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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelhurst Post Acute & Rehabilitation	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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents received appropriate pain management for 1 of 5 sampled residents (#78) reviewed for pain. This placed residents at risk for pain and discomfort. Findings include:Resident 78 was admitted to the facility on [DATE] with diagnoses including aftercare following knee replacement surgery and pain.The 6/11/26 Hospital Discharge Instructions indicated staff were to administer oxycodone PRN (1-3 tablets of 5 mg-15 mg oxycodone) and Tylenol 500 mg at bedtime. The last documented administration of oxycodone 5 mg occurred on 6/11/26 at 8:42 AM.The 6/11/26 at 9:52 PM, admission Nursing Collection Tool revealed Resident 78 reported sharp left knee pain with a pain level of five, affecting sleep, social activities, physical activity, mobility, and emotions.The 6/12/26 at 1:20 PM, MAR revealed Resident 78 received oxycodone 5 mg and reported pain level of nine. (approximately 18 hours later)The 6/15/25 Pain care plan indicated Resident 78 was prescribed opioid medications for pain. The goal was to remain free from complications related to opioid use. Staff were to administer pain medications as ordered.On 6/22/26 at 12:00 PM, Witness 1 (Friend) and Witness 2 (Friend) stated Resident 78 arrived at the facility on 6/11/26 at approximately 9:00 PM, following knee surgery and was in a lot of pain. Witness 1 further stated Resident 78 did not receive pain medication until the following day 6/12/26, which was a concern due to her/his discomfort.On 6/22/26 at 3:42 PM, Resident 78 stated she/he was discharged from the hospital following knee surgery and arrived at the facility on 6/11/26 at approximately 9:00 PM. Resident 78 stated her/his pain increased after arrival and reported a pain level of greater than six. Resident 78 stated staff told her/him they did not have her/his pain medication available, and the resident did not receive pain medication until the following day, and her/his knee was painful. On 6/24/26 at 6:57 PM, Staff 10 (CNA) stated Resident 78 arrived from the hospital after having knee surgery and reported her/his pain level was a seven out of 10 and she/he was uncomfortable. Staff 10 reported the concern to the nurse and overheard the nurse advising the resident that her/his pain medications were not available.On 6/25/26 at 8:39 AM, Witness 3 (Pharmacists) stated staff did not order Resident 78's oxycodone until 6/12/26. Witness 3 stated the facility first requested authorization to access oxycodone from the Pyxis (automated medication dispensing system requiring pharmacy authorization for medication access) on 6/12/26 at approximate 10 AM, however, staff did not pull the medication at that time. Witness 3 stated the same staff requested authorization again on 6/12/26 at approximately 1:12 PM. Staff pulled one 5 mg oxycodone tablet. Witness 3 further stated the pharmacy delivered Resident 78's oxycodone on 6/12/26 at approximately 2:00 PM.On 6/25/26 at 10:16 AM, Staff 11 (RN) confirmed Resident 78 had an order for oxycodone at the time of admission and the facility should have had the medication on hand. Staff 11 stated she contacted the pharmacist to request oxycodone from the Pyxis machine. Staff 11 stated only one tablet was available and the resident declined the medication because the resident wanted her/his full prescribed dose. Staff 11 stated she offered ice to the resident for her/his knee discomfort, which the resident accepted while waiting for her/his pain medication. Staff 11 confirmed she did not document the resident's refusal of the half dose of pain medication and did not notify the physician of the resident knee pain. Staff 11 stated she did not assess Resident 78 for (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain and on 6/12/26 Resident 78's pain level increased from seven to a nine.On 6/26/26 at 11:31 AM, Staff 12 (RNCM) confirmed nurses were required to assess and address pain at admission. Staff 12 confirmed Resident 78 was admitted after 8:00 PM, on 6/11/26 following hospital discharge and had not received pain medication until 6/12/26 the next day. Staff 12 confirmed admission documentation reflected Resident 78 expressed sharp left knee pain with a pain level of five. Staff 12 stated nursing staff were expected to offer pain medication, document if a resident refused and notify the physician. Staff 12 confirmed Resident 78 did not receive pain medication until after 1:00 PM, the following day, at which time Resident 78's pain level was reported as nine out of 10. Staff 12 further stated oxycodone should have been available via Pyxis and was unaware the Pyxis did not have the full dose needed for Resident 78.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and record review it was determined the facility failed to ensure x-rays were obtained as ordered for 1 of 2 sampled residents (#128) reviewed for change of condition. This placed residents at risk for delayed treatment. Findings include: Resident 128 was admitted to the facility in 2/2026 with a diagnosis of a pelvic fracture. Progress Notes revealed the following:-3/1/26 Resident 128's physician was notified Resident 128 had an unwitnessed fall; her/his oxygen saturation was 85 percent on room air; oxygen was applied and her/his oxygen levels increased to 93 percent. -3/1/26 Resident 128's physician response included stat (to be done immediately) chest x-ray. Resident 128's clinical record did not have x-rays obtained on 3/1/26.On 6/25/26 at 9:24 AM Staff 18 (RN) stated if an x-ray was ordered stat, the order was to be completed the day it was ordered. If the x-ray technician was not able to come to the facility, the physician was to be notified. On 6/26/26 at 10:32 AM Staff 2 (DNS) stated stat orders were to be obtained within four to six hours. Staff 2 stated if the orders were not able to be obtained within four to six hours the physician was to be notified. Staff 2 stated there was no x-ray obtained on 3/1/26 and no indication staff called the physician.