STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385044	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menlo Park Post Acute	745 NE 122nd Avenue Portland, OR 97230

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 41458 Based on interview and record review it was determined the facility failed to inform residents and/or the residents' responsible party of the risks and benefits, and to ensure consent was obtained for the use of psychotropic medications for 2 of 5 sampled residents (#s 34 and 66) reviewed for unnecessary medications. This placed residents at risk for lack of informed consent. Findings include: The facility's Psychoactive Medications policy, dated 8/1/24, indicated risks and benefits of drug use and revealed informed consent was to be obtained from the resident/resident representative prior to administration of any psychoactive medication. 1. Resident 34 was admitted to the facility in 3/2023 with diagnoses including major depressive disorder. Resident 34's 10/2024 MAR revealed the resident received the following psychotropic medications as ordered by her/his physician: -Buspirone (a medication to treat anxiety), three times a day for anxiety. -Sertraline (a medication to treat depression), one time a day for major depression. -Clonidine (a medication to treat anxiety), every 6 hours as needed for anxiety. Review of Resident 34's health record revealed no documentation to indicate the resident or her/his representative were informed of the risks and benefits of buspirone, sertraline or clonidine and no evidence the resident consented to receive the medications. On 11/6/24 at 11:51 AM Staff 2 (Interim DNS) stated it was her expectation nursing staff reviewed the risks and benefits of psychotropic medications with residents prior to the residents taking the medications and confirmed Resident 34 received buspirone, sertraline and clonidine without consent being obtained. 2. Resident 66 was admitted to the facility in 10/2024 with diagnoses including major depressive disorder. Resident 66's 10/2024 MAR revealed the resident received the following psychotropic medication as ordered by her/his physician: (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Quetiapine (a medication to treat major depressive disorder), one time a day at bedtime. Review of Resident 66's health record revealed no documentation to indicate the resident or her/his representative were informed of the risks and benefits of quetiapine and no evidence the resident consented to receive the medication. On 11/6/24 at 11:51 AM Staff 2 (Interim DNS) stated it was her expectation nursing staff reviewed the risks and benefits of psychotropic medication with residents prior to the residents taking the medication and confirmed Resident 34 received quetiapine without consent being obtained.

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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. 41458 Based on observation and interview it was determined the facility failed to ensure a homelike environment for 1 of 1 facility reviewed for dining. This placed residents at risk for a lessened quality of life. Findings include: Observations on 11/5/24 through 11/8/24 between the hours of 8:00 AM and 12:35 PM revealed meals were served with plastic spoons, plastic glasses and Styrofoam cups. On 11/5/24 at 12:38 PM Resident 66 was eating lunch. Resident 66 held up a plastic spoon and stated, they give us this crap to eat with. On 11/6/24 at 1:38 PM Staff 29 (CNA) stated residents usually received regular forks and knives but were given plastic spoons, plastic glasses and Styrofoam cups for at least the past month. Staff 29 stated this was not homelike. On 11/6/24 at 1:42 PM Staff 30 (Dietary Manager) stated the facility did not have enough glasses, cups or silverware for all of the meal service. Staff 30 stated plasticware and Styrofoam cups were not homelike. On 11/8/24 at 9:17 AM Staff 13 (Activities Director) confirmed multiple residents complained about paper and Styrofoam cups, plastic glasses and plastic utensils. Staff 13 reported the residents stated it feels like a fast food restaurant rather than a homelike environment when they received plastic and Styrofoam dishware and utensils.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43690 Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from verbal abuse by a resident for 1 of 1 sampled residents (#19) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 19 admitted to the facility in 3/2024 with diagnoses including infection and anxiety disorder. A 10/10/24 Quarterly MDS revealed Resident 19 had moderate cognitive impairment. Resident 17 admitted to the facility in 10/2024 with diagnoses including amputation and obesity. A 10/23/24 Admission MDS revealed Resident 17 was cognitively intact. On 11/6/24 at 11:55 AM Resident 17 was observed to enter the doorway of Resident 19's room where she/he proceeded to yell and swear at Resident 19. Resident 17 told Resident 19 to stop fucking yelling out and to turn her/his damn tv down. The interaction was observed by Staff 13 (Activities Director), Staff 22 (Physical Therapy Assistant), Staff 21 (CMA) and Witness 1 (Family Member). On 11/6/24 at 12:02 PM Staff 22 stated he was doing a