

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Laurelhurst Village		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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>38140</p> <p>Based on observation, interview and record review it was determined the facility failed to assess residents for safe self-administration of medication for 2 of 2 sampled residents (#s 65 and 69) reviewed for self-administering medication. This placed residents at risk for an unsafe medication regimen. Findings include:</p> <p>1. Resident 65 admitted to the facility in 4/2024 with diagnoses including kidney failure.</p> <p>Resident 65's 1/6/25 Quarterly MDS assessed her/him with a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Resident 65's 3/11/25 Physician Orders included an order for Zinc Oxide External Paste 20 % which directed staff to apply to [genital area] topically two times a day for skin care, for three days and apply to affected areas topically as needed for skin care. An order for Hydrocortisone External Cream 2.5 % directed staff to apply to affected areas topically as needed for skin care, apply BID with Ketoconazole (antifungal medication) when skin folds were flared.</p> <p>On 3/11/25 at 9:27 AM, 12:34 PM, 3:30 PM and 3/12/25 at 8:49 AM, Resident 65 was observed to lay in her/his bed with one tube of the Zinc Oxide External Paste and two tubes of the Hydrocortisone External Cream on her/his window seal. Resident 65 stated the tubes were there for the past several months, she/he used the cream as needed and sometimes on her/his neck when it itched.</p> <p>Resident 65's health record showed no evidence she/he was assessed to self-administer the Zinc Oxide External Paste or Hydrocortisone External Cream.</p> <p>On 3/12/25 at 9:20 AM, Staff 7 (LPN/Resident Care Manager) confirmed and removed the tube of Zinc Oxide External Paste and two tubes of the Hydrocortisone External Cream from Resident 69's her/his window seal. Staff 7 stated Resident 65 was not assessed to self-administer the creams and she would expect a nurse to complete an assessment before allowing any resident to keep over-the-counter medications at their bedside.</p> <p>2. Resident 69 admitted to the facility in 2/2025 with a diagnoses including dementia and diabetes.</p> <p>A 3/3/25 Admission MDS assessed Resident 69 with a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>(continued on next page)</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/10/25 at 10:13 AM, Resident 69 requested her/his cough drops from her/his bedside dresser drawer. Resident 69 stated she/he sucked on her/his cough drops often.</p> <p>On 3/11/25 at 12:53 PM and 3/13/25 at 8:55 AM Resident 69 was observed with three packs of Fisherman's Friend extra strong cough drops at bedside, packs were within her/his reach and she/he was sucking on something.</p> <p>Review of Resident 69's health record reveal no indication she/he was safe to self-administer cough drops from bedside.</p> <p>On 3/13/25 at 9:16 AM Staff 8 (LPN/Resident Care Manager) stated she was unaware Resident 69 used cough drops while in the facility and removed the cough drops from her/his room. Staff 8 stated she expected residents to be assessed by a licensed nurse for safe self-administration of cough drops and for the cough drops to be kept locked up. Staff 8 confirmed Resident 69 did not have a self-administration assessment completed to ensure Resident 69 was safe with the cough drops.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents who were unable to carry out ADLs independently received transfer assistance for 1 of 3 sampled residents (#90) reviewed for activities. This placed residents at risk for lack of transfer assistance and isolation. Findings include:</p> <p>The facility's 3/2018 Activities of Daily Living Policy indicated appropriate care and services were to be provided to residents unable to carry out ADLs independently, including appropriate support and assistance with transfers.</p> <p>Resident 90 was admitted to the facility in 12/2024 with diagnoses including hemiparesis (weakness on one side of the body), hemiplegia (paralysis on one side of the body) and aphasia (a language disorder that affects a person's ability to communicate) following a stroke.</p> <p>Resident 90's 12/25/24 Admission MDS indicated the resident was rarely/never understood, severely impaired for decision making and dependent on assistance from staff for transfers.