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	05/22/2026

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 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** Based on observation, interview, and record review it was determined the facility failed to ensure proper labeling of biologicals for 1 of 2 medication rooms, and failed to ensure medication and medication carts were properly secured for 4 of 4 random observations of medication carts reviewed for medication storage. This placed residents at risk for reduced efficacy of medication and unauthorized access to medications. Findings include:1. On 5/20/26 continuous observations were made from 11:44 AM to 11:49 AM of the medication cart on [NAME] Hall. The cart was observed to be unlocked and unattended. On 5/20/26 at 11:49 AM Staff 4 (CMA) acknowledged the medication cart was unlocked, unattended and contained resident medications. On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for medication carts to be locked when unattended.2. On 5/21/26 continuous observations were made from 1:01 PM to 1:02 PM of the medication cart on [NAME] Hall. The cart was observed to be unlocked and unattended.On 5/21/26 at 1:02 PM Staff 10 (LPN) acknowledged the medication cart was unlocked, unattended and contained resident medications. On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for medication carts to be locked when unattended.3. On 5/22/26 continuous observations were made from 8:35 AM to 8:36 AM of the medication cart on [NAME] Hall. The medication cart was unattended, the key was hanging out of the narcotic drawer, and there was a medication cup full of pills sitting on top of the cart.On 5/22/26 at 8:36 AM Staff 11 (RN) acknowledged the key was hanging out of the narcotic drawer, there was a medication cup full of pills sitting on top of the cart and the cart was left unattended.On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for medications and medication carts to be locked when unattended.4. On 5/22/26 at 9:49 AM the [NAME] Hall medication cart was observed to be unlocked and unattended. Staff 11 (RN) was observed to enter a resident's room.On 5/22/26 at 9:49 AM Staff 11 returned to the medication cart and acknowledged the medication cart was unlocked and unattended and contained resident medications. On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for medication carts to be locked when unattended.5. On 5/21/26 at 10:59 AM one open, undated, vial of tuberculin (used for the testing in the diagnosis of Tuberculosis) was observed in the [NAME]/[NAME] Hall medication room refrigerator.The manufacturer's instructions indicated to discard the medication 30 days after opening. On 5/21/26 at 10:59 AM Staff 3 (LPN) acknowledged the vial of tuberculin was open and not labeled with an open date. On 5/21/26 at 1:30 PM Staff 2 (DNS) stated the expectation was for tuberculin to be labeled with an open date.

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 - Few	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. Based on observation, interview and record review it was determined the facility failed to maintain a homelike environment for 1 of 3 sampled residents (#44) reviewed for environment. This placed residents at risk for an unsafe and unkempt physical environment. Findings include:Resident 44 admitted to the facility in 3/2025 with diagnoses including schizophrenia. Maintenance requests reviewed from 3/2026 to 5/2026 indicated there was no damaged furniture in Resident 44's room that required repairment. On 5/18/26 at 2:20 PM the closet in Resident 44's room was observed to have a broken bottom drawer, which was unsecured on the bottom level of the closet and no longer attached to the frame. On 5/21/26 at 10:50 AM Staff 14 (CNA) stated she was aware Resident 44's closet had a broken bottom drawer. Staff 14 stated the drawer was broken for approximately six weeks.On 5/21/26 at 11:11 AM Staff 15 (Maintenance Director) stated nursing staff were expected to complete an electronic maintenance request when they were aware of damaged furniture in a resident's room. Staff 15 stated he was unaware of damaged furniture in Resident 44's room. Staff 15 acknowledged Resident 44's closet was in disrepair and the broken drawer needed to be removed. On 5/22/26 at 12:03 PM Staff 1 (Administrator) confirmed Resident 44's closet was in disrepair and not reported to maintenance staff or repaired in a timely manner.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure gradual dose reductions were completed when indicated for 1 of 5 sampled residents (#1) reviewed for medications. This placed residents at risk for adverse side effects of psychotropic medication. Findings include: Resident 1 was readmitted to the facility in 3/2026 with diagnoses including depression and insomnia.Resident 1 had a physician order dated 3/27/26 for trazodone 50 mg. The order indicated, Give 1 tablet by mouth at bedtime for insomnia, which was discontinued on 4/6/26. A new physician order dated 4/6/26 for trazodone 50 mg stated, Give 50 mg by mouth at bedtime related to depression.Resident 1's MAR indicated the medication was documented as administered to Resident 1 from 4/6/26 through 5/21/26.Resident 1's 4/21/26 Psychoactive Drug Review indicated the Interdisciplinary Team (IDT) recommended a gradual dose reduction (GDR) to decrease trazodone from 50 mg to 25 mg and to change the diagnosis for use of trazodone from insomnia to depression. The review indicated the physician verbally agreed with the