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	02/13/2026

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review it was determined the facility failed to ensure dishwasher temperatures met the minimum requirements for 1 of 1 dishwasher and failed to ensure food was labeled and stored in a manner to minimize spoilage and cross contamination for 1 of 1 resident refrigerator reviewed for the kitchen. This placed residents at risk for food borne illnesses, communicable diseases, and un-sanitized dishware and utensils. Findings include: The facility's Dishwashing policy dated 8/2024 included the following:- Do not run dishes through until machine has reached proper temperature for your specific machine. This may take multiple cycles.- Check for proper temperatures and pressure. Log Temps, if deficient, tell FNS Manager and/or Maintenance Director. The facility's Resident Food from Outside Source policy dated 8/2024 included the following:- Refrigerated food items from an outside source is stored in a container with the following information on it: date product was received, name of product, resident name and room number. - Refrigerated foods that are unlabeled or undated, when noted, is discarded.- Homemade items, restaurant leftovers, take out items, milk, cottage cheese and similar type items is discarded on day three. 1. On 2/11/26 at 10:21 AM, the dishwasher temperature log was observed to be blank for 2/11/26. On 2/11/26 at 10:21 AM, the dishwashing machine's temperature gauge was observed to be at 110*F and Staff 20 (Dietary Aide) was observed rinsing dirty dishes and loading them onto a rack. He stated the machine was a low temperature machine and confirmed the machine's current thermometer read was 110*F. Staff 20 stated the temperature was supposed to be at 120*F and confirmed the log for 2/11/26 was blank. He stated he usually checked the temperature before washing dishes and after washing dishes. From 10:21 AM to 10:31 AM, the temperature gauge remained at 110*F, Staff 20 completed three loads of dishes and was preparing a fourth load into the dishwasher. On 2/11/26 at 10:32 AM, Staff 7 (Dietary Director) confirmed the dishwasher was a low temperature machine and required the temperature to be at or above 120*F in order for the dishes and utensils to be considered sanitized. She stated staff did not touch the machine and did not have the ability to adjust it.On 2/11/26 at 10:40 AM, Staff 20 continued to unload and load the dishwasher with dirty dishes while the thermometer gauge remained at 110*F.On 2/11/26 at 11:03 AM, Staff 21 (Dietary Aide) inserted a thermometer into the water of the dishwashing machine, which read 111*F. On 2/11/26 at 11:09 AM, Staff 7 inserted a thermometer into the water of the dishwashing machine, which read 118*F. She confirmed the dishwasher was not at the temperature needed in order for the dishes and utensils to be appropriately sanitized. She stated when the temperature was not at 120*F or above, staff were expected to let her know immediately.On 2/12/26 at 4:02 PM, Staff 1 (Administrator) stated he expected the dishwasher to be at the appropriate level for dishes and utensils to be sanitized. He stated he expected for staff to inform management immediately when the temperature of the dishwasher was below it's appropriate level. 2. On 2/11/26 at 8:41 AM, the inside of the resident refrigerator (a refrigerator designated for residents' food only) was observed to have a bag with a resident's name and room number on it, but no date.On 2/12/26 at 8:58 AM, the inside of the resident refrigerator was observed to have a bag with a resident's name and room number on it, but no date. Inside of the bag included a container of watermelon, cantaloupe and honey dew melon in (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a pool of liquid, but no date or expiration; a rotisserie chicken inside of a bag with no date or expiration; and two slices of processed cheese enclosed in plastic packaging with no date or expiration. On 2/12/26 at 9:05 AM, Staff 22 (Dietary Aide) stated he checked the resident refrigerator each day but did not throw away any of the contents inside of the resident refrigerator. He stated it was the responsibility of CNAs and housekeeping to throw away resident items in the refrigerator.On 2/12/26 at 10:12 AM, Staff 18 (CNA) stated when residents or family brought in food from outside of the facility, CNAs were responsible to put the resident's name, room number, and date it was received on the container. She stated CNAs threw away spoiled food or after the third day after it was received.On 2/12/26 at 10:17 AM, Staff 19 (CNA) stated when residents wanted to store their own food in the