</p> <p>Resident 90's 2/20/25 Care Plan revealed the following:</p> <ul style="list-style-type: none"> <li>-A tilt-in-space wheelchair (a specialized wheelchair that allowed the entire seating system to tilt backward while maintaining the seat-to-back angle) was provided by therapy.</li> <li>-Staff were to use caution during transfers.</li> <li>-A mechanical lift was to be used for all transfers.</li> </ul> <p>Observations of Resident 90 from 3/10/25 through 3/13/25 between 8:33 AM to 3:41 PM revealed the resident to be in her/his room in bed with her/his eyes open at times, and closed at others. When the resident was awake, she/he smiled and attempted to communicate with the state surveyor through gestures and grunts, but her/his responses to questions were unable to be understood.</p> <p>On 3/10/25 at 1:22 PM, Witness 1 (Family Member) stated she wanted staff to assist Resident 90 to transfer into her/his wheelchair as the resident enjoyed to be around people and out of her/his room.</p> <p>On 3/12/25 at 3:46 PM, Staff 21 (CNA) stated Resident 90 loved to be up in the wheelchair, in the dining room and outside. Staff 18 stated therapy staff were the only ones allowed to transfer the resident out of bed into her/his wheelchair, and she was unsure why.</p> <p>On 3/12/25 at 3:57 PM, Staff 16 (LPN) stated it was good to encourage [Resident 90] to get up in the wheelchair but could not recall the last time she offered the resident the opportunity to transfer into her/his wheelchair.</p> <p>On 3/12/25 at 4:02 PM Staff 18 (LPN Resident Care Manager) stated there was no reason why [Resident 90] can't get up, and although the resident did not last long up in her/his wheelchair, she/he liked seeing a different view and it was better than nothing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/13/25 at 10:28 AM, Staff 23 (CNA) stated nursing staff had not been allowed to get [Resident 90] up for weeks because of therapy.</p> <p>On 3/13/25 at 11:24 AM, Staff 24 (Director of Rehabilitation) stated Resident 90 was provided with a tilt-in-space wheelchair on 2/20/25 and she did not know why [the resident] could not get up and be transferred out of bed. Staff 24 further indicated the therapy department never said [she/he] needed to stay in bed.</p> <p>On 3/13/25 at 3:12 PM, Staff 3 (DNS) acknowledged Resident 90 was not getting up out of bed and stated she expected nursing staff to provide transfer assistance to Resident 90. Staff 3 stated if a resident refused, staff were expected to reapproach and offer assistance at different times throughout the day.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47000</p> <p>Based on observation, interview and record review it was determined the facility failed to provide an ongoing program to support individual activity interests and preferences for 2 of 3 sampled residents (#s 72 and 90) reviewed for activities. This placed residents at risk for isolation, lack of social interaction and engagement. Findings include:</p> <p>The facility's 2/2005 Activities Policy indicated the facility would provide an activities program that addressed the intellectual, social, spiritual, creative and physical needs, capabilities and interests of each resident. The activity program would promote each resident's self-respect by providing activities that supported self-expression and choice.</p> <p>1. Resident 72 was admitted to the facility in 11/2024 with diagnoses including colon cancer and adjustment disorder with anxiety and depression.</p> <p>Resident 72's 11/22/24 Activity Profile revealed the following activity interests and preferences:</p> <ul style="list-style-type: none"> <li>-The resident preferred afternoon activities in her/his room or in the facility's activity room.</li> <li>-The resident enjoyed music, especially classical and favorites from the past, and television, in particular crime dramas, Channel 10, history documentaries and the news.</li> <li>-The resident liked to read non-fiction books and autobiographies.</li> <li>-The resident enjoyed book reviews, current events and art/music appreciation.</li> <li>-The resident had a spiritual affiliation and wanted to receive clergy visits.