physician Recapitulation Orders dated 12/8/24, revealed the following medications to be administered in the morning at 7:00 AM or 7:30 AM: *Midodrine (a cardiovascular agent) 5 mg, administer every Tuesday, Thursday, and Saturday 20 minutes prior to dialysis to treat hypotension. *Nephro-Vite Oral Tab 0.8 mg (B-Complex & Folic Acid), administer one tablet in the morning as a supplement. *Sevelamer Carbonate (a phosphate binder) administer 800 mg three times daily for renal failure. *Amlodipine Besylate (a calcium channel blocker), administer 10 mg for hypertension. *Folic Acid (a B vitamin supplement), administer 400 mcg by mouth every day shift as a supplement. *Carvedilol (a beta blocker), administer 25 mg every morning for hypertension. *Losartan Potassium (a angiotensin receptor blocker), administer 50 mg every morning for hypertension. *Omeprazole (a proton pump inhibitor), administer 40 mg by mouth twice times daily for heartburn. *Prazosin (treats high blood pressure), administer 3 mg every morning for hypertension. *Dicylomine (treats irritable bowel syndrome), administer 1 capsule by mouth. *Metoclopramide (treats stomach problems), administer 1 tablet by mouth before meals for gastroparesis. *Sucralfate (treats stomach problems) suspension administer 10 ml by mouth before meals for gastric protection. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MARs from 12/1/24 through 1/17/25 revealed 20 opportunities on dialysis days for Resident 50 to receive her/his medications before leaving for dialysis. There were multiple instances when the MARs indicated the resident was out of the facility and did not receive her/his medications or indicated they were administered. On 1/15/25 at 5:15 AM, Staff 25 (LPN) stated Resident 50 attended dialysis on Tuesday, Thursday, and Saturday. The resident received an oxycodone (a pain medication) for her/his chronic pain, and did not receive any other medications until she/he returned to the facility, which was after 10:00 AM. During a continuous observation on 1/16/25 from 5:00 AM through 5:40 AM Resident 50 was up, dressed, and stopped at the nurse's station. Staff 23 (LPN) administered a pain pill, handed Resident 50 the communication binder, and the resident sat in the front lobby until her/his ride arrived at 5:40 AM. Staff 23 stated the only medication administered to the resident prior to leaving for dialysis was the pain medication. On 1/16/25 at 11:26 AM, Resident 50 returned from dialysis, and stated she/he went to dialysis routinely and took a pain medication prior to leaving the facility. Resident 50 stated she/he returned around lunch time and received her/his morning medications upon returning to the facility. On 1/16/25 at 7:32 AM, Staff 23 (LPN) stated the resident only received pain medication before being sent to dialysis. Staff 23 stated the resident received her/his morning medications once she/he returned from dialysis. On 1/16/25 at 1:28 PM, Staff 22 (LPN) stated Resident 50 did not receive her/his morning medications on dialysis days until the resident returned from the dialysis unit. Staff 22 stated this was a concern and the resident's medication times needed to be adjusted. Staff 22 stated the resident did not have any side effects due to the medications not being administered on dialysis days, to her knowledge. On 1/17/25 at 9:51 AM, Staff 21 (CMA) stated when she arrived on shift, Resident 50 was gone for dialysis, and she saved the resident's medications until she/he returned from the dialysis center. Staff 21 stated she was told by a nurse to chart the medications as out or check off as administered because the medications would show late in the electronic system. On 1/17/25 at 10:31 AM, Staff 3 (RNCM) and at 11:39 AM, Staff 2 (DNS) stated both were unaware Resident 50 did not receive her/his scheduled morning medications until after she/he returned from dialysis. Staff 3 stated staff were expected to seek clarification regarding Resident 50's medications on her/his dialysis days, and acknowledged multiple medications were either not given or received after the resident returned from dialysis. b. A review of 15 Pre/Post Dialysis Communication forms from 12/24/24 through 1/16/25 revealed multiple instances when the dialysis forms were either inaccurate, not completed or not returned from the dialysis center. On 1/15/25 at 5:15 AM, Staff 25 (LPN) stated Resident 50 attended dialysis on Tuesday, Thursday, and Saturday. The resident took a dialysis communication book with her/him to dialysis. Staff 25 stated the forms were to be completed and placed back in the communication book; however this did not always occur. (continued on next page)

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Cedar Crossings	6003 SE 136th Avenue Portland, OR 97236

