STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385010	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelhurst Village	3060 SE Stark Street Portland, OR 97214

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation for 1 of 1 residents (#357) reviewed for misappropriation. This placed residents at risk for lack of medication efficacy and loss of property. Findings include: Resident 357 admitted to the facility in 9/2024 with diagnoses including hip fracture and lung disease. A 9/20/24 physician order instructed staff to administer Oxycodone (a pain reliever) one to two tablets every four hours as needed for pain. A 9/24/24 Admission MDS revealed Resident 357 had a BIMS score of 14, which indicated the resident was cognitively intact, and Resident 357 had frequent pain and received PRN pain medications. A review of Resident 357's clinical record revealed the following: -Discharge paperwork dated 10/9/24 indicated Resident 357 took home 56 Oxycodone tablets. -Discharge Summary dated 10/9/24 indicated Resident 357 took home all medications. -Narcotic logbook records dated 10/9/24 and 10/11/24 revealed Resident 357 signed both pages indicating she/he took home all their 112 Oxycodone tablets. -A facility destruction log dated 10/11/24 indicated 56 of Resident 357's Oxycodone were destroyed by two facility staff. On 3/10/25 at 12:49 PM, Resident 357 stated she/he discharged from the facility on 10/9/25 with her/his belongings including all their medications in a stapled paper bag. Resident 357 stated when she/he arrived home the Oxycodone tablets she/he signed for were not in the bag with the other medications. Resident 357 stated she/he placed a call to the facility on [DATE] and spoke to Staff 15 (LPN) to report the missing Oxycodone. Resident 357 stated Staff 15 informed the resident she placed the Oxycodone in the stapled paper bag sent home with Resident 357. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 5:09 PM, and on 3/12/25 at 9:41 AM, Staff 15 stated she discharged Resident 357 on 10/9/24. She stated during the discharge conversation she went over all Resident 357's medications, and signed a form with Resident 357 showing all medications were sent home including 56 Oxycodone. Staff 15 stated Resident 357 called her a few hours after she/he discharged to report the 56 Oxycodone were not in the stapled paper bag sent home with her/him. Staff 15 stated she told Resident 357 to look again and call her back. Staff 15 stated Resident 357 did not call her back and she did not report the missing Oxycodone to upper management. On 3/12/25 at 10:11 AM, Staff 17 (CMA) stated she was aware Resident 357 called the facility on 10/9/24 to report she/he was missing 56 Oxycodone. Staff 17 stated she did not report the missing pain medications to upper management and was unsure why the Oxycodone were destroyed by facility staff. On 3/12/25 at 1:45 PM, Staff 14 (RNCM) stated she unaware of the missing Oxycodone until 3/10/25. Staff 14 acknowledged the 56 Oxycodone were not sent home with Resident 357 and was unsure why the 56 Oxycodone were destroyed by the facility staff. On 3/12/25 at 1:53 PM, Staff 3 (DNS) stated she was unaware of the missing Oxycodone until 3/11/25. Staff 3 acknowledged all 112 Oxycodone belonged to Resident 357 and should have been sent home with the resident. Staff 2 stated she was unsure why 56 Oxycodone were destroyed by facility staff.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on interview and record review it was determined the facility failed to report timely to the State Agency an incident of alleged misappropriation of medications for 1 of 1 sampled residents (#357) reviewed for misappropriation. This placed residents at risk for diversion of medications and misappropriation of property. Findings include: The facility's 9/2022 Abuse, Neglect, Exploitation and Misappropriation of Resident Property Policy indicated the following: -It is the policy of this facility that all suspected alleged, or actual cases of resident abuse, including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to Federal and/or State regulations. -All covered individuals of the facility are mandatory reporters. It is the responsibility of the Administrator and Director of Nursing Services to ensure that these policies and procedures are followed. Resident 357 admitted to the facility in 9/2024 with diagnoses including hip fracture and lung disease. The 9/24/24 Admission MDS revealed Resident 357 had a BIMS score of 14, which indicated the resident was cognitively intact. On 3/10/25 at 12:49 PM Resident 357 stated she/he was discharged from the facility on 10/9/25 with her/his belongings including all their medications in a stapled paper bag. Resident 357 stated when she/he arrived home the Oxycodone tablets she/he signed for were not in the bag with the other medications. Resident 357 stated she/he placed a call to the facility on [DATE] and spoke to Staff 15 (LPN) to report the missing Oxycodone. Resident 357 stated Staff 15 informed the resident she placed the Oxycodone in the stapled paper bag sent home with Resident 357. On 3/10/25 at 5:09 PM, Staff 15 stated Resident 357 called her to report her/his Oxycodone was not sent home with her/him at the time of discharge on 10/9/24. Staff 15 acknowledged she did not report the allegation of misappropriation of the Oxycodone to upper management or the State Agency. On 3/12/25 at 10:11 AM, Staff 17 (CMA) stated she was aware Resident 357 called the facility on 10/9/24 to report 56 missing Oxycodone. Staff 17 acknowledged she did not report the allegation of misappropriation of the Oxycodone to upper management or the State Agency. On 3/12/25 at 1:53 PM, Staff 3 (DNS) stated it was her expectation for staff to escalate an allegation of misappropriation to her or a Resident Care Manager. Staff 3 stated she was made aware of the incident on 3/11/25 and confirmed the facility did not report the resident's missing medications to the State Agency.