</li> </ul> <p>Resident 72's 12/17/24 Significant Change in Status MDS indicated the resident was able to make her/himself understood and understand others without difficulty. The MDS also indicated listening to music, being around pets, keeping up with the news, going outside, participating in religious practices and having books, newspapers and magazines to read were important activities to the resident.</p> <p>Resident 72's 1/10/25 Care Plan revealed the following:</p> <ul style="list-style-type: none"> <li>-The resident would self-initiate activities daily.</li> <li>-The resident's activity interests included to read, watch television, listen to music and to receive visits from the facility's clergy.</li> <li>-Staff were to offer books of interest, activity check-ins and one-to-one visits as tolerated.</li> </ul> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 72's Activity Task Records from 2/12/25 through 3/13/25 revealed the resident did not participate in any group or self-directed activities and received a one-to-one visit on six different days. No evidence was found in the resident's clinical record to indicate the resident was offered the opportunity to be around pets, go outside, listen to music, read books, newspapers or magazines or participate in activities that involved book reviews, current events or art/music appreciation.</p> <p>The facility's 3/2025 Activity Calendar revealed the following scheduled activities:</p> <p>3/10/25:</p> <ul style="list-style-type: none"> <li>-10:00 AM Sensory Visits</li> <li>-2:00 PM Book Cart</li> <li>-4:00 PM UNO Club</li> </ul> <p>3/11/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Exercise &amp; Current Events</li> <li>-2:00 PM Crafts Corner</li> <li>-4:00 PM Bingo</li> </ul> <p>3/12/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Balloon Pickleball</li> <li>-12:00 PM Music with [NAME]</li> <li>-2:00 PM Fun with Limericks, St Paddy's Day Social</li> </ul> <p>3/13/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Exercise &amp; Current Events</li> <li>-2:00 PM [NAME] Pub Music</li> <li>-4:00 PM Craft Corner</li> </ul> <p>Observations of Resident 72 from 3/10/25 through 3/13/25 from 9:33 AM to 3:42 PM revealed the resident to be in her/his room in bed. The resident's television was observed to be on at times and off at others. No books, magazines or newspapers were observed in the resident's room. On 3/10/25 at 2:30 PM Resident 72 stated she/he wanted to get into her/his wheelchair everyday and go outside and get fresh air, but it never happened. Resident 72 stated she/he enjoyed socializing with others and did not like watching television.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/12/25 at 10:24 AM, Staff 23 (CNA) stated Resident 72 liked to watch television but did not know if she/he enjoyed music. Staff 23 stated the resident did not like to read, and she never observed the resident out of her/his room.</p> <p>On 3/12/25 at 3:39 PM, Staff 26 (CNA) stated Resident 72 was really confused and the resident spent all of her/his time in bed because she/he couldn't walk.</p> <p>On 3/13/25 at 10:37 AM, Staff 22 (LPN) stated Resident 72 never left her/his room, mostly just slept with her/his television on, and she had never seen reading material in the resident's room.</p> <p>On 3/14/25 at 9:41 AM, Staff 10 (Activities Director) stated Resident 72 was often sleeping, and her one-to-ones with the resident consisted of playing music for her/him and the resident's roommate. Staff 10 stated she had not offered the resident the opportunity to participate in any activities related to book reviews, current events or art/music appreciation and acknowledged that these were interests of the resident. Staff 10 stated Resident 72 was unable to self-initiate activities as she/he did not independently make activity requests and required encouragement. Staff 10 stated she had not assisted the resident to go outside when the weather was nice or to sit by a window as she had not seen [her/him] up in the wheelchair. Staff 10 stated the facility did not have any pet visits since the fall. Staff 10 stated she did have a fake cat and bunnies she utilized with residents but had not done so with Resident 72.</p> <p>On 3/14/25 at 10:55 AM, Staff 1 (Administrator) and Staff 2 (Assistant Administrator) acknowledged Resident 72 was not being offered activities tailored to the resident's interests.