STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E174	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Manor of Cascadia	2060 NE 238th Drive Wood Village, OR 97060

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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 - 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. 46491 Based on observation, interview and record review, it was determined the facility failed to maintain a homelike environment for 1 of 1 resident (#9) reviewed for homelike environment. This placed residents at risk for lessened quality of life. Findings include: Resident 9 admitted to the facility in 5/2020 with diagnoses including borderline personality disorder. Resident 9's 2/28/25 care plan found no indication for having a short chain on his/her bedside light. On 5/5/25 at 9:58 AM Resident 9 was observed to have a three to four inch chain on the light on the wall over his/her bed. Resident 9 stated she/he was unable to use it due to the short length and was unable to turn on the light independently. Resident 9 stated she/he became frustrated and had to ring his/her bell to have someone come turn on the light. Resident 9 further stated she/he should be able off her/his own light without assistance. On 5/6/25 at 1:54 PM Staff 30 (CNA) stated she thought Resident 9 was able to turn his/her bedside light on and off with the use of a reacher. On 5/7/25 at 9:36 AM Staff 12 (LPN) stated she did not think Resident 9 was capable of turning the bedside light on or off. However, Resident 9 frequently called for assistance. On 5/7/25 at 10:34 AM Staff 3 (RNCM) stated she was unaware that the bed light was short there was no intentional reason for keeping it short. On 5/7/25 at 11:13 AM Staff 13 (Environmental Services Director) stated the chain was short because Resident 9 had previously pulled on it with his/her body weight to reposition. It was unsafe for him/her to use it that way because it would break and send him/her backwards out of control. Staff 13 was unaware that Resident 9 was not able to turn the light on with the short chain. On 5/7/25 at 2:53 PM Staff 2 (DNS) confirmed Resident 9 should be able to turn on and off the bedside light. She knew it was short, but did not know Resident 9 was unable to turn it on and off without asking for help.

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 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. 46491 Based on interview and record review it was determined the facility failed to ensure residents were free from chemical restraints for 1 of 5 sampled residents (#57) reviewed for unnecessary medications. This placed residents at risk for changes to psychosocial well-being. Findings include: Resident #57 was admitted to the facility in 2/2025 with diagnoses including anxiety, hallucinations, and disorientation. A 3/31/25 physician order indicated Resident 57 was prescribed haloperidol Oral Tablet 5 MG (antipsychotic medication) twice daily as needed for 14 days. The Indication for use was hallucinations. A 4/14/25 physician order indicated Resident 57 was prescribed haloperidol Oral Tablet 5 MG twice daily as needed for 14 days. Indications for use were hallucinations or aggression. A 4/21/25 physician order indicated Resident 57 was prescribed haloperidol Oral Tablet 5 MG twice daily as needed for 14 days. Indications for use were hallucinations or aggression. Resident 57's MAR, behavior monitor and progress notes for 4/2025 and 5/2025 indicated she/he received haloperidol with no indication for use on the following days: 4/2/25 and 4/15/25 Resident 57 received two doses of haloperidol. On 4/3/25, 4/4/25, 4/5/25, 4/8/25, 4/11/25 and 4/14/25, 4/27/25, 4/30/25, 5/1/25 and 5/5/25 she/he receceived a single dose of haloperidol. On 5/8/25 11:55 AM Staff 31 (LPN) stated she was unsure why she would have given haloperidol if Resident 57 was not having behaviors on 4/30/25. She further stated she should have documented the specific behaviors in a progress note but did not. On 5/8/25 01:09 PM Staff 9 (LPN) stated she administered haloperidol on on 4/4/25, 4/5/25 and 4/8/25. because Resident 57 would not sleep for long periods of time. Staff 8 stated stated she should have documented the specific behaviors in a progress note but did not. On 5/8/25 at 1:30 PM Staff 22 (LPN) stated he administered haloperidol for agitation