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 1/16/25 from 5:00 AM through 5:40 AM, Resident 50 was up, dressed and stopped at the nurses station. Staff 23 (LPN) handed Resident 50 the communication binder and the resident sat in the front lobby until her/his ride arrived at 5:40 AM. On 1/16/25 at 11:26 AM, Resident 50 was observed returning from her/his dialysis treatment and stated she/he took the communication binder prior to her/him leaving the facility on Tuesday, Thursday, and Saturday. Resident 50 returned to the facility, and the communication binder was in a basket on her/his front wheeled walker. On 1/16/25 at 7:32 AM, Staff 23 (LPN) and at 1:28 PM, Staff 22 (LPN) both stated the communication binder forms were not always accurate or completed because they had two different forms available to use. Staff 22 stated the forms in the dialysis binder were to be transcribed and then given to medical records to upload in the electronic system. On 1/17/25 at 9:31 AM, Staff 3 (RNCM) and at 11:39 AM, Staff 2 (DNS), both acknowledged the Dialysis Communication Forms were inaccurate. Staff 2 stated staff were expected to complete the dialysis form in the electronic system, print it out, and place the form in the dialysis communication binder. Staff were to ensure all information was compete and accurate.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36494 Based on interview and record review the facility failed to provide sufficient nursing staff to ensure residents attained or maintained their highest practicable mental, physical, and psychosocial well-being for 5 of 9 sampled residents (#s 2, 8, 22, 26 and 57) reviewed for call light wait times and staffing. This placed residents at risk for lack of ADL care needs. Findings include: a. Resident 26 was admitted to the facility in 2/2023 with diagnoses including morbid obesity and diabetes. On 1/13/25 at 10:34 AM, Resident 26 stated call light response times took 45 minutes. Resident 26 stated she/he needed assistance with ADL care. Resident 26's call light response logs from 1/1/25 through 1/14/25 revealed six times when the the response time was 16 to 30 minutes, and six times when the response time was greater than 30 minutes. b. Resident 22 was admitted to the facility in 10/2024 with diagnoses including morbid obesity and right leg lower amputation. On 1/13/25 at 1:00 PM, Resident 22 stated she/he needed assistance to change her/his brief and staff could take 30 minutes or up to an hour to respond to her/his call light. Resident 22 stated she/he sat in a wet and soiled brief on more than one occasion due to long call light response times. Resident 22's call light response logs from 12/24/25 through 1/13/25 revealed seven times when the the response time was 16 to 30 minutes, and three times when the response time was greater than 30 minutes. c. Resident 57 was admitted to the facility in 7/2024 with diagnoses including lung and brain cancer. On 1/13/25 at 3:53 PM, Witness 3 (Complainant) stated Resident 57's call light was activated for 30 minutes or longer before the resident received assistance; and that happened on more than one occasion. Witness 3 stated the resident attempted to remove her/his own brief due to long call light response times. Resident 57's call light response logs from 11/20/24 through 1/7/25 revealed six times when the the response time was 16 to 30 minutes. d. Resident 2 was admitted to the facility in 4/2022 with diagnoses including diabetes. On 1/14/25 at 10:30 AM, Resident 2 stated call light response times were long and she/he was not always changed timely. Resident 2 stated staff turned her/his call light off and indicated they would be back but did not return. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's call light response logs from 12/24/25 through 1/13/25 revealed 16 times when the the response time was 16 to 30 minutes, and three times when the response time was greater than 30 minutes. e. Resident 8 was admitted to the facility in 5/2024 with diagnoses including morbid obesity and diabetes. On 1/14/25 at 10:48 AM, Resident 8 stated call light response times were excessively long; sometimes over two hours. Resident 8's call light response logs from 12/24/25 through 1/13/25 revealed 17 times when the the response time was 16 to 30 minutes, and 10 times when the response time was greater than 30 minutes. f. Interviews with staff revealed the following: -On 1/14/24 at 2:50 PM, Staff 28 (CNA) stated call light response times were longer when the facility was short staffed, which occurred, on occasion. -On 1/15/25 at 5:40 PM, Staff 38 (CNA) stated call light response times were longer to answer when the facility was short staffed which occurred occasionally. Staff 38 stated not all staff assisted with answering call lights. -On 1/17/25 at 10:41 AM, Staff 39 (CNA) stated call light response times could be greater than 20 minutes when the facility was short staffed. On 1/17/25 at 1:23 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated staff were expected to answer call lights under 20 minutes and all staff were responsible for answering call lights. Staff 1 and Staff 2 acknowledged the long call light response times for residents 2, 8, 22, 26 and 57. g. A review of the facility's Direct Care Staff Daily Reports from 11/15/24 through 1/12/25 revealed the facility did not meet mandatory state minimum CNA ratios for one or more shifts on the following dates: 12/12/24: Day shift. 12/18/24: Day shift. 12/22/24: Day shift. 12/24/24: Day shift. 12/26/24: Day shift. 12/29/24: Day shift. 