</p> <p>2. Resident 90 was admitted to the facility in 12/2024 with diagnoses including hemiparesis (weakness on one side of the body), hemiplegia (paralysis on one side of the body) and aphasia (a language disorder that affects a person's ability to communicate) following a stroke.</p> <p>Resident 90's 12/25/24 Admission MDS indicated the resident was rarely/never understood and severely impaired for decision making. The Section F Preferences for Customary Routine and Activities Interview completed by the resident's family or significant other revealed listening to music, being around pets and going outside to get fresh air were important activities for the resident.</p> <p>Resident 90's 1/10/25 Care Plan revealed the following:</p> <ul style="list-style-type: none"> <li>-The resident preferred in-room activities.</li> <li>-The resident enjoyed classical and calming music, television and family visits.</li> <li>-The resident required one-to-one visits for cognitive stimulation and social interaction.</li> <li>-Staff were to allow the resident the freedom to choose between facility provided group activities and preferred independent pursuits.</li> <li>-Staff were to encourage the resident to go outside in the courtyard to view wildlife.</li> <li>-Staff were to encourage the resident to participate in hallway activities.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 90's Activity Task Records from 2/10/25 through 3/11/25 revealed the resident to participate in one group activity, received a one-to-one visit on seven days and watched television in her/his room on two occasions. No evidence was found in the resident's clinical record to indicate the resident was offered the opportunity to be around pets or to go outside or which shows the resident preferred to watch on television.</p> <p>The facility's 3/2025 Activity Calendar revealed the following scheduled activities:</p> <p>3/10/25:</p> <ul style="list-style-type: none"> <li>-10:00 AM Sensory Visits</li> <li>-2:00 PM Book Cart</li> <li>-4:00 PM UNO Club</li> </ul> <p>3/11/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Exercise &amp; Current Events</li> <li>-2:00 PM Crafts Corner</li> <li>-4:00 PM Bingo</li> </ul> <p>3/12/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Balloon Pickleball</li> <li>-12:00 PM Music with [NAME]</li> <li>-2:00 PM Fun with Limericks, St Paddy's Day Social</li> </ul> <p>3/13/25:</p> <ul style="list-style-type: none"> <li>-11:00 AM Exercise &amp; Current Events</li> <li>-2:00 PM [NAME] Pub Music</li> <li>-4:00 PM Craft Corner</li> </ul> <p>Observations of Resident 90 from 3/10/25 through 3/13/25 between 8:33 AM to 3:41 PM revealed the resident to be in her/his room in bed with her/his eyes open at times, and closed at others. When the resident was awake, she/he smiled and attempted to communicate with the state surveyor through gestures and grunts, but her/his responses to questions were unable to be understood. The resident's television was observed to be on and tuned to the SyFy Channel (a channel specializing in science fiction, fantasy, horror and paranormal programming), the History Channel (known for its programming focused on historical events, figures and phenomena) or the Simpson's (an animated sitcom).</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/10/25 at 1:22 PM, Witness 1 (Family Member) stated Resident 90 always liked to be outside as it had a major effect on [her/his] mental wellness. Witness 1 stated staff were aware it was important for the resident to go outside but the facility was too short staffed to get [her/him] up and get [her/him] outside. Witness 1 stated the resident enjoyed socializing, being around people and out of [her/his] room. Witness 1 further stated the resident enjoyed art, massages and to watch something positive on television such as nature programming.</p> <p>On 3/12/25 at 3:46 PM, Staff 21 (CNA) stated Resident 90 loved to be up in the wheelchair, in the dining room and outside. Staff 21 further stated she did not think the resident cared for music, did not know if she/he liked pets and spent her/his days watching television in her/his room.</p> <p>On 3/12/25 at 3:57 PM, Staff 16 (LPN) stated Resident 90 was not getting up and not sure why. Staff 16 stated she could not recall the last time she offered the resident the opportunity to transfer into her/his wheelchair and thought the resident was comfortable watching her/his shows on the SyFy Channel in her/his room.