

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/26/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to maintain resident rooms and equipment for 2 of 2 rooms (Room #s 361 and 370) and 1 of 2 Units (ICF-Intermediate Care Facility) reviewed for environment and resident council. This placed residents at risk for injury. Findings include: 1. On 6/23/26 at 9:25 AM room [ROOM NUMBER] was observed to have three areas of missing laminate on the sink counter. Each missing laminate area was less than or equal to 0.5 inches in diameter and were rough when touched. On 6/26/26 at 7:59 AM 13 (CNA) stated when he entered room [ROOM NUMBER], the room door opened inward, and the door blocked the sink. Staff 13 stated if he noticed missing laminate he would notify maintenance, but he never saw the missing laminate in room [ROOM NUMBER]. On 6/26/26 at 9:03 AM Staff 14 (Maintenance Director) stated when facility maintenance was required, staff were to notify him, and then he would assign the task to his staff. Staff 14 stated he was not aware of the missing laminate, the edges needed to be dremmed to be smooth to prevent potential skin injury. 2. On 6/23/26 at 9:23 AM with Staff 5 (CNA) room [ROOM NUMBER]'s laminate sink counter was observed to have a large piece of laminate missing. The missing laminate piece was approximately eight inches long by two inches high and was rough to touch. Staff stated he never noticed the missing laminate, but if he did, he would notify maintenance. On 6/26/26 at 9:03 AM Staff 14 (Maintenance Director) stated when facility maintenance was required, staff were to notify him, and he would assign the task to his staff. Staff 14 stated he was not aware of the missing laminate, the edges needed to be dremmed smooth to prevent potential skin injury. 3. Resident 104 was admitted to the facility in 6/2023 with a diagnosis of a stroke. Resident 104's Care Plan revised on 1/28/25 revealed she/he was to use a cane for mobility. Resident 104's 3/27/26 Quarterly MDS revealed she/he was cognitively intact. On 6/25/26 at 2:00 PM during a Resident Council Meeting, Resident 104 stated when she/he was weighed on the ICF wheelchair scale, the support towel (collapsible column) was really loose, and it made her/him feel off balanced. On 6/26/2026 7:59 AM with Staff 13 (CNA) the ICF scale on the third floor was observed to have a support column. The support column, when touched, was loose and moved approximately one inch forward and back. Staff 13 stated the support column was loose for about six months. On 6/26/26 at 9:53 AM Staff 14 (Maintenance Director) stated staff were to notify him if facility maintenance needed to be completed. Staff 14 stated no one informed him the scale column on the ICF was loose.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review it was determined the facility failed to monitor temperatures in the medication refrigerators for 3 of 3 medication refrigerators. This placed residents at risk for receiving medications with reduced efficacy. Findings include: The undated PharMerica Refrigerator Temperatures indicated CDC recommends Twice Daily Temps if Vaccines are Present 1. On 6/25/26 at 9:15 AM, the medication room refrigerator temperature logs for the second floor were reviewed for 6/1/26 through 6/25/26 and revealed no temperatures were recorded for 6/1/26 through 6/25/26 for the day shift and 6/3/26, 6/22/26, 6/23/26 temperatures were not recorded for the night shift. On 6/25/26 at 9:15 AM, Staff 6 (LPN) stated the day shift nurses, and night shift nurses were supposed to document the temperature of the refrigerator, and verified vaccines were present in the refrigerator. 2. On 6/25/26 at 9:23 AM, the medication room refrigerator temperature logs for the third floor were reviewed for 6/1/26 through 6/25/26 and revealed no temperatures were recorded for 6/1/26 through 6/25/26 for the day shift and 6/7/26 and 6/25/25 for the night shift. On 6/25/26 at 9:23 AM, Staff 3 (LPN) stated the day shift nurses and night shift nurses were supposed to document the temperature of the refrigerator, and verified vaccines were present in the refrigerator. 