refrigerator, CNAs were responsible for putting the resident's name, room number, and date it arrived on the container. She stated CNAs were not supposed to throw away anything and dietary staff were responsible for cleaning and throwing away food. On 2/12/26 at 10:20 AM, Staff 17 (CNA) stated CNAs were responsible for putting a resident's name, room number, and the day it was received onto the container when residents bring food from outside of the facility. She stated CNAs did not throw away any food from the resident refrigerator and it was the responsibility of kitchen or housekeeping staff to do so.On 2/12/26 at 10:28 AM, Staff 7 (Dietary Director) confirmed the resident refrigerator had an undated bag that contained the undated container of melons, undated rotisserie chicken and two undated slices of processed cheese. She stated it was the responsibility of CNAs to receive a resident's food from outside and to put their name, room number, and day it was received onto the container. Staff 7 stated she expected for dietary staff, CNAs and housekeeping to work together to ensure unlabeled food, expired food, and food that has been in the refrigerator for three days to be thrown out. On 2/13/26 at 8:18 AM, Staff 1 (Administrator) stated he expected for dietary staff, housekeeping and CNAs to work together to ensure unlabeled food, expired food, or food that has been in the resident refrigerator for three days to be thrown out.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to complete comprehensive MDS assessments in the required timeframe for 3 of 26 sampled residents (#s 30, 62 and 66) reviewed for resident assessment. This placed residents at risk for unassessed needs. Findings include:1. Resident 66 was admitted to the facility in 1/2021 with a diagnosis of an encounter for orthopedic aftercare following surgical amputation. Resident 66's 1/6/26 Annual MDS Assessment was listed in her/his health record as in progress and was not signed or submitted by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 66's 1/6/26 Annual MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated the assessment was partially completed and not ready to be submitted. Staff 36 stated the assessment was a priority but she did not know when she would be able to complete it and submit it. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 2. Resident 30 was admitted to the facility in 5/2024 with a diagnoses including heart failure. Resident 30's 1/15/26 (Re-Admission) admission MDS assessed her/him as cognitively intact with little to no interest in doing things. The Activities CAA summary only addressed activities as to observe resident's acclimation to facility and will encourage and assist resident with activity programming as resident is accepting. No other information was documented as assessed for the reasons for little to no interest in recreational, diversional or leisure interest. On 2/13/26 at 924 AM Staff 9 (Activity Director) stated she did not complete or contribute information for Resident 30's leisure and recreational activity preferences for the MDS. On 2/13/26 at 12:42 PM Staff 2 (DNS) expected the triggered Activities CAA in Resident 30's 1/15/26 admission MDS to fully assess the resident's activity needs and preferences. No additional information was provided. 3. Resident 62 was admitted to the facility on [DATE] with diagnoses including third degree burns. The 2/1/26 admission MDS was completed and signed on 2/10/26, two days past the fourteen-day completion timeframe. On 2/12/26 at 1:44 PM Staff 4 (LPN Resident Care Manager) confirmed the late MDS completion date.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review it was determined the facility failed to complete Quarterly MDS assessments in the required timeframe for 7 of 8 sampled residents (#s 12, 15, 26, 45, 51, 67 and 80) reviewed for resident assessment. This placed residents at risk for unassessed needs. Findings include:1. Resident 12 was admitted to the facility in 7/2022 with a diagnosis of pneumonia. Resident 12's 1/6/26 Quarterly MDS was listed as in her/his health record as in progress and was not completed or signed by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 12's 1/6/26 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated there were still sections of the assessment that she needed to complete before she submitted it. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 2. Resident 15 was admitted to the facility in 6/2025 with a diagnosis of multiple rib fractures. Resident 15's 12/22/25 Quarterly MDS Assessment was listed in her/his health record as in progress and was not completed or signed by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 15's 1/6/26 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated the assessment was partially completed and not ready to be submitted. Staff 36 stated the assessment was a priority but she did not know when she would be able to complete it and submit it. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 3. Resident 26 was admitted to the facility in 4/2019 with a diagnosis of combined systolic (congestive) and diastolic (congestive) heart failure (a type of heart failure characterized by the heart being unable to contract and relax properly). Resident 26's 12/16/25 Quarterly MDS Assessment was submitted on 2/12/26 (58 days after the Assessment Review Date). On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 26's 12/16/26 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated it was not ideal that Resident 26's 12/16/25 Quarterly Assessment was completed more than 14 days after the ARD. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 4. Resident 45 was admitted to the facility in 6/2021 with a diagnosis of ataxic gait (an unsteady, uncoordinated walking pattern caused by brain damage). Resident 45's 12/17/25 Quarterly MDS Assessment was listed in her/his health record as in progress and was not completed or signed by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 45's 12/17/25 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated a fair amount of the assessment was partially completed but it was not ready to be submitted. Staff 36 stated she did not know when it would be ready to submit. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 5. Resident 51 was admitted to the facility in 10/2022 with a diagnosis of hemiplegia and hemiparesis (neurological conditions causing one-sided body weakness or paralysis) following a stroke. Resident 51's 1/6/26 Quarterly MDS Assessment was listed in her/his health record as in progress and was (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not completed or signed by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 51's 1/6/26 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated the interviews were done but the part she was responsible for completing was not done yet. Staff 36 stated she did not know when it would be ready to submit. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 6. Resident 67 was admitted to the facility in was admitted to the facility in 6/2019 with a diagnosis of dementia. Resident 67's 12/23/25 Quarterly MDS Assessment was listed in her/his health record as in progress and was not completed or signed by the recertification survey exit date of 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 67's 12/23/25 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated she was still waiting for additional data in order to submit the assessment. Staff 36 stated she did not have a timeline for the data or submission. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans. 7. Resident 80 was admitted to the facility in 5/2023 with a diagnosis of metabolic encephalopathy (a brain dysfunction caused by illness, organ failure or chemical imbalances that alter brain metabolism). Resident 80's 1/6/26 Quarterly MDS was listed in her/his health record as in progress and was not completed or signed by the recertification survey exit date 2/13/26. On 2/13/26 at 12:21 PM Staff 36 (RN, MDS Coordinator) acknowledged Resident 80's 1/6/26 Quarterly MDS Assessment was not completed within 14 days of the Assessment Review Date (ARD). Staff 36 stated the interviews were done but the part she was responsible for completing was not done yet. Staff 36 stated she did not know when it would be ready to submit. On 2/13/26 at 1:10 PM Staff 1 (Administrator) acknowledged the resident's assessment was not completed timely and he knew it was also an issue for other residents. Staff 1 stated he expected all residents' MDS Assessments to be completed timely because they were an important factor in developing and maintaining resident-centered care plans.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview and record review it was determined the facility failed to provide resident centered activities for 5 of 5 sampled residents (#s 2, 3, 20, 30 and 60) reviewed for activities. This placed residents at risk for diminished quality of life. Findings include: The facility's undated Activities policy included the following: - Activity programs are designed to meet the interests of and support the physical, mental and psychosocial wellbeing of each resident.- Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of wellbeing and to promote or enhance physical, cognitive or emotional health.- Activities are not necessarily limited to formal activities being provided only by activities staff.