and because Resident 57 was difficult to control. Staff 22 could not specifically remember why he administered haloperidol on 4/11/25. Staff 22 further stated he should have documented the specific behaviors in a progress note but did not. On 5/8/25 at 1:54 PM Staff 19 (LPN) stated she administered haloperidol at the instruction of two other nurses because Resident 57 pulled the fire alarm multiple times on 5/4/25. On 5/8/25 at 2:02 PM Staff 32 (LPN) stated she administered haloperidol on 5/1/25 because Resident 57 thought there were people coming in and out of his/her room and wanted to get up. Staff 32 stated she should have documented whether the administration was effective. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 3:31 PM Staff 28 (LPN) stated she gave haloperidol when Resident 57 had behaviors and agitation and stated he was not aggressive on 4/3/25. She further stated she should have documented the specific behaviors in a progress note but did not. On 5/9/25 at 9:11 AM Staff 2 (DNS) stated Resident 57 was only to receive haloperidol for aggression or hallucinations. Staff 2 stated nurses should have documented the specific hallucinations or aggressive behaviors, as well as all non-pharmacological interventions attempted with Resident 57 prior to the administration of haloperidol, in a progress note. Staff 2 further stated staff should have documented whether the administration was effective in resolving the behaviors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46491 Based on interview, and record review it was determined the facility failed to develop comprehensive care plans that included interventions for the use of psychotropic medication for 1 of 5 sampled resident (#57) reviewed for unnecessary medications. This placed the resident at risk for side effects and unnecessary medication. Findings include: Resident 57 was admitted to the facility in 2/2025 with diagnoses including anxiety, hallucinations and disorientation. A review of Resident 57's physician orders found the following active orders for psychotropic medications: Buspirone HCl oral tablet. Give 15 mg by mouth in the morning for irritability related to anxiety disorder, unspecified and give 15 mg by mouth one time a day for irritability at 4 PM. Do not give at 6 PM per provider. Lamotrigine oral tablet. Give 25 mg by mouth one time a day for mood stabilization related to major depressive disorder, recurrent. Mirtazapine Oral tablet. Give 7.5 mg by mouth one time a day related to insomnia. Duloxetine HCl oral capsule delayed release sprinkle 30 MG. Give 1 capsule by mouth one time a day for mood/depression related to major depressive disorder, recurrent, unspecified. Olanzapine oral tablet disintegrating. Give 15 mg by mouth one time a day related to hallucinations, unspecified. Haloperidol oral tablet. Give 5 mg by mouth as needed for twice daily as needed for hallucinations or aggression for 14 Days. A review of Resident 57's 2/24/25 care plan found no interventions for the use of psychotropic medications. There was no evidence resident-specific interventions for the use of psychotropic medications were developed in Resident 57's health record. On 5/9/25 at 9:11 AM Staff 2 (DNS) confirmed Resident 57's clinical record lacked interventions for the use of psychotropic medication.

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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. 46491 Based on interview and record review it was determined the facility failed to timely assess and implement appropriate interventions for a change of condition or accident for 1 of 1 sampled resident (#27). This placed the residents at risk for choking. Findings include: Resident 27 admitted to the facility in 10/2019 with diagnoses including stroke. Resident 27's 4/20/25 comprehensive assessment noted coughing and choking during meals and when swallowing medications. A 4/18/25 physician orders revealed Resident 27 was on a dental/mechanical soft texture, nectar thick liquids consistency. A 5/2/25 progress note found Resident 27 choked during dinner and the Heimlich maneuver was administered successfully by Staff 28 (LPN). A 5/5/25 physician order revealed Resident 27's diet was changed to a pureed texture, three days after Resident 27's choking episode On 5/8/25 at 3:42 PM Staff 28 stated during dinner on 5/2/25 Resident 27 