3. On 6/25/26 at 9:30 AM, the medication room refrigerator temperature logs for the fourth floor were reviewed for 6/1/26 through 6/25/26 and revealed no temperatures were recorded for 6/1/26, 6/2/26, 6/5/26, 6/14/26, 6/15/26, 6/16/26 through 6/22/26, and 6/25/26 for the day shift and 6/7/26, and 6/2/26, 6/6/26, 6/10/26, 6/12/26, 6/14/26, and 6/16/26 through 6/18/26 for the evening shift. On 6/25/26 at 9:30 AM, Staff 6 (RN) stated the day shift nurses, and evening shift nurses were supposed to document the temperature of the refrigerator, and verified vaccines were present in the refrigerator. RN Staff 6 stated if the temperatures were out of parameters (measurable factors that help define a system), staff should notify the Director of Nursing Services (DNS) immediately. On 6/25/26 at 9:38 AM, Staff 2 (DNS) confirmed day shift nurses, and night shift nurses were responsible for checking the temperatures of the refrigerators in the medication storage rooms and documenting temperatures. Staff 2 stated her expectation was for the documents to be filled out and accurate and if the temperatures were out of parameters she should be notified immediately.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to prepare and handle food in a sanitary manner in 3 of 4 resident refrigerators reviewed for food service. This placed residents at risk for foodborne illness. Findings include: 1. On 6/25/26 at 9:54 AM, observation was made of the ICF (Intermediate Care Facility) 3 resident refrigerators. The following food items were found unlabeled and undated: hot dogs, buns, pizza snacks, pickles, potato salad and a cup of melted ice cream. On 6/25/26 at 9:55 AM, Staff 25 (CNA) stated she was unsure of the process when a resident brought food in from an outside source, but thought staff were required to date and label residents' food. Staff 25 stated she was unsure how long food could remain in the refrigerator. On 6/25/26 at 11:02 AM, Staff 2 (DNS) observed food items that were unlabeled and undated and confirmed residents' food was required to be labeled and dated, and staff were expected to follow proper labeling and dating procedures. 2. On 6/25/26 at 10:55 AM, observations were made of the ICF (Intermediate Care Facility) 4 resident refrigerators. The following food items were found unlabeled and undated: feta cheese, lean cuisines, chicken and vegetable dumplings, two large boxes of hot pockets, olives and broccoli. On 6/25/26 at 10:56 AM, Staff 26 (CNA) stated CNAs were responsible for labeling and dating residents' food and kitchen staff was responsible for ensuring food was not expired. On 6/25/26 at 11:02 AM, Staff 2 (DNS) observed food items that were unlabeled and undated and confirmed residents' food was required to be labeled and dated, and staff were expected to follow proper labeling and dating procedures. 3. On 6/25/26 at 11:08 AM, observations were made of the SNF (Skilled Nursing Facility) 1 resident refrigerators. The following foods were observed unlabeled and undated: three boxes of lean cuisines meals, a pint of Ben & Jerry's ice cream, yogurt, and an opened undated Red Bull. On 6/25/26 at 11:09 AM, Staff 2 (DNS) observed food items that were undated and unlabeled and confirmed residents' food was required to be labeled and dated, and staff were expected to follow proper labeling and dating procedures. On 6/25/26 at 11:15 AM, Staff 27 (Dietary Aid) stated he was trained to check refrigerators to ensure food was dated and labeled. Staff 27 stated he was not trained to check freezer items for dating, labeling, or expiration. Staff 27 stated he checked all refrigerators the previous day and did not observe any items requiring removal. On 6/25/26 at 11:18 AM, Staff 28 (Cook) stated he checked the resident's refrigerator and freezers daily and was unaware of any foods that needed to be removed. On 6/25/26 at 11:19 AM, Staff 23 (Dietary Manager) stated the expectation was for staff to check resident refrigerators and freezers daily and remove any food that was not dated or labeled.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to ensure a resident's grievance was completed timely for 1 of 13 sampled residents (#39) who attended resident council meeting. This placed residents at risk for unresolved concerns. Findings include: Resident 39 was admitted to the facility in 3/2025 with a diagnosis of cancer. Resident 39's 3/26/26 Quarterly MDS revealed she/he was cognitively intact. Resident 39's Grievances included the following: -On 4/4/26 Resident 39 reported concerns related to staffing and food services. A follow up to this grievance was not completed until 5/6/26.-On 4/18/16 Resident 39 reported concerns related to another resident's behaviors. A follow up to this grievance was not completed until 4/30/26.