- Other facility staff may also provide the activities.- Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board (e.g., bed bound or visually impaired residents).- Residents are encouraged, but not required, to participate in scheduled activities. 1. Resident 20 was admitted to the facility in 1/2026 with diagnoses including blindness in left and right eyes and dysphagia following cerebral infarction (difficulty swallowing following a stroke). The 5-Day Admissions MDS with an ARD of 2/2/26 revealed Resident 20 had a BIMS score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance with all ADLs, including always needing assistance with reading written materials. Resident 20's 1/2026 Activity Profile revealed it was very important to listen to music she/he liked and to go outside for fresh air when the weather was good. It also revealed Resident 20 found it somewhat important to do things with groups of people. Review of Resident 20's Care Plan initiated 2/10/26 indicated for staff to encourage Resident 20 to attend activities and to provide assistance as needed. On 2/9/26 at 10:53 AM, Resident 20 stated she/he did not know the facility had activities and she/he had not been invited to any activities. Observations of the activities calendar for 2/10/26 included music and ice cream at 11:00 AM and a popcorn social at 2:00 PM. On 2/10/26 at 2:06 PM, Resident 20 stated she/he was not invited to music and ice cream or to the popcorn social and was not aware of the activities. Observations of the activities calendar for 2/11/26 included Bingo at 2:00 PM. On 2/11/26 at 2:35 PM, Witness 2 (Family Member) took a folder out of Resident 20's drawer. Observations of the contents inside of the folder included crossword puzzles, wordsearches, coloring pages, and colored pencils. Witness 2 stated Resident 20 was given the folder when she/he first moved into the facility as independent activities. Witness 2 stated she/he was not sure how Resident 20 could utilize the materials, as Resident 20 was visually impaired. On 2/11/26 at 2:35 PM, Resident 20 stated she/he did not know the facility was playing Bingo at 2:00 PM and stated, I love Bingo. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/26 at 9:27 AM, Staff 16 (CNA) stated residents were informed of activities when Staff 9 (Activities Director) announced the event on the overhead speaker and Staff 9 was the person who informed residents of activities that were available. Staff 16 stated Resident 20 liked to sleep all day. On 2/12/26 at 10:03 AM, Staff 17 (CNA) stated Staff 9 was responsible for giving out activities' schedules for the month and day to residents and Staff 9 informed residents by making announcements on the overhead speaker. Staff 17 stated if residents wanted to join an outing, residents would go to the front desk and sign their names on a sheet. Staff 17 was not aware of Resident 20's preferences but stated it could be found on her/his care plan. Observations of the activities calendar for 2/12/26 included an outing at 10:00 AM. On 2/12/26 at 3:12 PM, Resident 20 stated she/he did not know there was an outing for the activity. Resident 20 stated she/he would have liked to go if she/he knew about it. On 2/12/26 at 3:15 PM, Staff 9 stated she had informed Resident 20 to reach out to Staff 9 if she/he needed other activities. Staff 9 stated she passed out a reading material to residents each morning to inform residents of the day's activities, and she typically made an announcement on the overhead speaker 20-30 minutes before the start of the activity. Staff 9 stated she did not pass out the reading material to Resident 20, because she/he was typically asleep. Staff 9 acknowledged Resident 20 would not be able to see the reading material and stated she did not follow up throughout the day with Resident 20 to inform her/him of the day's activities. Staff 9 stated independent activities included crossword puzzles, newspapers, and coloring pages and were provided to residents, but acknowledged these items were inappropriate for Resident 20. Staff 9 stated she had not procured music or audiobooks for Resident 20 and had not spent much time with her/him. On 2/12/26 at 4:10 PM, Staff 1 (Administrator) stated he expected for Staff 9 and CNAs to inform residents of the activities for the day. Staff 1 stated he expected for residents to be provided with activities and supplied with items appropriate for their level of function. 