12/30/24: Day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 12:51 PM, Staff 7 (Staffing Coordinator) stated at times it was difficult to cover shifts, especially when staff called at the last moment. Staff 7 stated she tried her best to ensure the facility met the state CNA minimum ratio. On 1/17/25 at 1:23 PM, Staff 1 (Administrator) and Staff 2 (DNS) were present for an interview. Staff 1 and Staff 2 acknowledged the above dates and stated the facility struggled at times meeting the state CNA minimum ratios. h. A list was provided from 11/2024 through 1/2025, which revealed the facility fluctuated between four to five bariatric residents. Review of the Direct Care Staff Daily Reports from 11/15/24 through 1/12/25 revealed the following dates when state bariatric staffing ratios were not met: 12/16/24: Day shift and Evening shift. 12/17/24: Day shift. 12/18/24: Day shift. 12/20/24: Day shift and Evening shift. 12/21/24: Evening shift. 12/22/24: Day shift. 12/24/24: Day shift and Evening shift. 12/25/24 Day shift. 12/26/24: Day shift. 12/28/24: Day shift and Evening shift. 12/29/24: Day shift. 12/30/24: Day shift. 12/31/24: Day shift. 1/1/25: Day shift and Evening shift. On 1/16/25 at 12:51 PM, Staff 7 (Staffing Coordinator) stated at times it was difficult to cover shifts, especially when staff called at the last moment. Staff 7 stated she tried her best to ensure the facility meets the state bariatric minimum ratio but was not always successful. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/25 at 1:23 PM, Staff 1 (Administrator) and Staff 2 (DNS) were present for an interview. Staff 1 and Staff 2 acknowledged the lack of coverage regarding the 14 days. Staff 1 and Staff 2 stated the facility struggled at times meeting the state bariatric minimum ratios.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36494 Based on interview and record review it was determined the facility failed to ensure each CNA received annual performance reviews for 5 of 5 randomly selected CNAs (#s 14, 15, 16, 17, and 18) reviewed for staffing. This failure placed residents at risk for lack of care by competent staff. Findings include: On 1/16/25 at 1:00 PM, Staff 2 (DNS) was asked for the annual performance reviews for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18. A review of the personnel profile records for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18 revealed no annual performance reviews were completed. On 1/16/25 at 1:22 PM, and 1/17/25 at 1:23 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 2 stated if there was nothing located in the personnel profile folders, the annual performance reviews were not completed. Staff 1 and Staff 2 acknowledged the annual performance reviews were not completed for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41458 Based on interview and record review it was determined the facility failed to ensure pharmacist recommendations were addressed for 1 of 5 sampled residents (#66) reviewed for unnecessary medications. This placed residents at risk for receiving ineffective or unnecessary medications. Findings include: Resident 66 was admitted to the facility in 9/2024 with diagnoses including insomnia. The 11/2024 Monthly Pharmacist Review of Resident 66's medication regimen revealed the following: -On 11/27/24 the pharmacist's recommendation advised the prescriber to reassess Resident 66's Melatonin 1 mg at bedtime (helps regulate sleep) and determine if the resident would benefit from an increase to 3 mg due to Resident 66 sleeping between one and four hours per night. Resident 66's clinical record revealed no indication the pharmacist's recommendation to increase the resident's Melatonin was addressed. On 1/15/25 at 11:42 AM Staff 4 (RNCM) reported she did not receive any follow up to Resident 66's 11/27/24 pharmacist recommendation to increase the resident's Melatonin from 1 mg to 3 mg. On 1/15/25 at 2:09 PM Staff 2 (DNS) confirmed the facility did not receive a response from Resident 66's provider regarding the 11/27/24 pharmacist's recommendation. Staff 2 reported the provider did not consistently respond to pharmacist recommendations which caused delays in follow up.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50926 Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals were secured and not expired for 3 of 4 medication carts reviewed for medication storage. This placed residents at risk for adverse medication effects. Findings include: The facility's Storage of Medication Policy, dated [DATE], states the facility drugs and biologicals will be stored in locked compartments, drugs with missing, incomplete, improper, or incorrect labels would be returned to the pharmacy, and discontinued or outdated drugs would be returned or destroyed. On [DATE] at 5:26 AM, during an observation of the [NAME] Hall diabetic/treatment cart assisted by Staff 23 (LPN) the following items were identified: -Naloxone Nasal Spray Pharmacy Label had an expiration date of [DATE]. -Lantus (Glargine) insulin vial was opened. No open date was written on the supplied label. The pharmacy fill date was [DATE]. This type of insulin had a 28-day use by date after opening. -An unlabeled and opened bottle of insulin was found in a plastic cup in the cart with a resident name on it. There was no opened date on the vial. -A Humulin Kwik Pen was found, it was unlabeled. The open