-On 5/22/26 Resident 39 reported concerns related to the manner other residents accessed an ice machine. A follow up was not completed until 6/1/26.On 6/25/26 at 2:00 PM Resident 39 stated she /he filed three grievances, and it took almost one month before Staff 1 (Administrator) provided her/him with the written resolution. Resident 39 stated she/he was provided the completed grievances on 6/25/26.On 6/26/26 at 10:12 AM Staff 1 stated when a resident filed a grievance the department which conducted the investigation was to provide a resolution to a resident within a week. Staff 1 stated she did not provide Resident 39 timely resolutions.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to follow physician orders and clarify physician orders for 3 of 7 sampled residents (#s 6, 90, and 136) reviewed for dialysis and nutrition. This placed residents at risk for worsening conditions. Findings include: 1 Resident 6 was admitted to the facility in 5/2026 with diagnoses including asthma and diabetes. A review of Resident 6's weight record revealed Resident 6 had a 17-pound weight gain increasing from 169 pounds on 5/18/26 to 186 pounds on 5/22/26. A 5/22/26 Progress Note revealed Resident 6's provider was notified of an increase in bilateral leg edema. A 5/22/26 Provider Progress Note indicated the plan for Resident 6 was, new orders for furosemide (a medication to decrease water retention), new orders for labs, and a new order for a chest x-ray. A 5/26/26 Provider Progress Note revealed Resident 6 had a new diagnosis of heart failure. A 6/25/26 review of Resident 6's medical record revealed no evidence the chest x-ray was completed. On 6/26/26 at 11:07 AM, Staff 11 (RN) stated Resident 6 was having increased leg edema and received orders for furosemide and to elevate her/his legs. Staff 11 stated she did not review the provider's notes; the RNCM was responsible for reviewing provider notes. Staff 11 was unable to locate an order for the chest x-ray on 5/22/26 or chest x-ray results. On 6/26/26 at 12:32 PM, Staff 12 (RNCM) stated her process was to review provider's notes and to clarify any orders if necessary. Staff 12 stated she missed the provider's note on 5/22/26 related to the chest x-ray. Staff 12 stated the provider should have been notified and asked for clarification on whether they wanted the chest x-ray completed for Resident 6. On 6/26/26 at 12:59 PM, Staff 2 (DNS) stated RNCMs were required to review provider notes and reach out for clarification. Staff 2 stated her expectation would have been for staff to reach out to the provider for clarification regarding Resident 6's chest x-ray order. 2 Resident 131 was admitted to the facility on [DATE] with diagnoses including end stage renal disease with dialysis, high blood pressure, and immunodeficiency due to post kidney transplant. A 6/15/26 care plan review indicated Resident 131's medications were to be held on dialysis days per order. A review of Resident 131's medical record revealed no evidence of orders to hold medications on dialysis days. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 6/2026 MAR revealed the following medications were held on 6/16/26, 6/18/26, 6/20/26, and 6/23/26 due to Resident 131 being at dialysis: calcium acetate (a medication that binds phosphate), torsemide (a diuretic medication), Protonix (a medication to lower stomach acid), nifedipine (a medication used to treat high blood pressure), aspirin, NPH insulin (a long acting insulin), finasteride (a medication used to treat enlarged prostates), lactobacillus (a probiotic) Nystatin swish and swallow (a medication used to treat oral yeast), and multiple vitamins. The 6/2026 MAR also revealed Resident 6 had not received Envarsus (a medication used to help prevent organ rejection) four times. On 6/24/26 at 2:50 PM, Staff 2 (DNS) stated Resident 131 did not have orders to hold medications on dialysis days. Staff 2 stated the provider was not notified of the missed medications. Staff 2 stated staff were expected to give medications as ordered, clarify any questions with the provider, and notify the provider for any missed medications. 