choked and became very rigid. Staff 28 did the Heimlich maneuver with a CNA and Resident 27 recovered. Staff 28 notified the on-call provider and stated she should have downgraded Resident 27's diet texture to puree at that time but did not. There was no evidence in Resident 27's health record the speech language pathologist was notified after his/her choking episode on 5/2/25. On 5/9/25 at 10:15 AM Staff 30 (Director of Rehabilitation) stated she was not notified until 5/5/25 regarding Resident 27's choking incident, which occurred on 5/2/25 (three days later). She immediately placed orders to downgrade the diet texture to puree and stated she consulted with the speech-language pathologist for safety. Staff 30 stated she would have done so on 5/2/25 if she were notified of the chocking incident. On 5/9/25 at 10:29 AM Staff 2 (DNS) acknowledged Resident 27's diet should have been downgraded immediately after the choking incident on 5/2/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43690 Based on observation, interview and record review it was determined the facility failed to provide care planned safety interventions for 1 of 4 sampled residents (#24) reviewed for accidents. This placed residents at risk for injury. Findings include: Resident 24 was admitted to the facility in 2018 with diagnoses including Wernicke's encephalopathy (a neurological disorder) and dementia. Resident 24's 4/30/25 Quarterly Smoking Evaluation indicated the resident was to use smoking gloves when smoking. A review of Resident 24's 5/2/25 Quarterly MDS Assessment revealed she/he had moderate cognitive impairment. Resident 24's 8/7/22 Care Plan indicated she/he used smoking materials and was to wear smoking gloves when smoking. On 5/6/25 at 8:33 AM Resident 24 was observed smoking in the facility designated smoking area without smoking gloves on. On 5/6/25 at 8:35 AM Resident 24 stated she/he was not wearing her/his smoking gloves because staff did not offer to provide them to her/him. On 5/6/25 at 8:36 AM Staff 18 (CNA) confirmed Resident 24 was smoking without her/his smoking gloves on and stated she/he should have had them on. On 5/6/25 at 8:39 AM Staff 2 (DNS) stated Resident 24 was care planned to wear smoking gloves to prevent her/his knuckles from burns. Staff 2 acknowledged Staff 18 did not offer Resident 24 her/his smoking gloves.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 43690 Based on interview and record review it was determined the facility failed to ensure residents received trauma informed care for 2 of 3 sampled residents (#s 18 and 30) reviewed for behavioral and emotional care needs. This placed residents at risk for re-traumatization. Findings include: The facility's 10/2022 Trauma Informed Care Policy and Procedure revealed the following: -Screen residents for a traumatic event, series of events, or set of circumstances which resulted in actual harm or threat of harm. Determine how the individual perceives the event, as stressful or not. Evaluate how the event adversely impacts the person. -Collaborate with the resident and/or resident advocate to plan for treatment or intervention(s) of resident choice, as indicated and/or appropriate. -Person-centered care planning addresses the following: a. Identify the effects of the trauma on the resident and how that may be manifested in a resident's behavior. b. Address triggers for re-traumatizing and interventions to avoid such an experience, such as loud noises, smells, textures, cold/hot, confinement, invasion of perceived privacy, etc. c. Develop interventions to reduce potential triggers and promote coping techniques. d. Coordinate recovery concepts with counseling and/or therapy, as indicated. 1. Resident 18 was admitted to the facility in 11/2023 with diagnoses including schizophrenia (chronic brain disorder) and PTSD (Post-Traumatic Stress Disorder). Resident 18's 4/7/25 Quarterly MDS indicated the resident was cognitively intact. Resident 18's 4/16/25 Behavior/Psychoactive Quarterly Assessment indicated Resident 18 had auditory hallucinations that bothered her/him and occurred anytime of day. No evidence was found in Resident 18's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 5/7/25 at 8:30 AM Resident 18 stated she/he did not recall if the facility had asked her/him about any triggers she/he had. Resident 18 stated she/he heard voices that would get loud and would cause her/him to scream out for help. On 5/7/25 at 12:55 PM Staff 10 (CNA) and at 1:00 PM Staff 9 (LPN) stated they thought Resident 30 might have PTSD because she/he was a veteran but were unaware if the resident had any triggers. Staff 9 and Staff 10 stated the only behavior Resident 18 displayed was she/he would yell out. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 1:50 PM Staff 6 (Social Services) stated resident trauma screenings were to be completed at the time of admission for all residents. Staff 6 stated a care plan had not been developed related to Resident 18's history of trauma or potential triggers. Staff 6 stated she was not aware if Resident 18 had any triggers. On 5/7/25 at 1:58 PM Staff 2 (DNS) and Staff 7 (Clinical Resources) acknowledged Resident 18 had a diagnosis of PTSD and nothing was implemented related to Resident 18's trauma or her/his trauma triggers. 2. Resident 30 was admitted to the facility in 8/2022 with diagnoses including major depressive disorder and PTSD (Post-Traumatic Stress Disorder). Resident 30's 3/1/25 Quarterly MDS indicated the resident was cognitively intact. No evidence was found in Resident 30's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 5/7/25 at 9:52 AM Staff 8 (Activity Director) stated Resident 30 had a few behaviors and could become frustrated with other residents. Staff 8 stated he thought Resident 30 probably had some triggers and could easily become frustrated or lose her/his patience, but was not aware if the resident had any specific triggers. On 5/7/25 at 10:47 AM Resident 30 stated no one at the facility discussed the cause of her/his PTSD or potential triggers for re-traumatization. Resident 30 stated she/he would easily lose her/his patience with others and become frustrated. When asked what triggered her/his behaviors the resident stated I don't want to talk about it. On 5/7/25 at 12:55 PM, Staff 10 (CNA) and at 1:00 PM Staff 9 (LPN) stated they did not know if Resident 30 had PTSD and were unaware if the resident had any triggers. On 5/7/25 at 1:50 PM Staff 6 (Social Services) stated resident trauma screenings were to be completed at the time of admission for all residents. Staff 6 stated a care plan had not been developed related to Resident 30's history of trauma or potential triggers. Staff 6 stated she was not aware if Resident 30 had any triggers. On 5/7/25 at 1:58 PM Staff 2 (DNS) and Staff 7 (Clinical Resources) acknowledged Resident 30 had a diagnosis of PTSD and nothing was implemented related to Resident 30's trauma or her/his trauma triggers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46491 Based on interview and record review it was determined the facility failed to act upon pharmacist recommendations for 1 of 5 sampled residents (#57) reviewed for unnecessary medications. This placed residents at risk for a decrease in their quality of life. Findings include: Resident 57 was admitted to the facility on ,d+[DATE] with diagnoses including anxiety, hallucinations and disorientation. A review of Resident 57's physician orders found an active order for Olanzapine oral tablet disintegrating (an antipsychotic medication). Give 15 mg by mouth one time a day related to hallucinations. A review of pharmacy recommendations for Resident 57 dated 3/19/25 included the following recommendation for the use of Olanzapine: 'If the antipsychotic order is to continue, please update the medical record to include . a list of symptoms or target behaviors (e.g., hallucinations) including their impact on the resident (e.g., increases distress, presents a danger to the resident or others, interferes with their ability to eat) AND documentation that other causes (e. g., environmental) and medications have been considered, that individualized nonpharmacological interventions are in place and that ongoing monitoring has been ordered.' A review of Resident 57's clinical record lacked specific target behaviors and their impact on the resident, documentation that other causes and medications had been considered and individualize nonpharmacological interventions were in place. There was no evidence in Resident 57's health record that the facility followed up or implemented the pharmacy recommendations. On 5/09/25 at 9:11 AM Staff 2 (DNS) confirmed the pharmacist's recommendation were not followed.