therapy session with Resident 17 when the resident unexpectedly stopped in the doorway of Resident 19's room and started shouting and cursing at Resident 19. Staff 22 stated he went into Resident 19's room to ask if she/he was ok. Staff 22 stated Resident 19 said she/he did not know what happened or why Resident 17 was screaming at her/him. On 11/7/24 9:29 AM Resident 19 stated a resident was at her/his doorway and was yelling at her/him. Resident 19 stated she/he felt scared and did not know why she/he had been yelled at. On 11/7/24 at 9:38 AM Staff 21 stated she observed Resident 17 in the doorway of Resident 19's room yelling at her/him. Staff 21 stated she went to get help from another staff member when Resident 17 was swearing at Resident 19 in an escalated voice. On 11/7/24 at 9:48 AM Staff 13 stated she was in a resident room across the hall when she heard Resident 17 yell at Resident 19 your tv is too fucking loud and you are too loud. Staff 13 stated she went into Resident 19's room to make sure she/he was ok. Staff 13 stated Resident 19 said she/he felt weird and she/he did not know why Resident 17 yelled at her/him. On 11/7/24 at 10:20 AM Resident 17 stated she/he stopped in the doorway of Resident 19's room and yelled at her/him. Resident 17 stated she/he yelled at resident 19 to turn her/his damn tv down, used the f-word a few times, told the resident to use her/his damn call light and told the resident she/he was the rudest person in the building. Resident 17 also stated I have a tendency to lose control of my emotions and I rage at times. Raging has been a part of my life since middle school. On 11/7/24 at 2:18 PM Witness 10 stated Resident 19 had a bad day the day of the incident. Witness 10 stated Resident 19's emotions run high sometimes and she/he rages. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 12:22 PM Staff 1 (Administrator) and Staff 2 (Interim DNS) were notified of the findings of this investigation. Staff 1 stated moving forward, Resident 17 was to let staff know when she/he was frustrated. Staff 1 stated it was his expectation to keep residents safe, protected and free from abuse at all times.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41458 Based on interview and record review it was determined the facility failed to ensure transfer notices with appeal rights were provided in writing to residents and their representatives, and to ensure the Office of the State Long-Term Care Ombudsman was notified of resident hospitalization s for 1 of 1 sampled resident (#73) reviewed for hospitalization s. This placed residents at risk for lack of information regarding their options, rights, and lack of advocacy from the Ombudsman Office. Findings include: Resident 73 was admitted to the facility in 9/2024 with diagnoses including complications of a foreign body accidentally left in the body following heart catheterization (a procedure that uses a catheter to diagnose and treat heart conditions). A review of Resident 73's health record revealed she/he was transferred to the hospital on 10/8/24. No evidence was found in Resident 73's health record to indicate a transfer notice with appeal rights was provided in writing to the resident or their representative upon transfer to the hospital, or that the Office of the State Long-Term Care Ombudsman was notified of the resident's transfer to the hospital. On 11/7/24 at 2:44 PM Staff 28 (Medical Records) indicated she was aware the Office of the State Long-Term Ombudsman needed to be notified when residents transferred to the hospital but she had not notified the Ombudsman's office of resident hospital transfers since 8/2024. On 11/7/24 at 2:50 PM Staff 2 (Interim DNS) stated the charge nurse was supposed to complete the written notification of transfer for residents transferring to the hospital and Staff 28 was to notify the Office of the State Long Term Care Ombudsman when residents transferred to the hospital. Staff 2 confirmed neither was completed when Resident 73 transferred to the hospital on 10/8/24.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41458 Based on interview and record review it was determined the facility failed to provide residents with a written notice of the facility's bed hold policy at the time of transfer to the hospital for 1 of 1 sampled resident (#73) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: Resident 73 was admitted to the facility in 9/2024 with diagnoses including complications of a foreign body accidentally left in the body following heart catheterization (a procedure that uses a catheter to diagnose and treat heart conditions). A review of Resident 73's health record revealed she/he was transferred to the hospital on 10/8/24. No evidence was found in Resident 73's health record to indicate a written bed hold policy with reserved bed payment was provided to the resident or their representative upon transferring to the hospital on 10/8/24. On 11/7/24 at 2:50 PM Staff 2 (Interim DNS) stated the charge nurse was supposed to provide a written bed hold policy with reserved bed payment to the resident upon transfer to the hospital. Staff 2 confirmed Resident 73 did not receive a written bed hold policy when she/he transferred to the hospital on 10/8/24.