</p> <p>On 3/12/25 at 4:02 PM, Staff 18 (LPN Resident Care Manager) stated Resident 90 liked to see a different view outside of her/his room, and enjoyed to go outside if the weather was nice or to sit in her/his wheelchair and look out the window in the facility's dining room. Staff 18 stated she had never seen staff assist the resident outside.</p> <p>On 3/13/25 at 10:28 AM, Staff 23 (CNA) stated Resident 90 spent her/his days watching cartoons or the SyFy channel on television and only left her/his room with the assistance of therapy staff. Staff 23 stated she had never observed the resident to listen to music or receive any pet visits.</p> <p>On 3/13/25 at 10:41 AM, Staff 22 (LPN) stated Resident 90 did not like music but enjoyed watching cartoons on television. Staff 22 further stated she had never seen the resident to receive any pet visits.</p> <p>On 3/14/25 at 10:02 AM, Staff 10 (Activities Director) stated the last group activity Resident 90 attended was on 2/27/25 and she could not recall another instance. Staff 10 stated the facility did not have any pet visits since the fall. Staff 10 stated she did have a fake cat and bunnies she utilized with residents but had not done so with Resident 90. Staff 10 stated she put up cute animal pictures in rooms of resident who enjoyed pets but had not offered the activity to Resident 90. Staff 10 stated she was aware the resident enjoyed to go outside but had not offered the resident the opportunity or to sit by a window since 12/25/24.</p> <p>On 3/14/25 at 10:55 AM, Staff 1 (Administrator) and Staff 2 (Assistant Administrator) acknowledged Resident 90 was not being offered activities tailored to the resident's interests.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50930</p> <p>Based on observation, interview and record review it was determined the facility failed to properly dispose of expired medications for 3 of 3 medication storage rooms, 4 of 5 medication carts, and 1 of 3 medication storage refrigerators. This placed residents at risk for lack of medication efficacy and adverse reactions from expired medications. Findings include:</p> <p>The facility's Storage of Medications policy with revision date 11/2020 did not address vials of medications but indicated outdated medications were to be destroyed by the facility. The manufacturer insert indicated a multi-dose vial of Tuberculin should be dated when opened and thrown away after 30 days to avoid oxidation and degradation.</p> <p>During a review of the fourth-floor medication storage room on 3/11/25 at 3:24 PM, the following expired medication was found:</p> <ul style="list-style-type: none"> <li>- One box of nicotine transdermal 14mg patches with an expiration date of 2/2025.</li> </ul> <p>On 3/11/25 at 3:33 PM, Staff 27 acknowledged the transdermal patches were expired and not discarded. Staff 27 stated the expectation was for expired medications to be discarded.</p> <p>During a review of the third-floor medication cart on 3/11/25 at 3:52 PM, the following expired medications were found:</p> <ul style="list-style-type: none"> <li>- One bottle of saline nasal spray with an expiration date of 1/2025.</li> <li>- One bottle of liquid geri tussin (cough suppressant) with an expiration date of 10/2024.</li> <li>- One bottle of liquid acid reducer with an expiration date of 2/2025.</li> </ul> <p>On 3/11/25 at 3:59 PM, Staff 28 acknowledged the medications were expired and the expectation was expired medications were to be destroyed. Staff 28 admitted not knowing the facility's medication storage policy.</p> <p>During a review of the second-floor medication storage room on 3/11/25 at 4:05 PM, the following expired medications were found:</p> <ul style="list-style-type: none"> <li>- One bottle of vitamin C 250mg tablets with an expiration date of 2/2025.</li> <li>- One tube of Vitamin A&amp;D Ointment with an expiration date of 12/2024.</li> <li>- One tube of triple antibiotic ointment with an expiration date of 1/2025.</li> </ul> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/11/25 at 4:16 PM, Staff 16 acknowledged the medications were expired and the expectation was expired medications were to be destroyed. Staff 16 admitted not knowing the facility's medication storage policy.