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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. 52549 Based on interview and record review it was determined that the facility failed to ensure residents were free from unnecessary bowel and antihypotensive medications for 2 of 5 sampled resident (#s 20 and 35) reviewed for unnecessary medications. This placed the resident at risk for adverse side effects from medication complications. Findings include: 1. Resident 20 was admitted to the facility in 3/2025 with the diagnosis including hypotension. Resident 20's 3/21/25 through 4/22/25 Physician Orders indicated the resident received midodrine (used to raise blood pressure) three times daily and was to be held for SBP (systolic blood pressure) greater than 120. A review of Resident 20's 3/2025 and 4/2025 MARs revealed Resident 20 received the midodrine on the following dates with the SBP above 120: -3/23/2025 AM dose, SBP was 122. -3/23/2025 AM dose, SBP was 122. -3/24/2025 Mid-day dose, SBP was 121. -3/27/2025 AM dose, SBP was 131. -3/27/2025 Mid-day dose, SBP was 131. -3/27/2025 PM dose, SBP was 130. -3/29/2025 PM dose, SBP was 127. -3/31/2025 PM dose, SBP was 132. -4/11/2025 AM dose, SBP was 146. -4/11/2025 Mid-day dose, SBP was 146. -4/12/2025 PM dose, SBP was 136. -4/14/2025 AM dose, SBP was 145. -4/14/2025 Mid-day dose, SBP was 145. -4/17/2025 AM dose, SBP was 134. -4/17/2025 Mid-day dose, SBP was 134. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/18/2025 AM dose, SBP was 141. -4/18/2025 Mid-day dose, SBP was 141. -4/19/2025 PM dose, SBP was 140. -4/21/2025 PM dose, SBP 137. Resident 20's 4/23/25 through 5/9/25 Physician Orders indicated the resident received midodrine three times daily and was to be held for SBP greater than 130. A review of Resident 20's 4/2025 and 5/2025 MARs revealed Resident 20 received the midodrine on the following dates with the SBP above 130: -4/25/2025 AM dose, SBP 140. -4/25/2025 PM dose, SBP was 140. -5/1/2025 AM dose, SBP was 132. -5/1/2025 Mid-day dose, SBP was 142. -5/2/2025 AM dose, SBP was 138. On 5/8/25 at 9:11 AM Staff 15 (LPN) stated she administered the midodrine medication to Resident 20 on 5/2/25 when she should not have, as her/his SBP above 130. On 5/8/25 at 1:12 PM Staff 24 (LPN) stated Resident 20's midodrine should have been held when her/his SBP above 130. On 5/8/25 at 1:19 PM Staff 2 (DNS) reviewed Resident 20s's MARs from 3/2025, 4/2025, and 5/2025 and acknowledged the medication was given unnecessarily 24 times when it should have been held. 43691 2. Resident 35 was admitted to the facility in 5/2022 with diagnoses including bipolar disorder and a hip fracture. A 3/14/25 physician order stated Resident 35 was to receive two 8.6 mg tablets of senna twice a day for constipation and the medication was to be held for loose stools. The medication was scheduled to be received between 6:00 AM and 10:00 AM for the AM dose and between 4:00 PM and 7:00 PM for the PM dose. Review of Resident 35's 4/2025 and 5/2025 MARs revealed Resident 35 received her/his senna medication twice a day every day from 4/1/25 through 5/7/25. Review of Resident 35's 4/8/25 through 5/7/25 Bowel Movement Consistency records revealed the following errors of administration of senna: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/8/25 at 3:17 AM Resident 35 had a type 7 bowel movement (Watery, no solid pieces. Entirely liquid). On 4/8/25 Resident 35 received her/his AM and PM doses of senna. On 4/8/25 at 7:09 PM Resident 35 had bowel movement recorded at type 7. - On 4/10/25 at 7:30 PM Resident 35 had a type 6 bowel movement (Fluffy pieces with ragged edges, a mushy stool). Resident 35 received her/his AM dose of senna on 4/11/25. Resident 35 did not experience a normal consistency bowel movement until 4/11/25 at 1:59 PM. - On 4/13/25 at 9:19 PM Resident 35 had a type 6 bowel movement. On 4/14/25 at 5:59 AM Resident 35 had another type 6 bowel movement. Resident 35 received her/his AM dose of senna on 4/14/25. Resident 35 did not experience a normal consistency bowel movement until 4/14/25 at 1:31 PM. - On 4/17/25 at 12:59 PM Resident 35 had a type 7 bowel movement. On 4/17/25 at 5:04 PM Resident 35 had another type 7 bowel movement. Resident 35 received her/his PM dose of senna on 4/17/25 and her/his AM dose on 4/18/25. Resident 35 did not experience a normal consistency bowel movement until 4/18/25 at 12:59 PM. - On 4/21/25 at 4:36 PM and 6:06 PM Resident 35 had type 6 bowel movements. Resident 35 received her/his 4/21/25 PM and 4/22/25 AM doses of senna, but