date written on the pen was ,d+[DATE]. This type of insulin had a 28-day use by date after opening. -An unlabeled tube of Solosite Wound Treatment Gel with an expiration date [DATE]. On [DATE] at 8:12 AM, The [NAME] Hall medication cart was observed outside of the dining room, unlocked and unattended. Several staff members and a resident walked past the unlocked cart. At 8:24 AM Staff 5 (LPN Resident Care Manager) acknowledged the medication cart was unlocked and was to be secured when not in use. On [DATE] at 8:30 AM, a review of the medication cart on [NAME] Hall revealed a medication storage card containing Lorazepam 1 mg tablets for a resident who no longer had an order for the medication and three loose tablets of an unknown ingredient found in the bottom of the medication drawer. Staff 5 confirmed the medications should have been destroyed. On [DATE] at 8:37 AM, an observation of the diabetic/treatment cart on [NAME] Hall revealed multiple opened medicated creams and ointments with no opened dates written on the provided labels. Staff 5 was uncertain if open dates were required. On [DATE] at 12:59 PM, during a review of the findings with Staff 2 (DNS), she stated she expected staff to properly store, label and destroy medications and biologicals according to the facility policy.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 46053 Based on observation, interview and record review it was determined the facility failed to provide dental services for 1 of 1 sampled resident (#36) reviewed for dental care needs. This placed residents at risk for unmet dental needs. Findings include: Resident 36 was admitted to the facility in 1/2024 with diagnoses including dysphagia (inability to chew and swallow safely) and pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit. A review of Resident 36's 11/9/24 Significant Change MDS revealed she/he had severe cognitive impairment, her/his own teeth that were not broken or decayed, did not wear dentures and required substantial to maximal physical assistance to perform oral hygiene. A review of Resident 36's clinical record revealed no indication the resident was seen by a dentist since admission to the facility. On 1/13/25 at 12:27 PM and 1/14/25 at 2:14 PM Resident 36 was observed to have jagged, broken and decayed teeth. She/he also had thick accumulations of oral secretions on her/his teeth and gums. On 1/14/25 at 8:59 AM Witness 1 (Family Member) stated he noticed a lot of buildup on Resident 36's teeth. He also stated he thought the caregivers swabbed Resident 36's teeth rather than brushing them. He reported he told facility staff Resident 36 needed dental care but it was not provided. On 1/17/25 at 8:23 AM Staff 19 (CNA) stated she swabbed Resident 36's teeth but did not use the sponge toothbrush much because Resident 36 was at risk of choking. On 1/17/25 at 8:30 AM Staff 20 (RN) stated the caregivers tried to clean Resident 36's mouth but she never looked at her/his teeth closely. She also reported the last time a dentist visited the facility was about a week ago and stated the dentist did not see Resident 36. On 1/17/25 at 9:32 AM Staff 2 (DNS) confirmed Resident 36's 11/9/24 MDS was inaccurate and she/he needed dental care. She added she expected dental needs to be identified timely.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 46053 Based on observation, interview and record review it was determined the facility failed to ensure waste was properly contained in dumpsters and the garbage storage area was maintained in a sanitary condition for 1 of 1 garbage area reviewed for kitchen sanitation. This placed residents at risk for potential exposure to pathogens related to the harborage and feeding of pests. Findings include: The facility's Food-Related Garbage and Refuse Disposal Policy dated October 2017 outlined the following: - Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. - Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. On 1/13/25 at 9:15 AM the outside dumpsters adjacent to the kitchen door to the parking lot were observed to be uncovered with garbage bags full of kitchen and resident care waste spilling over and covering the ground around the dumpsters. A minimum of 20 bags of garbage were piled on the ground in the parking lot in front of the dumpsters. On 1/13/25 at 9:36 AM Staff 9 (Dietary Manager) acknowledged the garbage was on the ground rather than in the bins with the lids closed. She stated the garbage collection usually occured three times each week and the garbage overflowing the dumpsters accumulated since the previous week. She reported an additional dumpster was ordered to contain the additional garbage because the facility's garbage needed to be contained in closed dumpsters. On 1/16/25 at 3:03 PM Staff 10 (Maintenance Director) stated he expected the facility's garbage to be contained within the dumpsters provided and an additional dumpster was being used to contain all of the garbage. He confirmed the facility's policy to maintain the area around the dumpsters clear of garbage bags and debris to limit its accessibility to pests. He stated staff was educated regarding the importance of keeping the garbage in the dumpsters with the lids closed and added the facility also had a