plan.On 5/22/26 at 9:32 AM, Staff 2 (DNS) stated that the GDR for Resident 1's trazodone was not completed. Staff 2 stated she thought the medication was changed but was unable to find documentation that the GDR was implemented and indicated she would follow up immediately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to complete a baseline care plan within 48 hours of a resident's admission for 1 of 5 sampled residents (#40) reviewed for medications. This placed residents at risk for unmet basic care needs. Findings include:Resident 40 admitted to the facility on [DATE] with diagnoses including muscle weakness and the need for assistance with personal care.A review of Resident 40's record revealed the baseline care plan was not completed until 4/14/26; 13 days after admission.On 5/22/26 at 9:24 AM Staff 12 (LPN Resident Care Manager) stated upon admission the charge nurse initiated the baseline care plan which included a residents ADLs and expected it to be completed within 72 hours of the resident's admission.On 5/22/26 at 10:36 AM Staff 2 (DNS) stated a baseline care plan included information about the resident's ADLs, nutrition, skin, pain, and fall risk. Staff 2 stated she expected the baseline care plan to be completed within 48 hours of a resident's admission and acknowledged Resident 40's baseline care plan was completed 13 days after admission.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review it was determined the facility failed to ensure residents received an assistive device to maintain vision ability for 1 of 1 resident (#48) reviewed for vision. This placed residents at risk for increased visual deficits. Findings include:Resident 48 was admitted to the facility in 2025 with diagnoses including diabetes and hypertension.The 4/21/25 Care Plan indicated Resident 48 had a vision deficit related to decreased visual acuity. Interventions included ensuring eyeglasses were clean, appropriate and being worn.A 12/9/25 provider vision progress note indicated an eye exam was completed for an evaluation of cataract with blurry vision to both the right and left eye. The evaluation indicated glasses were prescribed and would be shipped to the facility two weeks from receipt of payment.On 5/18/26 at 1:44 PM and 5/21/26 at 1:52 PM Resident 48 stated she/he saw the eye doctor in January and received a new prescription for glasses but hadn't received any glasses yet. Resident 48 stated she/he could barely see out of the glasses she/he currently wore and had to get really close to the TV. Resident 48 stated she/he had been waiting months and did not know where her/his new glasses were.A 5/21/26 physician visit progress note indicated Resident 48's chief complaint included poor vision. The resident had an eye exam in January and ordered glasses but did not receive them. The progress note indicated the plan related to Resident 48's visual loss was to follow up on the eyeglasses.On 5/21/26 at 10:03 AM Staff 8 (SSD) and Staff 9 (Social Services Coordinator) stated once an eye exam was completed and it was determined glasses were needed, the facility received an invoice from the optometrist. The invoice was then given to the resident by Social Services to inform them of the cost. Staff 8 stated she never received any invoice from Resident 48's 12/9/25 vision exam and acknowledged no follow up was done.On 5/22/26 at 11:11 AM Staff 1 provided Resident 48's invoice for a new prescription for eyeglasses. Staff 1 (Administrator) stated the invoice for Resident 48's new glasses was just now received and the facility did not assist with obtaining glasses in a timely manner.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure resident narcotic drug records were in order and an account of all controlled drugs was maintained for 1 of 4 medication carts reviewed for medication storage. This placed residents at risk for inaccurate clinical records related to narcotics and drug diversion. Findings include:1. On 5/20/26 at 9:06 AM the [NAME] Hall Controlled Substance Book was reviewed with Staff 6 (LPN). There were no signatures observed for the 5/20/26 day shift controlled medication count. Staff 6 stated she did not count the controlled medications with another staff before coming on shift.On 5/20/26 at 7:05 PM Staff 5 (LPN) stated he worked night shift on 5/19/26 and did not count controlled medications with staff before leaving the facility.On 5/21/26 at 1:30 PM Staff 2 (DNS) stated the expectation was for two staff to count controlled medications between shifts, compare them to the Controlled Substance Book and sign the signature page after the count was completed.2. On 5/20/26 at 9:06 AM Staff 6 (LPN) was observed to compare the actual controlled medications present in the cart to the Controlled Substance Book on [NAME] Hall. There was a discrepancy on page five between the medication card and the Controlled Substance Book. Page five indicated there were three Norco (narcotic pain medication) tabs remaining and the medication card indicated there were two tabs remaining. Staff 6 stated Staff 5 did not update the Controlled Substance Book. On 5/20/26 at 7:05 PM Staff 5 (LPN) stated he worked on 5/19/26 night shift and administered Norco to a resident. Staff 5 stated he did not record the Norco administration in the controlled substance book.On 5/21/26 at 1:30 PM Staff 2 (DNS) stated the expectation was for each responsible staff to count controlled medications between shifts and compare them to the Controlled Substance Book to ensure accuracy.