3. Resident 90 was admitted to the facility in 7/2021 with a diagnosis of kidney disease. Resident 90's Progress Notes revealed the following: -5/1/26 note written by Staff 17 (LPN) indicated Resident 90 reported burning with urination and was concerned about a possible UTI. The note indicated Resident 90's physician was to be notified and she/he would be monitored. -5/2/26-5/4/26 there were no notes. -5/5/26 Resident 90's physician was notified of a need for a narcotic refill. -5/6/26 and 5/7/26 Resident 90 was assessed to have no signs of infection to her/his toe. (There were no notes related to monitoring Resident 90 for signs of a possible UTI.) -5/8/26 staff notified Resident 90's physician that she/he had a low blood pressure of 78/40 and reported blurred vision. Resident 90 was transported to the hospital. Resident 90's clinical record did not reveal documentation Resident 90's physician was notified of her/his reports of burning with urination or a possible UTI. Resident 90's 5/8/26 hospital History and Physical revealed she/he reported having signs of a UTI for about two days, with increased frequency and incontinence. Resident 90 was identified to be retired health care worker and recognized [her/his] symptoms well. Resident 90's 5/11/26 hospital Discharge Summary revealed she/he was admitted to the hospital with altered mental status and pain with urination and was diagnosed with a UTI. On 6/25/26 at 7:58 PM Staff 17 stated she wrote the 5/1/26 note related to Resident 90 reports of burning with urination. Staff 17 acknowledged Resident 90's clinical record did not indicate her/his physician was notified and staff did not monitor her/him for a possible UTI after 5/1/26. On 6/26/26 at 11:04 AM Staff 2 (DNS) stated if residents had burning with urination, their physician was to be notified, and staff were to monitor the resident every shift to assess for a possible UTI. Staff 2 indicated Resident 90's UTI diagnosis and treatment were delayed.		

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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 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 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services 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 monitor dialysis port and failed to care plan dialysis port for 1 of 1 sampled resident (#131) reviewed for dialysis. This placed residents at risk for dialysis related complications. Findings include: Resident 131 was admitted on [DATE] with diagnoses including end stage renal disease. A review of Resident 131's care plan revealed a 6/14/26 care plan for peritoneal dialysis (a process to filter blood using the lining of the stomach), a 6/14/26 care plan to use enhanced barrier precautions due to the peritoneal dialysis catheter, a 6/15/26 care plan indicating dialysis access was through the peritoneal catheter, and a 6/17/26 care plan for peritoneal dialysis catheter care. No information was found on the care plan regarding Resident 131's dialysis port. On 6/22/26 at 2:50 PM, Resident 131 stated she/he was doing peritoneal dialysis at home, but at the facility Resident 131 stated she/he was doing hemodialysis (a medical procedure that uses machines to filter the blood) through a chest port. Resident 131 stated staff did not check her/his chest port. A review of Resident 131's medical record revealed no indication 131's chest port was being monitored. On 6/26/26 at 10:53 AM, Staff 11 (RN) stated Resident 131 had a chest port which she checked on dialysis days. Staff 11 stated there was no order to check the chest port, she just knew it needed done. On 6/26/26 at 12:28 PM, Staff 12 (RNCM) stated Resident 131 did not have orders to monitor the chest port and was not care planned to monitor the chest port. Staff 12 stated staff were expected to check the chest port every shift, and this should be documented in the TAR. On 6/26/26 at 12:51 PM, Staff 2 (DNS) acknowledged Resident 131 did not have orders to monitor the chest port and was not care planned for monitoring of the chest port. Staff 2 stated staff were expected to monitor the chest port before and after dialysis and every shift. Staff 2 stated this should be documented in the TAR and on the care plan.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review it was determined the facility failed to assess a resident prior to implementing bedrails for 1 of 4 sampled residents (#54) reviewed for accidents. This placed residents at risk for entrapment. Findings include: Resident 54 was admitted to the facility in 11/2025 with a diagnosis of a stroke with paralysis to the left side. Resident 54's 11/28/29 Device/Mattress Safety Observation form revealed the type of device was a bed rail, but the form did not identify the length of the rail. The form indicated Resident 54 was able to move in bed but was not able to transfer independently, and the rail was not a restraint. There was no