tall bin to serve as an overflow dumpster. On 1/17/25 at 9:40 AM Staff 2 (DNS) stated she expected the facility's garbage to be contained in the dumpsters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46053 Based on observation, interview and record review it was determined the facility failed to follow infection control practices for 2 of 4 sampled residents (#s 36 and 49) reviewed for infection control. This placed residents at risk for cross contamination. Findings include: 1. Resident 36 was admitted to the facility in 1/2024 with diagnoses including dysphagia (inability to chew and swallow safely) and pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit. A review of Resident 36's 11/9/24 Significant Change MDS revealed she/he had severe cognitive impairment and required substantial to maximal physical assistance to complete toileting hygiene. Resident 36's care plan and signed physician's orders indicated staff were to follow enhanced barrier precautions when providing her/him care that involved physical contact. A sign posted on the outside of Resident 36's room outlined the following information and guidance: - Everyone must clean their hands, including before entering and when leaving the room. - Providers and staff must also wear gloves and a gown for changing linens, providing hygiene and changing briefs or assisting with toileting. On 1/15/25 at 10:39 AM Resident 36 was observed to walk to the door of her/his room wearing a T-shirt and a brief. The brief was visibly soiled with a bowel movement. Staff 20 (RN) approached Resident 36 and accompanied her/him back to her/his bed. Staff 20 drew the curtain closed around the bed, exited the room and called for CNA assistance. On 1/15/25 at 10:49 AM Staff 35 (CNA) entered Resident 36's room without donning a mask or gown from the PPE kit positioned in the hallway outside of Resident 36's room. Staff 35 performed hand hygiene and closed the door. On 1/15/25 at 11:10 AM Staff 35 exited Resident 36's room. He reported he provided toileting hygiene assistance by changing her/his brief. He also stated he cleaned and changed anything that could have been soiled including the sheets and [her/his] pillow case. Staff 35 stated he did not wear a gown to provide these cares but reported, Normally I totally would wear a gown and gloves when doing it for him. On 1/15/25 at 11:12 AM Staff 20 stated she expected all staff who provided hands-on care for Resident 36 to follow enhanced barrier precautions because she/he has a PEG tube (a feeding tube that is surgically inserted through the skin and stomach wall into the stomach). On 1/17/25 at 9:45 AM Staff 2 (DNS) stated she expected staff to follow enhanced barrier precautions when providing any cares that could result in exposure to Resident 36's PEG tube. 43691 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 49 was admitted to the facility in 12/2024 with diagnoses including chronic obstructive pulmonary disease. A physician order from 12/20/24 included Resident 49 was to have a Foley catheter to assist with bladder elimination. On 1/13/25 at 10:49 AM Resident 49 was observed in her/his room. Resident 49 was observed to have a catheter. No instructions regarding enhanced barrier precautions were observed outside of Resident 49's room. On 1/13/25 at 12:15 PM Staff 41 (CNA) was observed entering and exiting Resident 49's room. Staff 41 stated they were providing hands on care to Resident 49 which included a brief change. Staff 41 stated gloves were worn but no additional PPE was worn when providing hands on care for Resident 49. On 1/16/25 at 8:51 AM Staff 8 (Infection Preventionist) stated enhanced barrier precautions were to be followed when hands on care was provided to Resident 49 due to her/him having a Foley catheter. Staff 8 confirmed enhanced barrier precautions were not followed as required for Resident 49. On 1/16/25 at 9:08 AM Staff 1 (Administrator) confirmed enhanced barrier precautions were to be followed with Resident 49 due to the use of a Foley catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385284	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crossings	6003 SE 136th Avenue Portland, OR 97236

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 36494 Based on interview and record review it was determined the facility failed to have a system in place to ensure CNA staff received 12 hours of in-service training annually for 5 of 5 randomly selected staff members (#s 14, 15, 16, 17, and 18) reviewed for in-service training. This placed residents at risk for lack of competent staff. Findings include: On 1/16/25 at 1:00 PM, Staff 2 (DNS) was asked for a list of training hours for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18. A review of the personal profile records for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18 revealed no training hours were completed. On 1/16/25 at 1:22 PM, and 1/17/25 at 1:23 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 2 stated if there was nothing located in the personal profile folders, the 12 hours of in-service training annually was not completed. Staff 1 and Staff 2 acknowledged the 12 hour in-service training were not completed for Staff 14, Staff 15, Staff 16, Staff 17, and Staff 18.