

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER Village Manor of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 NE 238th Drive Wood Village, OR 97060	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001</p> <p>Based on interviews and record review, it was determined the facility failed to protect the resident's right to be free from physical abuse from other residents for 1 of 6 sampled residents (#52) reviewed for abuse. This placed residents at risk for physical abuse. Findings include:</p> <p>Resident 49 was admitted to the facility in 5/2023 with diagnoses including schizoaffective disorder (a mental health condition where a person experiences symptoms of schizophrenia, such as hallucinations and delusions, and a mood disorder, such as mania or depression).</p> <p>Resident 52 was admitted to the facility in 1/2024 with diagnoses including psychosis (a state where a person loses touch with reality, experiencing hallucinations and delusions).</p> <p>On 1/22/25 a Facility Reported Incident (FRI) was received by the State Survey Agency, which alleged Resident 49 slapped Resident 52 on the left side of her/his face.</p> <p>A 1/22/25 Progress Note indicated Resident 49 hit Resident 52 in the face.</p> <p>A 1/27/25 facility investigation revealed on 1/22/25 at 4:30 AM staff heard yelling from room [ROOM NUMBER] and found Resident 49 standing over Resident 52's bed yelling at her/him. Staff got in between the residents and kept them separated until EMTs arrived. Resident 49 was sent to the hospital.</p> <p>On 5/6/25 at 8:41 AM Resident 52 revealed on 1/22/25 in the middle of the night, she/he was woken up by Resident 49 hitting her/him. Resident 52 stated she/he sat up in bed and kicked Resident 49 away from her/him. Resident 52 stated staff came in and kept Resident 49 away from her/him until Resident 49 left with EMTs. Resident 52 denied injury from the incident and stated Resident 49 was moved to a new room because Resident 52 was not comfortable sleeping in the same room as Resident 49.</p> <p>Resident 49 refused to be interviewed.</p> <p>On 5/8/25 at 1:16 PM Staff 26 (RN) stated Resident 49 had an incident a few months ago where she/he hit Resident 52 while Resident 52 was sleeping. Staff 26 stated Resident 52 had no injuries from the incident. However, Resident 52 expressed feeling scared about sleeping in the same room as Resident 49, so Resident 49 was moved to a new room.</p> <p>(continued on next page)</p>

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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NAME OF PROVIDER OR SUPPLIER Village Manor of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 NE 238th Drive Wood Village, OR 97060	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/8/25 at 1:24 PM Staff 4 (RNCM) stated there was an incident between Resident 49 and Resident 52 in 1/2025. Staff 4 stated Resident 49 hit Resident 52 in the face while Resident 52 was sleeping. Staff 4 stated after the incident, Resident 49 was placed on a psychiatric hold for medication adjustment and when Resident 49 returned to the facility, she/he was moved to a new room.</p> <p>On 5/9/25 at 11:48 AM Staff 2 (DNS) acknowledged the incident between Resident 49 and Resident 52 occurred and the incident met the definition of abuse.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to report an allegation of abuse to the State Agency (SA) within the mandated timeframe for 1 of 6 sampled residents (#2) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>The facility's Freedom from Abuse, Neglect and Exploitation policy, last revised 8/1/23, indicated the following:</p> <p>-Allegations of verbal, sexual, physical, mental, corporal punishment, involuntary seclusion, and neglect of the resident, as well as mistreatment, injuries of unknown source, exploitation, deprivation of goods and services by staff, and misappropriation of resident property are reported to the administrator immediately and the state agency within two hours if there was alleged abuse or serious bodily injury as a result of an event.</p> <p>Resident 2 was admitted to the facility in 10/2019 with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and history of traumatic brain injury.</p> <p>Resident 59 was admitted to the facility in 4/2025 with diagnoses including dementia and delirium (a disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings).</p> <p>The facility's FRI received on 4/20/25 at 11:14 PM, revealed on 4/20/25 at 4:50 PM, Resident 59 forcefully shoved Resident 2 against the wall, staff intervened, separated the residents and escorted Resident 2 to her/his room.</p> <p>On 5/8/25 at 10:20 AM, Staff 20 (LPN) stated around 4:50 PM, Resident 2 attempted to walk past Resident 59 and Resident 59 charged at Resident 2; pushing her/him into the wall. Resident 59 then took her/his hands and threw Resident 2 into the wall. Staff 20 stated she was a new nurse and had not previously completed a FRI so she contacted Staff 2 (DNS) who provided assistance and later a night shift nurse also helped with the report. As a result, the FRI was not submitted to the SA within the mandated timeframe.</p> <p>On 5/9/25 at 8:22 AM, Staff 2 (DNS) stated Staff 20 was in contact with her several times regarding the incident on 4/20/25 between Resident 2 and Resident 59. Staff 2 acknowledged the FRI was not completed within the mandated timeframe.</p>