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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** 41458 Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 3 of 5 sampled residents (#s 8, 34 and 66) reviewed for unnecessary medications. This placed residents at risk for adverse medication consequences. Findings include: 1. Resident 34 was admitted to the facility in 3/2023 with diagnoses including major depression and diabetes. a. A 10/28/24 Physician Order indicated Resident 34 was prescribed clonidine (an anti-anxiety medication) one tablet every six hours as needed. Hold if systolic blood pressure (SBP-the maximum pressure in your blood vessels when your heart contracts and pumps blood) was less than 110. Resident 34's 10/2024 MAR indicated the resident received clonidine one time on 10/29/24, three times on 10/30/24 and one time on 10/31/24. A review of Resident 34's health record revealed no evidence the resident's blood pressure was assessed prior to administering clonidine. On 11/7/24 at 8:33 AM Staff 12 (LPN) reviewed Resident 34's MAR and stated the resident's SBP was not assessed prior to administering Resident 34's clonidine because the MAR was not set-up in a way staff would know to check the resident's blood pressure and hold the medication if the resident's SBP was less than 110. On 11/7/24 at 11:57 AM Staff 4 (LPN-Care Manager) confirmed there was no evidence staff assessed Resident 34's SBP prior to administering the resident's clonidine. b. An 8/1/24 Physician Order indicated Resident 34 was prescribed metoprolol succinate ER (to treat high blood pressure) to be given in the morning. Hold if systolic blood pressure (SBP-the maximum pressure in your blood vessels when your heart contracts and pumps blood) was less than 110 and/or heart rate (HR) was less than 55. Resident 34's 10/2024 MAR indicated the resident received metoprolol succinateER on all days. A review of Resident 34's health record revealed no evidence the resident's blood pressure and heart rate were assessed prior to administering metoprolol succinate ER. On 11/7/24 at 8:33 AM Staff 12 (LPN) reviewed Resident 34's MAR and stated the resident's SBP and HR were not assessed prior to administering Resident 34's metoprolol because the MAR was not set-up in a way staff would know to check the resident's blood pressure and HR and hold the medication if SBP was less than 110 and HR was less than 55. On 11/7/24 at 11:57 AM Staff 4 (LPN-Care Manager) confirmed there was no evidence staff assessed Resident 34's SBP and HR prior to administering the resident's metoprolol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 66 was admitted to the facility in 10/2024 with diagnoses including major depressive disorder. a. A 10/8/24 Physician Order indicated Resident 66 was prescribed Clindamycin Phosphate External topical medication (a topical antibiotic) to be applied to affected area every morning and at bedtime. Resident 66's 10/2024 MAR indicated the resident's Clindamycin topical antibiotic was not applied according to physician orders on the following days: -10/9 AM; -10/17 PM. On 11/7/24 at 8:24 AM Staff 12 (LPN) stated on 10/9/24 she did not apply Resident 34's Clindamycin topical antibiotic because she was unable to locate the medication in the cart. On 11/7/24 at 11:21 AM Staff 4 (LPN-Care Manager) confirmed Resident 34's Clindamycin topical antibiotic was not provided on 10/9/24 and 10/17/24 and there was no documentation in the resident's health record as to why the medication was missed. b. A 10/8/24 Physician Order indicated Resident 66 was prescribed Diprolene External Ointment (for relief of redness, swelling, heat, inflammation and itching caused by skin problems) to be applied to affected areas in the morning and at bedtime. Resident 66's 10/2024 MAR indicated the resident's Diprolene was not applied according to physician orders on the following days: -10/9 AM; -10/11 AM. On 11/7/24 at 8:24 AM Staff 12 (LPN) stated on 10/9/24 she did not apply Resident 34's Diprolene External Ointment because she was unable to locate the medication in the cart. On 11/7/24 at 11:21 AM Staff 4 (LPN-Care Manager) confirmed Resident 66's Diprolene External Ointment was not provided on 10/9/24 and 10/11/24 and there was no documentation in the resident's health record as to why the medication was missed. c. A 10/11/24 Physician Order indicated Resident 66 was prescribed Protonix (treats gastric reflux and damage to the esophagus) one time a day. Resident 66's 10/2024 MAR indicated the resident's Protonix was not given according to physician orders on the following days: -10/12; -10/22; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/25 and -10/26. On 11/7/24 at 8:24 AM Staff 12 (LPN) stated she did not know why Resident 66's Protonix was not administered. On 11/7/24 at 11:21 AM Staff 4 (LPN-Care Manager) confirmed Resident 66's Protonix was not administered on 10/12/24, 10/22/24, 10/25/24 and 10/26/24 and there was no documentation in the resident's health record as to why the medication was missed. Staff 4 stated Protonix was stored in the facility's Cubex (automated medication dispensing system) so the medication was available and should not have been missed. 