</p> <p>During a review of the second-floor medication cart on 3/11/25 at 4:21 PM, the following expired medication was found:</p> <ul style="list-style-type: none"> <li>- One bottle of liquid geri tussin with an expiration date of 9/2024.</li> </ul> <p>On 3/11/25 at 4:28 PM, Staff 16 acknowledged the medications were expired and the expectation was expired medications were to be destroyed. Staff 16 admitted not knowing the facility's medication storage policy.</p> <p>During a review of the skilled unit first-floor medication storage room on 3/13/25 at 10:05 AM, the following expired medications were found:</p> <ul style="list-style-type: none"> <li>- Two open and used multi-dose vials of Tuberculin (solution used in testing for Tuberculosis) with no open dates.</li> <li>- One bottle of sodium chloride tablets with an expiration date of 2/2025.</li> </ul> <p>On 3/13/25 at 10:25 AM, Staff 17 acknowledged the medications were expired and the expectation was for expired medications to be destroyed or sent back to the pharmacy.</p> <p>During a review of the skilled unit first-floor medication cart on 3/13/25 at 10:31 AM, the following expired medication was found:</p> <ul style="list-style-type: none"> <li>- One bottle of vitamin C 250mg tablets with an expiration date of 2/2025.</li> </ul> <p>On 3/13/25 at 10:40 AM, Staff 17 acknowledged the medications were expired and the expectation was for expired medications to be destroyed or sent back to the pharmacy.</p> <p>During a review of the skilled unit second-floor medication cart on 3/13/25 at 10:43 AM, the following expired medication was found:</p> <ul style="list-style-type: none"> <li>- One bottle of vitamin C 250mg tablets with an expiration date of 2/2025.</li> </ul> <p>On 3/13/25 at 10:50 AM, Staff 29 acknowledged the medications were expired and the expectation was for expired medications to be destroyed and order replacements if needed. Staff 16 admitted not knowing the facility's medication storage policy.</p> <p>On 3/13/25 at 3:56 PM, Staff 3 stated the expectation was for all staff handling medications to know and follow the medication storage policy. She stated the facility policy was to destroy expired medications and order replacements if needed. She stated Tuberculin multi-dose vials should be dated when opened and thrown away after 28 days.</p>		

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Laurelhurst Village		STREET ADDRESS, CITY, STATE, ZIP CODE  3060 SE Stark Street Portland, OR 97214	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51846</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure food was labeled and stored in a manner to minimize spoilage and cross contamination for 1 of 1 kitchen and 3 of 3 dining room refrigerator units and freezers reviewed for sanitary conditions. This placed residents at risk for foodborne illness and unappetizing meals. Findings include:</p> <p>The facility's Preventing Foodborne Illness - Food Handling Policy dated ,d+[DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.</li> </ul> <p>The facility's Personal Food Storage dated ,d+[DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated staff for food safety.</li> <li>- Designated facility staff will be assigned to monitor individual room storage and refrigeration units for food or beverage disposal.</li> </ul> <p>1. The following items were observed in the facility's main kitchen:</p> <p>On [DATE] at 9:22 AM, the refrigerator had an unlabeled plastic wrapped stainless steel container filled with filets of a white product.</p> <p>On [DATE] at 9:25 AM, the freezer had a package of unlabeled and undated frozen red patties, which possibly was ground beef.</p> <p>On [DATE] at 11:28 AM, the dry storage room had cans of dented apple pie filling, black beans, and diced peaches. There was an unlabeled and undated open bag of croutons.</p> <p>On [DATE] at 9:30 AM, Staff 4 (Dietary Manager) acknowledged the unlabeled product in the plastic wrapped stainless steel container and stated the frozen red patties were veggie patties. Staff 4 stated food items were expected to be labeled and dated with the date they were prepared or opened.</p> <p>On [DATE] at 11:31 AM, Staff 4 acknowledged the dented cans and stated the dented cans were expected to be taken out of the pantry and placed into the office. Staff 4 acknowledged the bag of opened croutons and could not decipher the writing on the bag. Staff 4 reiterated the expectations of labeling and dating opened packages with the date the package was opened.