

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER Laurelhurst Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review it was determined the facility failed to provide care in a timely manner for 1 of 3 residents (#303) reviewed for ADLs and transfers. This placed residents at risk for pain and discomfort related to delayed care. Findings include: Resident 303 was admitted to the facility in 2021 with diagnoses including breast cancer and congestive heart failure. A 9/23/25 Quarterly MDS revealed Resident 303 had a BIMS score of 15 which indicated the resident was cognitively intact. Resident 303's 9/2025 care plan revealed she/he required two-person assistance for bed mobility and transfers and was incontinent of bowel and bladder. A grievance was submitted by Resident 303 on 9/28/25 regarding the delay in being assisted to bed on the evening of 9/27/25. The grievance indicated Resident 303 stated she/he preferred to go to bed around 5:00 PM but was not assisted until approximately 9:00 PM. The resident reported she/he was aware there was only one CNA working on her/his floor that evening and expressed this was a staffing failure and totally unsafe. Resident 303 further stated she/he was in pain from being up in her/his wheelchair for so long. The grievance was reviewed by Staff 3 (Former Administrator), who acknowledged the incident occurred and verified staffing shortages contributed to the delay. On 10/30/25 at 12:35 PM Resident 303 stated she/he preferred to go to bed between the hours of 4:30 PM and 5:00 PM each evening to rest, watch television or use her/his computer. Resident 303 stated on the evening of 9/27/25, she/he was not assisted to bed until approximately 9:00 PM. Resident 303 stated her/his legs became painful from sitting in her/his wheelchair for an extended period, and she/he was drenched in urine by the time she/he was transferred to bed and changed. On 10/31/25 at 5:44 AM Staff 7 (RN) stated the facility was short staffed on the evening of 9/27/25. Staff 7 confirmed Staff 9 (CNA) worked alone for approximately four hours on the evening of 9/27/25. Staff 7 further stated Resident 303 complained her/his legs were hurting and had soaked through her/his brief. Staff 7 stated the resident appeared frustrated from the long wait that evening. On 10/31/25 at 2:36 PM Staff 9 (CNA) stated he worked alone for approximately four hours during the evening shift on 9/27/25. Staff 9 stated he was responsible for 20 residents, including several who required two-person assistance for transfers and care. Staff 9 further stated he was unable to assist Resident 303 to bed at her/his requested time because he was covering the floor without additional CNA support. Staff 9 stated at approximately 9:00 PM, he and the charge nurse were able to transfer Resident 303 to bed and provide incontinence care. Staff 9 indicated the resident told him she/he was sore from sitting for an extended period and her/his brief was soaked and her/his pants were damp. On 10/31/25 at 3:06 PM Staff 5 (Resident Care Manager/LPN) stated she was aware the facility was short-staffed on the evening of 9/27/25 because Resident 303 informed her. Staff 5 confirmed Staff 9 worked alone for approximately four hours, caring for 20 residents, seven of whom required two-person assistance. Staff 5 stated Resident 303 was not assisted to bed per her/his request and preferences due to not having adequate staffing on 9/27/25. On 11/3/25 at 3:41 PM Staff 2 (DNS) confirmed the facility was short-staffed on the evening of 9/27/25 and acknowledged the incident involving Resident 303 occurred. Staff 2 stated it was her expectation Resident 303's needs and preferences were honored.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 385010	If continuation sheet Page 1 of 3

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review it was determined the facility failed to provide nutritional supplements as ordered for 4 of 5 residents (#s 305, 306, 307 and 308) reviewed for nutritional supplements. This placed residents at risk for weight loss and inadequate nutrition. Findings include:1. Resident 306 was admitted to the facility in 10/2024 with diagnoses including dysphagia (difficulty swallowing) and malnutrition.A physician order from 6/27/25 included 120 ml of Medpass 2.0, a nutritional supplement, to be provided to Resident 306 three times a day between meals.Review of the 10/2025 MAR revealed 9, which indicated the medication was unavailable, was entered on 10/12/25, 10/13/25, 10/14/25, 10/15/25, 10/20/25, 10/21/25, 10/22/25, 