50926 3. Resident 8 was admitted ,d+[DATE] with diagnoses that included high blood pressure and sleep apnea. An 8/22/24 Physician Order indicated Resident 8 was prescribed Prozasin (a medication used for high blood pressure and treatment of nightmares) with instructions to hold the medication if the systolic blood pressure (SBP) was less that 110. Review of Resident 8's 10/2024 MAR revealed the resident's Prozasin was given outside of the physician's parameters on the following days: -10/11/24 SPB 103 -10/24/24 SBP 94 -10/30/24 SBP 104 -10/31/24 SBP 56 On 11/7/24 at 2:48 PM Staff 3 (RNCM) confirmed medication documentation indicated the medication was administered on the dates the systolic blood pressure was below 110. On 11/8/24 at 8:33 AM Staff 16 (CMA) confirmed medication documentation indicated the medication was administered on the dates the systolic blood pressure was below 110. On 11/8/24 at 11:03 AM Staff 2 (Interim DNS) notified of findings and no additional information was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 41458 Based on observation, interview, and record review it was determined the facility failed to assist in vision care needs for 1 of 1 sampled resident (#34) reviewed for vision. This placed residents at risk for impaired vision. Findings include: Resident 34 was admitted to the facility in 3/2023 with diagnoses including major depression and diabetes. A 12/27/23 Request for Medical Eye Care, resident authorization form, indicated Resident 34 consented to have a vision examination on 12/27/23. The 9/14/24 Quarterly MDS indicated Resident 34 had intact cognitive functioning and the resident wore glasses. A review of Resident 34's heath record revealed no evidence a vision examination was scheduled or completed. Observations from 11/5/24 through 11/7/24 between the hours of 10:14 AM and 9:01 PM revealed Resident 34 was not wearing glasses. On 11/5/24 at 9:23 AM, Resident 34 stated she/he was supposed to get glasses last year around Christmastime but nothing happened. Resident 34 stated she/he asked for an appointment several times but was yet to be scheduled for a vision examination. On 11/7/24 at 8:43 AM, Staff 2 (DNS) confirmed there was no evidence in Resident 34's health record that a vision examination was completed. Staff 2 stated the resident authorized to have a vision examination completed last December but the examination was never scheduled. On 11/7/24 at 8:47 AM, Staff 14 (Social Services Director) confirmed Resident 34 should have been scheduled for a vision examination but her/his examination fell through the cracks and was not completed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 43690 Based on interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 1 sampled resident (# 39) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include: The facility's 8/2024 Trauma-Informed Care Policy and Procedure revealed the following: -Realize the prevalence of trauma: Through education and training of care staff, -Recognize how trauma affects individuals: Through education and identification of triggers, -Responding/putting knowledge into practice: Through development of resident-centered care planning, and -Resisting re-traumatization: Through avoiding identified triggers and making empathetic, reasonable modifications to the care approach and environment. Resident 39 was admitted to the facility in 7/2022 with diagnoses including Post-traumatic stress disorder (PTSD) and major depressive disorder. Resident 39's 7/25/22 Social Services Assessment revealed the resident was not assessed for her/his diagnosis of PTSD. Resident 39's 10/9/24 Quarterly MDS revealed the resident was able to make her/himself understood and understood others without difficulty. No evidence was found in Resident 39's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers. On 11/5/24 at 3:14 PM Staff 14 (Social Services Director) stated resident trauma screenings were to be completed at the time of admission for all residents, especially those residents with a diagnosis of PTSD. On 11/5/24 at 3:42 PM Staff 4 (LPN Care Manager) acknowledged the findings of this investigation and stated Resident 39 should have had trauma informed screening completed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41458 Based on interview and record review it was determined the facility failed to ensure CNAs received annual performance reviews for 5 of 5 randomly selected CNA staff (#s 6, 7, 8, 9 and 10) reviewed for sufficient and competent staffing. This placed residents at risk for lack of care by competent staff. Findings include: A review of personnel records on 11/6/24 at 12:01 PM with Staff 23 (Human Resources/Payroll) indicated the following employees had not received their annual performance evaluations: -Staff 6 (CNA), hire date 9/17/15: no annual performance review was completed. -Staff 7 (CNA), hire date 9/16/14: no annual performance review was completed. -Staff 8 (CNA), hire date 9/15/17: no annual performance review was completed. -Staff 9 (CNA), hire date 8/1/08: no annual performance review was completed. -Staff 10 (CNA), hire date 6/24/14: no annual performance review was completed. On 11/6/24 at 12:01 PM Staff 23 confirmed annual performance reviews for Staff 6, Staff 7, Staff 8, Staff 9 and Staff 10 were not completed.