additional information related to the placement of the rail. Resident 54's 11/29/26 Order Details revealed she/he was to have bilateral one quarter rails for mobility. The order instructions included staff were to monitor Resident 54 for entrapment. Resident 54's 12/2/26 admission MDS revealed she/he had moderate cognitive impairment, was able to make her/his needs known, but had difficulty learning new information. Resident 54 was assessed to not attempt to get out of bed by her/himself due to left side paralysis. Resident 54 was also assessed to have increased confusion and hallucinations. Resident 54's Care plan updated on 1/2/26 indicated she/he required assistance with ADLs and used one quarter side rails for bed mobility. Resident 54's 6/4/26 Quarterly MDS revealed she/he was severely cognitively impaired. Resident 54's 6/15/26 side rail consent revealed she/he consented to the use of side rails. On 6/22/26 at 1:30 PM Resident 54 was observed with one quarter rails which were located bilaterally. The rails were located bilaterally at middle of the mattress. Resident 54's right leg was observed over the rail on the left side of the bed. A CNA entered the room and shut the door. On 6/24/26 9:08 AM Staff 22 (CNA) stated Resident 54 at times attempted to get out of bed without assistance, hallucinated, and had rails positioned in the middle of the bed. Staff 22 stated Resident 54 was often found in bed in varying positions and at times had one leg over the bed rail. On 6/24/2026 9:36 AM Staff 15 (CNA) stated Resident 54 was always moving her/his legs in bed. On 6/25/26 at 10:12 AM Staff 16 (RA) stated Resident 54's mental status varied each day, some days she/he was very coherent and other days she/he hallucinated. Staff 16 stated Resident 54 was able to move her right side, could use the rail to reposition, and in the past was observed with her/his right leg over the rail. On 6/24/26 at 9:18 AM Staff 21 (LPN Resident Care Manager) stated rails were usually used by residents to assist with bed mobility. The rail placement was near the head of the bed. Staff 21 stated if the rails were longer, like quarter or half rails, the rails at times could extend from the head of the bed down to a resident's rib cage area. On 6/25/26 at 11:00 AM with Staff 21 Resident 54 was observed in bed with the rail placement in the middle of the bed (aligned with Resident 54's ribs to buttock region.) Staff 21 acknowledged if Resident 54 attempted to swing her/his right leg over the edge of the bed, the rails would inhibit her/his movement. Resident 54 was asked if she/he liked the rails, and she/he stated she/he hated the rails; they hurt her/his knees, and she/he am always hitting the rails. On 6/26/26 at 10:48 AM Staff 2 (DNS) stated the facility usually used assist/mobility bars. Staff 2 stated Resident 54 was busy in her/his bed and moved a lot. Staff 2 stated the rails were generally located at the head of the bed and there was no clear assessment or rationale for Resident 54's rail placement to be in the middle of the bed.		

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NAME OF PROVIDER OR SUPPLIER Laurelhurst Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3060 SE Stark Street Portland, OR 97214	
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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.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure menus were followed for 1 of 5 sampled residents (#78) observed during dining observations. This place residents at risk for lack of honored preferences and nutrition. 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 physician order revealed Resident 78 was allergic to gluten (a protein found in wheat, barley, and rye) and required a gluten free diet. On 6/12/26 a Change of Diet indicated Resident 78 was allergic to gluten, melon, carrots, and bananas. The 6/15/26 Food care plan indicated Resident 78 had Celiac disease (a condition in which eating gluten causes damage to the small intestine) and required a gluten free diet. The 6/22/26 admission Dietary Profile indicated Resident 78 had a regular diet, gluten allergy, and required a gluten free diet. On 6/22/26 at 11:54 AM, Resident 78 stated staff asked about her/his food preferences and allergies sometime after admission; however, staff did not appear to understand Celiac disease and which foods contained gluten. Resident 78 stated she/he was served foods inconsistent with her/his dietary needs for approximately four days despite