</p> <p>2. On [DATE] at 11:56 AM, the second floor Intermediate Care Facility (ICF) unit freezer had an unopened package of frozen purple Ube steamed buns unlabeled, undated and expired on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 11:58 AM, Staff 25 (CNA) was unable to confirm who the package belonged to and acknowledged the expiration date.</p> <p>On [DATE] at 3:42 PM, Staff 18 (LPN Resident Care Manager) confirmed the expired package in the freezer and stated dietary staff were responsible for cleaning out and monitoring the contents in the refrigerator.</p> <p>On [DATE] at 4:00 PM, Staff 20 (CNA) stated it was the responsibility of staff to take resident food items from the resident, label a name or room number onto the item, date any open or unopened product, and staff were to place item into the unit refrigerator.</p> <p>On [DATE] at 10:50 AM, Staff 4 (Dietary Manager) stated dietary staff restocked and checked refrigerators daily and were expected to throw away expired product from the unit refrigerators.</p> <p>3. The following sign was posted on the third floor refrigerator door:</p> <p>- Attention Staff: Please date all containers when opened.</p> <p>From [DATE] at 1:04 PM to [DATE] at 10:16 AM, the following items were observed on the third floor of the ICF building:</p> <p>Third Floor ICF Refrigerator:</p> <p>- An opened container of vanilla nutritional supplement, not dated.</p> <p>- A tumbler with blue cap filled with white liquid, not labeled or dated.</p> <p>- A plastic container with red chunks of product, not labeled or dated.</p> <p>- An opened container of sour cream, not dated.</p> <p>Third Floor ICF Freezer:</p> <p>- A glass container of frozen blueberries, not labeled or dated.</p> <p>- Homemade popsicles held in their plastic popsicle mold, not labeled or dated.</p> <p>On [DATE] at 3:52 PM, Staff 19 (CNA) acknowledged the unlabeled and undated items in the refrigerator and freezer. Staff 19 stated not all CNAs cleaned out the refrigerators.</p> <p>On [DATE] at 3:42 PM, Staff 18 (LPN Resident Care Manager) stated dietary staff were responsible for cleaning out and monitoring the contents in the refrigerator.</p> <p>On [DATE] at 4:00 PM, Staff 20 (CNA) stated it was the responsibility of staff to take resident food items from the resident, label a name or room number onto the item, date any open or unopened product, and staff were to place item into the unit refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 10:50 AM, Staff 4 (Dietary Manager) stated dietary staff restocked and checked refrigerators daily and were expected to throw away expired product from the unit refrigerators.</p> <p>4. The following sign was posted on the fourth floor refrigerator door:</p> <ul style="list-style-type: none"> <li>- Attention Staff: Please date all containers when opened.</li> </ul> <p>From [DATE] at 1:15 PM to [DATE] at 10:10 AM, the following items were observed on the fourth floor of the ICF building's refrigerator:</p> <ul style="list-style-type: none"> <li>- A clear cup of white liquid with plastic wrap covering the top, not labeled or dated.</li> <li>- An opened container of thickened white liquid, not dated. The packaging stated to discard four days after opening.</li> <li>- An opened container of thickened juice, with no date which was opened. There was a date of ,d+[DATE] on the bottom of the container.</li> </ul> <p>On [DATE] at 4:00 PM Staff 20 (CNA) stated it was the responsibility of staff to take resident food items from the resident, label a name or room number onto the item, date any open or unopened product, and staff were to place item into the unit refrigerator.</p> <p>On [DATE] at 10:45 AM, Staff 4 (Dietary Manager) stated the date on the bottom of the thickened liquids were to indicate the date in which the liquid was delivered to the facility. Staff 4 stated when staff opened the containers, the expectation was for staff to immediately write the date visibly onto the container, as to not create a health hazard for residents. Staff 4 stated dietary staff restocked and checked refrigerators daily and were expected to throw away expired product from the unit refrigerators.</p>		