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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. Based on interview and record review it was determined the facility failed to ensure pharmacist recommendations were addressed for 2 of 5 sampled residents (#s 1 and 10) reviewed for unnecessary medications. This placed residents at risk for receiving ineffective or unnecessary medications. Findings include:1. Resident 1 was readmitted to the facility in 3/2026 with diagnoses including chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe) and depression.A pharmacist recommendation dated 4/17/26 for Resident 1 indicated, This resident is currently receiving the antipsychotic medication Abilify (aripiprazole) for a diagnosis noted on the MAR of depression. Would recommend monitoring for movement disorders such as Extrapyramidal Side Effects and Tardive Dyskinesia with AIMS (Abnormal Involuntary Movement Scale) testing upon initiation of antipsychotic medications, and also during dosage changes and then every 6 months. I was unable to locate in the chart where AIMS testing had been completed.A second pharmacist recommendation dated 5/9/26 included the same recommendation. The 5/9/26 recommendation had AIMS Completed handwritten on it; however, there was no date or signature documented.A review of Resident 1's medical record revealed no documentation that an AIMS assessment was completed for Resident 1 prior to 5/21/26.On 5/21/26 at 11:29 AM, Staff 2 (DNS) stated the facility typically attempted to address pharmacist recommendations quickly, generally within 72 hours, and had nursing staff and physicians complete the recommended actions. Staff 2 stated the recommendation for Resident 1's AIMS assessment and monitoring must have fallen through the cracks on both 4/17/26 and 5/9/26. Staff 2 acknowledged the AIMS assessment was not completed.2. Resident 10 was admitted to the facility in 3/2025 with diagnoses including type 1 diabetes mellitus with ketoacidosis without coma (a severe lack of insulin that forces the body to burn fat for energy).A pharmacist recommendation dated 4/17/26 for Resident 10 indicated, Please clarify resident's order for Venlafaxine (antidepressant) 75 mg as the order on the MAR indicates ?one tablet once a day' as well as ?one tablet two times a day'. Charting on MAR indicates this medication is only being given once daily. In review of Resident 10's 04/26 and 5/25 MAR Resident 10 had been receiving Venlafaxine 75 mg once a day.The pharmacist recommendation was not addressed until 5/19/26. The pharmacist communication dated 5/19/26 indicated, Give 1x daily, Order 1x daily verified and clarified.A progress note dated 5/19/26 at 1:50 PM indicated the medication was changed to once daily per MD order. On 5/21/26 at 11:29 AM, Staff 2 stated the facility typically attempted to address pharmacist recommendations quickly, generally within 72 hours, and had nursing staff and physicians complete the recommended actions. Staff 2 stated she noticed the recommendation on 5/19/26 when pharmacy recommendations were requested for Resident 10 and addressed the recommendation at that time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure resident medical records were kept secured and confidential for 2 of 2 random observations. This placed residents at risk for lack of privacy and confidentiality. Findings include: 1. On 5/21/26 continuous observations were made from 1:01 PM to 1:02 PM of the medication cart on [NAME] Hall. The cart was observed to be unattended, the computer screen was open and displayed resident information.On 5/21/26 at 1:02 PM Staff 10 (LPN) acknowledged the medication cart was left unattended and the computer screen displayed resident information.On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for staff to lock the computer screen when the computer was unattended.2. On 5/22/26 at 9:49 AM the [NAME] Hall medication cart was observed to be unattended, the computer screen was open and displayed resident information. Staff 11 (RN) was observed to enter a resident's room.On 5/22/26 at 9:49 AM Staff 11 returned to the medication cart and acknowledged the medication cart was left unattended and the computer screen displayed resident information.On 5/22/26 at 10:05 AM Staff 2 (DNS) stated the expectation was for staff to lock the computer screen when it was unattended.