2. Resident 2 was admitted to the facility in 2024 with a diagnoses including major depression. Resident 2's 10/14/25 Annual MDS assessed her/him as cognitively intact. Very important Activity preferences were identified as music, pets and going outside. It was important to do her/his favorite activities. On 2/9/26 at 4:01 PM Resident 2 stated she/he was very bored most of the time with only one activity offered in the morning for less than 30 minutes and sometimes an afternoon program. Resident 2 stated there was very little interaction or engagement in the activities offered. Resident 2 stated the facility had books available to read in the past but they had been removed. On 2/11/26 at 8:31 AM Resident 2 was observed in her/his room with the television on and she/he talked about the lack of planned activities today so she/he would figure out something to do today. On 2/12/26 at 1:16 PM Staff 17 (CNA) stated she/he read the Kardex care plan to get information to care for residents and acknowledged no activity preferences were on Resident 2's Kardex. A Kardex care plan dated 2/12/26 revealed Resident 2 had no activity interests or preferences on the Kardex care plan to inform staff of the resident's activity preferences. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/26 at 9:24 AM Staff 9 (Activity Director) confirmed Resident 2 had no information to direct staff to assist the resident with activity preferences. Staff 8 acknowledged the lack of resident centered activity programming for Resident 2. On 2/13/26 at 12:31 PM Staff 1 (Administrator) stated he expected all residents to have individual activity programs to meet their interests both from groups and individual activities. 3. Resident 3 was admitted to the facility in 2023 with a diagnoses including anxiety. Resident 3' s 3/13/25 Annual MDS assessed her/him as cognitively intact. Very important Activity preferences were identified as reading materials, music, pets, religion, doing things with groups of people, going outside, the news and doing her/his favorite activities. On 2/9/26 at 12:21 PM Resident 3 stated she/he was often bored and watched a lot of television for background noise. Resident 3 stated she/he missed the book cart and bookshelf to have access to reading materials. Resident 3 showed an Activity calendar for groups and stated the very little number of things offered were not engaging or interesting. On 2/11/26 at 11:33 AM Staff 9 (Activity Director) was observed to sit at a dining room table and put a puzzle together. Resident 3 nor any other residents were engaged in the puzzle. On 2/12/26 at 1:16 PM Staff 17 (CNA) stated she/he read the Kardex care plan to get information to care for residents and acknowledged no activity preferences were on Resident 3's Kardex. A Kardex care plan dated 2/12/26 revealed Resident 3 had no activity interests or preferences on the Kardex care plan to inform staff of the resident's activity preferences. On 2/13/26 at 9:24 AM Staff 9 (Activity Director) acknowledged the lack of activity programming for Resident 3 and the resident liked to sit outside and watch television. On 2/13/26 at 12:31 PM Staff 1 (Administrator) stated he expected all residents to have individual activity programs to meet their interests both from groups and individual activities. 4. Resident 30 was initially admitted to the facility in 2024 with a diagnoses including depression. Resident 30's 1/15/25 admission MDS assessed her/him as cognitively intact. Very important Activity preferences were identified as music, pets, news, to go outside and do her/his favorite things. Its was somewhat important for Resident 30 to have access to books, religion and doing things with groups of people. On 2/9/26 at 10:01 AM Resident 30 stated she/he was bored at times and was very upset her/his television remote control did not work all the time when she/he wanted to have the television available. Resident 30 was observed to click on buttons on her/his remote control and the television did not turn on. On 2/12/26 at 1:16 PM Staff 17 (CNA) stated she/he read the Kardex care plan to get information to care for residents and acknowledged no activity preferences were on Resident 30's Kardex. A Kardex care plan dated 2/12/26 revealed Resident 30 had no activity interests or preferences on (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Kardex care plan to inform staff of the resident's activity preferences. On 2/13/26 at 9:24 AM Staff 9 (Activity Director) acknowledged the lack of activity programming for Resident 30 and she was not aware Resident 30 had difficulty with the television remote. Staff 8 stated the resident liked to talk some with her and watch television. On 2/13/26 at 12:31 PM Staff 1 (Administrator) stated he expected all residents to have individual activity programs to meet their interests both from groups and individual activities. 