notifying nursing and dietary staff. Resident 78 stated friends brought food to the facility because the kitchen kept serving her/him meals with gluten. Resident 78 expressed concerns of the dietary staffs understanding of Celiac disease and what foods she/he could consume. On 6/22/26 at 12:00 PM, Witness 1 (Friend) and Witness 2 (Friend) stated they brought food to Resident 78 because the facility continued to serve foods inconsistent with the resident's dietary needs related to Celiac disease. They stated Resident 78 described the experience as distressing and expressed concerns regarding the facility's meal service. On 6/25/26 at 10:16 AM, Staff 11 (RN) stated Resident 78 had Celiac disease and was served foods inconsistent with the resident's dietary needs on multiple occasions. Staff 11 stated dietary staff told her they had not received a dietary slip identifying the residents' gluten free diet. Staff 11 stated for the first couple days the resident's meal ticket did not indicate a gluten free diet and she returned Resident 78's breakfast because it was not gluten free. Staff 11 stated Resident 78 expressed concerns that consuming gluten could cause diarrhea and abdominal pain. On 6/26/26 at 1:32 PM, surveyors requested both a regular and alternative test tray. Surveyors observed the meal was not consistent with the posted menu, as beef stroganoff was served with orzo instead of the listed egg noodles. On 6/26/26 at 1:42 PM, Staff 23 (Dietary Manager) confirmed the meal served was not consistent with the posted menu and confirmed the menu was not followed as indicated.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to provide palatable food to 2 of 5 residents (#s 19 and 78) reviewed for food. This placed residents at risk for weight loss and reduced quality of life. Findings include: 1. Resident 19 was admitted to the facility in 10/2025 with diagnoses including depression and anxiety. The 3/26/26 resident Council minutes revealed residents expressed concerns food lacked flavor and was not palatable. The 5/6/26 Quarterly MDS indicated Resident 19 was cognitively intact. On 6/23/26 at 9:14 AM, Resident 19 stated the food was too salty, did not look good, and was not good to eat. On 6/24/26 at 10:54 AM, Staff 24 (Cook) stated sometimes residents complained about cold food. Staff 24 stated every floor had a microwave that staff used to heat up the residents' food but then the food did not taste good. On 6/24/26 at 11:10 AM, Staff 23 (Dietary Manager) stated she was unaware of recent food complaints but was aware residents expressed concerns in the past about food being cold and not palatable. On 6/26/26 at 1:32 PM, surveyors requested both a regular and an alternative test tray. Surveyors received a quesadilla and steamed broccoli. The quesadilla was tough to chew along the edges, the cheese was not melted, and the broccoli was cold. Additionally, the tray included beef stroganoff with rice and a dinner roll. The beef stroganoff was bland and lacked flavor. On 6/26/26 at 1:42 PM, Staff 23 confirmed the food was cold and not palatable. Staff 23 also stated the beef stroganoff was bland and would have been improved with sour cream. 2. Resident 78 was admitted to the facility on [DATE] with diagnoses including aftercare following knee replacement surgery and pain. On 6/22/26 at 11:54 AM, Resident 78 stated the food did not always taste good. On 6/24/26 at 11:10 AM, Staff 23 (Dietary Manager) stated she was unaware of recent food complaints but was aware residents expressed concerns in the past about food being cold and not palatable. On 6/26/26 at 1:32 PM, surveyors requested both a regular and an alternative test tray. Surveyors received a quesadilla and steamed broccoli. The quesadilla was tough to chew along the edges, the cheese was not melted, and the broccoli was cold. Additionally, the tray included beef stroganoff with rice and a dinner roll. The beef stroganoff was bland and lacked flavor. On 6/26/26 at 1:42 PM, Staff 23 confirmed the food was cold and not palatable. Staff 23 also stated the beef stroganoff was bland and would have been improved with sour cream.