did experience a normal consistency bowel movement until 4/12/25 at 12:37 PM. - On 4/26/25 at 3:33 PM Resident 35 had a type 7 bowel movement. Resident 35 received her/his PM dose senna on 4/26/25, her/his AM and PM doses of senna on 4/27/25, and her/his AM dose of senna on 4/28/25. Resident 35 did not experience a normal consistency bowel movement until 4/28/25 at 1:35 PM. - On 5/5/25 at 8:36 PM Resident 35 had a type 6 bowel movement. Resident 35 received her/his AM dose of senna on 5/6/25. Resident 35 did not experience a normal consistency bowel movement until 5/6/25 at 1:10 PM. On 5/8/25 at 9:42 AM Staff 27 (CNA) stated she had been instructed to report a loose stool bowel movement, which was at type 6 or type 7, to the CMA and charge nurse. On 5/8/25 at 9:53 AM Staff 4 (RNCM) stated she considered type 6 and type 7 to be loose stool. Staff 4 stated none of the bowel movement consistency ratings included the words loose stool which made it challenging to define. Staff 4 confirmed Resident 35's senna medication should have been withheld until her/his stool consistency returned to normal after experiencing loose stool on the dates listed above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E174	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Manor of Cascadia	2060 NE 238th Drive Wood Village, OR 97060

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 47001 Based on interview and record review it was determined the facility failed to provide therapy services for 1 of 3 sampled residents (#28) reviewed for falls. This placed residents at risk for falls. Findings include: Resident 28 was admitted to the facility in 8/2020 with diagnoses including dementia. A review of Resident 28's Physician Orders revealed an 4/8/25 order for PT to evaluate due to frequent falls. On 5/5/25 at 10:15 AM a motion detector alarm was heard going off in Resident 28's room. Resident 28 was observed standing at her/his bedside and turning the alarm off. On 5/8/25 at 10:20 AM Staff 26 (RN) stated Resident 28 had multiple falls in 4/2025, no falls in 3/2025, and two falls in 2/2025. Staff 26 stated Resident 28 had frequent falls related to self-transferring and weakness. On 5/8/25 at 11:06 AM Staff 2 (DNS) stated Resident 28 had eight falls in 4/2025. Staff 2 stated Resident 28's falls were related to Resident 28's impulsiveness and self-transferring. Staff 2 stated Resident 28 was on therapy in 3/2025 and therapy had ordered Resident 28 a wheelchair to help decrease the risk for falls. Staff 2 stated Resident 28 finished PT on 3/15/25. On 5/8/25 at 11:23 AM Staff 4 (RNCM) stated Resident 28 had a lot of falls, mostly in her/his room. Staff 4 stated Resident 28 was impulsive, did not use her/his call light, and would self-transfer which led to falls. Staff 4 stated Resident 28 started PT due to frequent falls. On 5/8/25 at 1:37 PM Staff 4 stated she saw the 4/8/25 order for PT but was unable to see when PT was started. On 5/9/25 at 8:24 AM Staff 29 (Therapy Manager) acknowledged Resident 28's 4/8/25 order for PT. Staff 29 stated she discussed the order for PT with Staff 4 and Staff 29 stated therapy was not appropriate for Resident 28 because she/he was seen by therapy 30 days prior. On 5/9/25 at 10:28 AM Staff 4 stated she emailed Staff 29 on 5/8/25 to request the PT notes for Resident 28. Staff 4 stated she was informed on 5/9/25 by Staff 29, via email, Resident 28's PT evaluation was not completed as ordered on 4/8/25. Staff 4 stated she was informed by Staff 29 Resident 28 was not appropriate for PT because she/he just came off therapy four weeks ago. Staff 4 stated she had not discussed this with Resident 28's provider, because she just became aware of it on 5/9/25. On 5/9/25 at 11:40 AM Staff 2 acknowledged there was an order for Resident 28 to have PT evaluation due to frequent falls on 4/8/25. Staff 2 stated Staff 29 sent an email which stated therapy was not indicated for Resident 28. Staff 2 stated this decision was discussed as an IDT (interdisciplinary team) group on 4/8/25 and she assumed the provider was informed verbally. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E174	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Manor of Cascadia	2060 NE 238th Drive Wood Village, OR 97060

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 12:18 PM Staff 29 stated Resident 28 was at risk for falls due to impulsiveness and poor safety awareness. Staff 29 stated she did not have a discussion with Resident 28's provider related to the appropriateness of Resident 28's 4/8/25 PT order for evaluation.