5. Resident 60 was initially admitted to the facility in 1/2026 with a diagnoses including spinal stenosis (narrowing of spinal canal causing pain). Resident 60's 1/19/25 admission MDS assessed her/him as cognitively intact. Very important Activity preferences were identified as reading/books, music, news, religion, going outside and doing things with groups of people. On 2/10/26 at 10:01 AM Resident 60 stated she/he was extremely bored and only had her/his cell phone for any distraction or entertainment. Resident 60 stated their family would come to visit to help break the boredom. Resident 60 stated she/he only went to therapy other wise she/he was in their room with no working television. On 2/10/26 at 3:18 PM Resident 60 was observed in her/his bed and looked at her/his person cell phone with no television on their side of room. Resident 60 had a small bag of popcorn which she/he received from the group activity which a person brought to her/him while in bed. On 2/12/26 at 1:16 PM Staff 17 (CNA) stated she/he read the Kardex care plan to get information to care for residents and acknowledged no activity preferences were on Resident 60's Kardex. A Kardex care plan dated 2/12/26 revealed Resident 60 had no activity interests or preferences on the Kardex care plan to inform staff of the resident's activity preferences. On 2/13/26 at 9:24 AM Staff 9 (Activity Director) acknowledged the lack of activity programming for Resident 60 and she was not aware Resident 60 did not have a working television in her/his room. Staff 8 stated Resident 60 liked to look at her/his phone, go to therapy balloon group and food groups sometimes. On 2/13/26 at 12:31 PM Staff 1 (Administrator) stated he expected all residents to have individual activity programs to meet their interests both from groups and individual activities.

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	02/13/2026

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review it was determined the facility failed to provide a qualified professional to direct the activities program for 1 of 1 facility reviewed for activities. This placed residents at risk for unmet physical, mental and psychosocial needs. Findings include:On 2/12/26 at 3:15 PM, Staff 9 (Activities Director) stated she was recently promoted to Activities Director and was not aware of any certifications, trainings, or qualifications required for the position. Staff 9 confirmed she was the person who planned the group and individual activities for residents.On 2/13/26 at 8:13 AM, Staff 1 (Administrator) confirmed Staff 9 had been the Activities Director since 12/2025 and did not have the appropriate certifications, trainings, or qualifications for the role.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview it was determined the facility failed to ensure waste was properly contained in dumpsters and garbage storage areas were maintained in a sanitary condition for 1 of 1 garbage area reviewed for kitchen sanitation. This placed residents at risk for exposure to pathogens related to the harborage and feeding of pests. Findings include: On 2/9/26 at 9:24 AM, the facility's dumpsters were observed to be very full and the doors did not close to enclose the trash.On 2/10/26 at 9:18 AM, the facility's dumpsters were observed to be very full and had trash overflowing from the top. Two inside out gloves were observed on the concrete where the dumpsters were and one large trash bag was placed in front of the dumpsters. On 2/10/26 at 3:30 PM, the facility's dumpsters were observed to be very full, trash overflowing from the top and four large bags were in front of the dumpsters. The ground around the dumpsters was observed to have miscellaneous trash items.On 2/11/26 at 5:00 AM, the facility's dumpsters were observed to be very full, trash overflowing from the top and more than four large bags placed in front of the dumpsters. The ground around the dumpsters was observed to have miscellaneous trash items including inside out gloves. On 2/11/26 at 6:44 AM, Staff 7 (Dietary Director) stated the dumpsters were shared by all of the employees of the facility.On 2/11/26 at 7:59 AM, Staff 10 (Maintenance Director) stated the garbage was supposed to be collected six times per week, Monday through Saturday. He stated the garbage company was also supposed to pick up the bags off the ground. Staff 10 stated he was not sure what happened on 2/9/26 and 2/10/26, but he did not get a phone call from the garbage company. Staff 10 acknowledged garbage should be contained in their receptacles and off the ground.On 2/13/26 at 8:20 AM, Staff 1 (Administrator) stated he expected the garbage to be contained in the receptacles and off the ground and for staff to notify management when the dumpsters became too full.