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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. 43690 Based on observation and interviews it was determined the facility failed to ensure medications and biologicals were maintained within secured (locked) locations, accessible only to designated staff for 3 of 6 medication and treatment carts reviewed for safe medication storage. This placed residents at risk for unsafe access to medications and diversion of medication. Findings include: The facility's 1/2023 Storage of Medication Policy stated: In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medications supplies should remain locked when not in use or attended by persons with authorized access. 1. On 11/6/24 at 1:38 PM a treatment cart was observed to be unlocked on Hall 1. The nurse was not in view of the cart. On 11/6/24 at 1:47 PM Staff 12 (LPN) confirmed the cart was unlocked. 43691 2. On 11/7/24 at 9:53 AM a medication cart was observed to be unlocked and unattended on Hall 3. On 11/7/24 at 9:57 AM Staff 32 (LPN) confirmed the cart containing perscription medications and inhalers was left unlocked and unattended. 50926 3. On 11/5/24 at 8:07 AM the treatment cart in Hall 1 was observed to be unlocked and unattended. Staff 19 (LPN) returned to cart within one minute. He explained the contents of the cart included wound treatment supplies, equipment for checking blood sugar levels, and residents' insulin (an injectable medication). He also confirm the treatment cart had been left unlocked and unattended. On 11/8/24 at 11:03 AM Staff 2 (Interim DNS) was notified of the findings. No additional information was provided. 4. On 11/6/24 at 8:55 PM the treatment cart and the Hall 1 medication cart were observed near the south entrance. The treatment cart was unlocked and the computer on the medication cart open to a resident's medical record. Both were unattended. At 9:00 PM Staff 17 (RN) confirmed the cart had been unlocked and the computer had been unsecured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385044	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menlo Park Post Acute	745 NE 122nd Avenue Portland, OR 97230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/8/24 at 11:03 AM Staff 2 (Interim DNS) was notified of the findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 43690 Based on observation, interview and record review it was determined the facility failed to ensure the ice machine and ice machine scoop were cleaned adequately to maintain sanitary conditions in 1 of 1 kitchen reviewed for sanitary kitchen services. This placed residents at risk of foodborne illness. Findings include: 1. On 11/4/24 at 9:34 AM the ice machine adjacent to the kitchen was observed to have a pink/black substance on a plastic shield inside the machine. Condensation was observed dripping over the substance onto the ice. On 11/4/24 at 9:39 AM Staff 18 (Maintenance Director) stated the ice machine was cleaned every month. Staff 18 acknowledged the presence of the pink/black substance and confirmed the ice machine should be free of any debris or contaminants. On 11/4/24 at 9:58 AM Staff 1 (Administrator) acknowledged the existence of pink/black substance inside the ice machine and stated the ice machine needed to be cleaned. 2. On 11/4/24 at 9:34 AM the ice machine scoop located on the wall next to the ice machine was observed to be stored in a clear plastic container with a black substance and clear slime on the bottom of the container. On 11/4/24 at 9:49 AM Staff 18 (Maintenance Director) stated the ice machine scoop container needed to be cleaned and acknowledged the presence of a black substance and clear slime. On 11/4/24 at 9:58 AM Staff 1 (Administrator) acknowledged the existence of black substance and clear slime on the bottom of the ice scoop container and stated the container needed to be cleaned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385044	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menlo Park Post Acute	745 NE 122nd Avenue Portland, OR 97230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41458 Based on interview and record review it was determined the facility failed to ensure CNA staff received 12 hours of in-service training annually for 5 of 5 randomly selected staff members (#s 6, 7, 8, 9, and 10) reviewed for evidence of in-service training. This placed residents at risk for lack of quality care. Findings include: On 11/6/24 at 1:19 PM Staff 23 (Human Resources/Payroll) provided a list of annual training hours for CNA staff which revealed the following: -Staff 6 (CNA): 0 annual training hours; -Staff 7 (CNA): 8 annual training hours; -Staff 8 (CNA): 11 annual training hours; -Staff 9 (CNA): 0 annual training hours and -Staff 10 (CNA) 8 annual training hours. On 11/6/24 at 1:19 PM Staff 23 confirmed Staff 6, Staff 7, Staff 8, Staff 9 and Staff 10 did not complete the required 12 hours of annual in-service training. On 11/8/24 at 11:09 AM Staff 1 (Administrator) acknowledged CNA staff were required to have 12 hours of annual in-service training.