10/24/25, 10/25/25, 10/26/25 and 10/27/25 for Medpass 2.0. On 10/30/25 at 9:40 AM Staff 23 (Dietary Manager) stated she was responsible for ordering Medpass 2.0 and confirmed there was a delay in administrative approval for the order she submitted on 10/24/25. Staff 23 stated the order she submitted on 10/24/25 had not been approved by administration until 10/27/25. Staff 23 stated the Medpass 2.0 supplies had been insufficient on previous orders during 10/2025 due to food order budget restrictions from administration. Staff 23 stated the insufficient supply of Medpass 2.0 was due to having been limited to ordering one pack of Medpass 2.0 but was required to order 2 packs of the nutritional supplement. She stated the order approval delay on 10/24/25 and previous order restrictions resulted in Medpass 2.0 being unavailable for Resident 306 on 11 days during 10/2025.On 10/31/25 at 10:29 AM Staff 27 (LPN) stated the Medpass 2.0 supplement was unavailable just about every day since the transition of ownership. Staff 27 stated she checked throughout the facility to locate a supply but was unable to locate the Medpass 2.0. On 11/3/25 at 2:02 PM Staff 2 (DNS) stated the 9 notation on the MAR indicated the Medpass 2.0 supplement was not available. Staff 2 confirmed Resident 306 did not receive Medpass 2.0 as ordered on 10/12/25, 10/13/25, 10/14/25, 10/15/25, 10/20/25, 10/21/25, 10/22/25, 10/24/25, 10/25/25, 10/26/25 and 10/27/25.2. Resident 307 was admitted to the facility in 4/2021 with diagnoses including Parkinson's disease and malnutrition.An 8/12/15 cognitive assessment determined Resident 307 had normal cognitive function.A physician order from 8/20/25 included 120 ml of Medpass 2.0, a nutritional supplement, to be provided to Resident 307 three times a day between meals.Review of the 10/2025 MAR revealed 9, which indicated the medication was unavailable, was entered on 10/24/25, 10/25/25, 10/26/25 and 10/27/25 for Medpass 2.0.On 10/30/25 at 9:40 AM Staff 23 (Dietary Manager) stated she was responsible for ordering Medpass 2.0 and confirmed there was a delay in administrative approval for the order she submitted on 10/24/25. Staff 23 stated the order she submitted on 10/24/25 had not been approved by administration until 10/27/25. She stated this delay resulted in the supplement being unavailable for Resident 307 on 10/24/25, 10/25/25, 10/26/25 and 10/27/27.On 10/31/25 at 10:29 AM Staff 27 (LPN) stated the Medpass 2.0 supplement was unavailable just about every day since the transition of ownership. Staff 27 stated she checked throughout the facility to locate a supply, but it is usually not available. On 11/3/25 at 1:58 PM Resident 307 stated she/he did not receive a nutritional supplement on 10/24/25, 10/25/25, 10/26/25 and 10/27/25.On 11/3/25 at 2:02 PM Staff 2 (DNS) stated the 9 notation on the MAR indicated the Medpass 2.0 supplement was not available. Staff 2 confirmed Resident 307 did not receive Medpass 2.0 as ordered on 10/24/25, 10/25/25, 10/26/25 and 10/27/25.3. Resident 305 was admitted to the facility in 4/2023 with diagnoses including stroke, dementia and failure to thrive.A physician order from 1/5/24 included 120 ml of Medpass 2.0, a nutritional supplement, to be provided to Resident 305 four times a day due to her/his failure to thrive.Review of the 10/2025 MAR revealed 9, which indicated the medication was unavailable, was entered on 10/25/25, 10/26/25 and 10/27/26 for Medpass 2.0.A purchase order from the dietary department, dated 10/24/25, indicated Medpass 2.0 was submitted for approval on 10/24/25 but was not approved until 10/27/25.On 10/30/25 at 9:40 AM Staff 23 (Dietary Manager) stated she was responsible for ordering Medpass 2.0 and confirmed there was a delay in administrative approval for the order she submitted on 10/24/25. She stated this delay resulted in the supplement being unavailable for Resident 305 on 10/25/25, 10/26/25 and 10/27/27. On 10/31/25 at 10:29 AM Staff 27 (LPN) stated the Medpass 2.0 supplement was unavailable just about every day since the transition of ownership. Staff 27 stated she checked throughout the facility to locate a supply, but it is usually not available. On 11/3/25 at 2:02 PM Staff 2 (DNS) stated the 9 notation on the MAR indicated the Medpass 2.0 supplement was not available. Staff 2 confirmed Resident 305 did not receive Medpass 2.0 as ordered on 10/25/25, 10/26/25 and 10/27/25.4. Resident 308 was admitted to the facility in 9/2014 with diagnoses including dysphagia (difficulty swallowing) and hemiplegia (loss of motor function on</p>		