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	385044	A. Building B. Wing	02/13/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to ensure proper hand hygiene was completed for 1 of 1 sampled employee (#27) and 3 of 3 sampled residents (#s) reviewed for infection prevention and control practices. This placed residents at risk for infections. Findings include:The 8/1/24 Hand Hygiene policy and procedure specified hand hygiene was required before and after assisting a resident with personal care, after handling soiled or used linens, before applying gloves, and after removing gloves. 1.On 2/10/26 at 9:09 AM Staff 27 (CNA) was observed wearing gloves and providing cares to Resident 8 who was on contact precautions (infection-control measures used to prevent the spread of germs). These cares included touching the resident's gown, legs and bedding, and combing her/his hair. Staff 27 placed the resident's linens into a bag, removed her gloves, and exited the room using the gloves to carry the bag. Staff 27 was observed continuously as she dropped off the dirty linens, proceeded down the hall with the dirty gloves in hand, dropped the gloves into a garbage can, and then picked up clean gloves and started to put them on to enter a new room. At no point was hand hygiene performed. On 2/10/26 at 9:25 AM Staff 27 stated hand hygiene should be done as soon as gloves came off, but hand sanitizer was hard on her skin and she preferred to wear gloves instead of always using sanitizer. On 2/13/26 at 10:54 AM Staff 4 (Infection Preventionist) stated hand hygiene should be performed by staff after the removal of gloves and after disposal of garbage or dirty linens, before they went on to their next task. Staff 4 stated staff would need to wash their hands if they did not want to use hand sanitizer. 2. During an 2/11/26 at 10:00 AM Residents Council meeting the residents expressed a concern they were not offered hand hygiene during the dining room meal services. During a 2/11/26 dining room observation from 11:33 AM to 12:00 PM no hand hygiene was offered to the residents in the dining room prior to receiving lunch. On 2/11/26 at 12:01 PM Resident 2, Resident 28 and Resident 80 were observed eating lunch in the dining room. The residents all stated they were not offered hand hygiene prior to the meal service and would have liked to have had clean hands to eat with during the meal. On 2/12/26 at 11:40 AM Staff 18 (CNA) stated the residents usually wash their hands in the morning and were not offered hand hygiene prior to serving lunch unless a resident requested to have their hands washed. During a 2/13/2026 at 12:42 PM Staff 2 (DNS) state she would expect the residents to be offered hand hygiene prior to eating a meal in the dining room.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed to self-administer medications for 2 of 5 sampled residents (#s 13 and 47) reviewed for accidents. This placed residents at risk for unsafe medication administration. Findings include:The facility's Self-Administration of Medication policy dated 8/2024 included the following:- Medication at bedside is stored in closed, locked cupboards or drawers. This includes over the counter medications.- The RCM (Resident Care Manager) evaluates the resident's ability to self-administer medications using the Self Administration Evaluation form. No medications are stored at bedside nor self-administered until evaluation complete. - A physician order is obtained indicating the specific medications that resident is able to self-administer.- Drug storage is the responsibility of the nursing staff. - Medications are indicated on the MAR as self-administered. 1. Resident 13 was admitted to the facility in 10/2024 with a diagnosis of fracture of neck of left femur. The Quarterly MDS with an ARD of 12/2/25 revealed Resident 13 had a BIMS score of 15, which indicated the resident was cognitively intact. A review of Resident 13's clinical record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer Senna (a laxative) and Tums (a chewable antacid). Observations on 2/9/26 at 12:57 PM and 2/10/26 at 9:33 AM revealed Resident 13 had one Tums tablet and one Senna pill inside of a small plastic cup on her/his bedside table. On 2/10/26 at 9:33 AM, Resident 13 stated staff had given her/him the Senna, but she/he did not want to take it and put it back in the plastic cup. Resident 13 stated she/he purchased Tums but also changed her/his mind about taking it. On 2/10/26 at 9:39 AM, Staff 12 (CMA) entered Resident 13's room and handed her/him a cup of medications with a cup of water. Observations revealed Staff 12 placed the cup of water next to the plastic cup containing the Tums and Senna and exited the room. On 2/10/26 at 1:56 PM, Resident 13 was observed exiting her/his