DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50R014	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY BLOSSOM COTTAGE	**11177 SE CHERRY BLOSSOM DR PORTLAND, OR 97216**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Comment The findings of the re-licensure survey conducted, 1/22/20 through 1/24/20, are documented in this report. It was determined the facility was in compliance with the OARs 411 Division 54 for Residential Care and Assisted Living Facilities and Home and Community Based Services Regulations OARs 411 Division 004.	C 000		
C 999	Technical Assistance Concerns were identified in the following areas and the facility was provided with technical assistance: C 305 Physician notification of refusals (j) The resident or the person legally authorized to make health care decisions for the resident has the right to consent to, or refuse, medications and treatments. (k) The physician or other practitioner must be notified if a resident refuses consent to an order. Subsequent refusals to consent to an order will be reported as requested by the prescriber. C 310 Accurate MARs (2) MEDICATION ADMINISTRATION. An accurate Medication Administration	C 999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50R014	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY BLOSSOM COTTAGE	11177 SE CHERRY BLOSSOM DR PORTLAND, OR 97216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 999	Continued From page 1 Record (MAR) must be kept of all medications, including over-the-counter medications that are ordered by a legally recognized prescriber and are administered by the facility. (b) MEDICATION RECORD. At minimum, the medication record for each resident that the facility administers medications to, must include: (A) Current month, day and year. (B) Name of medications, reason for use, dosage, route and date and time given. (C) Any medication specific instructions, if applicable (e.g., significant side effects, time sensitive dosage, when to call the prescriber or nurse). (D) Resident allergies and sensitivities, if any. (E) Resident specific parameters and instructions for p.r.n. medications. (F) Initials of the person administering the medication. C 555 Environment (a) A manually operated emergency call system must be provided in each toilet and bathing facility used by residents and visitors.	C 999		