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to ensure EBP (Enhance Barrier Precautions) were followed for 2 of 4 sampled residents (#s 9 and 28) reviewed for tube feeding and pressure ulcers. This placed residents at risk for cross contamination. Findings include: 1. Resident 9 was admitted to the facility in 5/2025 with a diagnosis of a stroke. Resident 9's Care Plan initiated 11/11/25 revealed she/he was to be in EBP related to her/his tube feeding. Interventions included gowns and gloves were to be worn with high contact tasks including bathing and personal hygiene. On 6/24/26 at 7:30 AM Resident 9's door was observed to be shut. Staff 19 (CNA) opened Resident 9's door and stepped out and summoned Staff 7 (LPN). Staff 19 was observed to be wearing scrubs and was not wearing a gown or gloves. Staff 19 then reentered Resident 9's room and shut the door. On 6/24/26 at 7:37 AM Staff 19 stated she assisted Resident 9 with personal hygiene and bathing. Staff 19 stated she wore a cloth gown, took it off to summon Staff 7 (LPN), reentered the room, and put on a clean cloth gown to continue assisting Resident 9 with personal hygiene. On 6/24/26 at 8:12 AM Staff 7 (LPN) stated if a resident was to have EBP, staff were to wear a disposable gown. Staff 7 stated she did not observe Staff 19 to wear a gown while providing care. On 6/24/26 at 10:24 AM Staff 20 (Infection Preventionist) stated when a resident was to have EBP staff were to wear nonpermeable disposable gowns, and not a cloth gown when providing high contact tasks. On 6/26/26 at 4:30 PM Staff 2 (DNS) stated staff were not to wear a cloth gown when providing high contact tasks when a resident was in EBP. 2. Resident 28 was admitted to the facility in 1/2026 with diagnoses including pressure ulcers, chronic lower extremity wounds, and MDRO (multidrug resistant organisms, germs that have become resistant to multiple antibiotics). A 6/2021 Center for Disease Control Consideration for Use of Enhanced Barrier Precautions (EBP) in Skilled Nursing Facilities identified that EBP was an approach of targeted gown and glove use for residents with wounds, regardless of the multidrug-resistant organism status of the resident, due to the common existence of organisms in nursing facilities. The 6/4/26 care plan included EBP related to chronic bilateral lower extremity wounds, and right rear thigh wounds. EBP was in place, gowns, gloves donned during the following care: dressing, bathing, showering, personal hygiene, brushing teeth, changing linens, changing briefs, assisting with toileting, wound care, and dressing changes. Strict hand hygiene before gloving and after glove removal was required. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at 1:32 PM, an EBP sign, with instructions to don gown and gloves, was observed in the hall and outside the door of Resident 28's room. A supply of gowns was observed near the door. Random observations from 6/22/26 through 6/24/26 on day and evening shifts, multiple staff were observed entering Resident 28's room without PPE. On 6/23/26 at 8:35 AM Resident 28's EBP sign had been removed. On 6/25/26 at 2:34 PM Staff 6 (RN) entered Resident 28's room to perform wound care to her/his feet. Staff 6 did not perform hand hygiene. Staff 6 donned gloves but not a gown. Resident 28 had an open area to her/his toes and heel. Staff 6 stated she/he was not aware she/he needed to wear a gown for wound care. On 6/26/26 at 12:18 PM Staff 20 (Infection Preventionist) stated the physician orders were still active for Resident 28 to be on EBP, and she did not know why staff removed the EBP sign and PPE. Staff 20 stated there were still orders		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review it was determined the facility failed to ensure a call light was accessible to a resident for 1 of 13 residents (#54) reviewed for staffing. This placed residents at risk for delayed care. Findings include: Resident 54 was admitted to the facility in 11/2026 with a diagnosis of a stroke. Resident 54's Care Plan revised 3/25/26 indicated she/he was at risk for falls and staff were to remind her/him to activate the call light for assistance. Observation on 6/23/26 at 8:23 AM revealed Resident 54's call light was not within reach. Staff 1 (Administrator) entered Resident 54's room and secured her/his call light within her/his reach. On 6/24/26 at 9:12 AM Resident 54 was observed in bed. Resident 54's call light was not on her/his bed. Staff 7 (LPN) entered Resident 54's room and located her/his call light under her/his bed. Staff 7 indicated the call light was to be secured to Resident 54's sheets or gown so she/he could reach it. On 6/24/26 at 9:36 AM Staff 15 (CNA) stated Resident 54 was able to activate the call light. On 6/26/26 at 10:48 AM Staff 2 (DNS) stated residents were to have their call lights within reach.		