room to use the restroom. At 2:00 PM, Resident 13 was observed walking with staff around the building. At 2:26 PM, Resident 13 was observed entering her/his room and the cup containing the Tums and Senna was still on her/his bedside table. On 2/10/26 at 2:51 PM, Staff 14 (CNA) stated she was unaware of Resident 13 being authorized to self-administer medications. She stated if medications were found on residents' bedside tables, she would inform the nurse. On 2/10/26 at 2:58 PM, Staff 15 (CNA) stated she was unaware of Resident 13 being authorized to self-administer medications. She stated if Resident 13 had medications at her/his bedside, she would let the nurse know. On 2/10/26 at 3:06 PM, Staff 13 (CMA) stated the process of giving medication to residents included ensuring residents completely swallowed oral medications safely prior to walking away from the (continued on next page)

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	385044	A. Building B. Wing	02/13/2026

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Menlo Park Post Acute	745 NE 122nd Avenue Portland, OR 97230

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. She stated if she saw any residents with a cup of medications on their bedside, she would inform the nurse. She was unaware of any residents who had authorization to self-administer their own medication. On 2/10/26 at 3:11 PM, Staff 11 (LPN) stated he expected staff to inform him of any resident who had medications at their bedside. He stated he did not know of any residents who had authorization to self-administer their own medication. At 3:16 PM, Staff 11 went into Resident 13's room and confirmed Resident 13 had one Tums and one Senna in a plastic cup on her/his bedside table. Staff 11 stated CMAs were expected to give medications and observe residents until all of the medications were gone and medications were not to be left unattended. On 2/12/26 at 4:02 PM, Staff 2 (DNS) stated she expected staff to remain with residents when residents took medications. She stated she expected staff to inform a nurse immediately if medications were found by a resident's bedside. 2. Resident 47 was admitted to the facility in 1/2026 with diagnoses including end stage renal disease. A 1/31/26 physician order included 5 ml of guaifenesin (Musinex) to be administered by a clinician as needed for coughing. On 2/9/26 at 10:19 AM three medication containers were observed at Resident 47's bedside table. No lock box was observed in Resident 47's room. Resident 47 stated she/he had those medications for a cough. Resident 47 stated other residents approached her/him and requested to receive a dose of those medications on multiple occasions. Review of Resident 47's records on 2/10/26 revealed no assessment for self-administration of any medications was performed for Resident 47. On 2/13/26 at 11:24 AM Staff 35 (LPN) stated a self-administration assessment was to be completed prior to a medication being left in a resident's room. If determined safe to self-administer a specific medication, new orders were placed by a physician, and the resident was provided a lock box and key for safe storage of medication. On 2/13/26 at 11:35 AM Staff 6 (RNCM) stated a medication self-administration assessment was done on residents to determine if there were safe to self-administer any medication. Staff 6 stated a medication self-administration assessment was not completed on Resident 47. Staff 6 entered Resident 47's room and confirmed Musinex, Musinex PM, and two saline nasal rinses were on Resident 47's bedside table and should not have been in Resident 47's room as she/he was not safe to self-administer those medications.

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	385044	A. Building B. Wing	02/13/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review the facility failed to ensure a resident right to privacy was honored for 1 of 2 sampled residents (#64) reviewed for privacy. The placed residents at risk for exposure of personal information. Findings include:Resident 64 was admitted to the facility in 2025 with diagnoses including heart failure.Resident 64's 8/15/25 admission MDS assessed her/him to be cognitively intact.Review of the 11/2025 Resident Council Meeting minutes revealed the council had a concern of to much into personal business. The 11/18/25 written response by Staff 8 (Social Services Director) revealed Resident 64 was upset because call was placed to APS [Adult protective Services] regarding misappropriation of funds.On 2/13/26 at 9:24 AM Staff 9 (Activity Director) acknowledged she assisted the residents with the Resident Council meetings. Staff 9 confirmed she read the written responses from the meeting minutes to the Resident Council out loud, exactly as written. Staff 9 confirmed Resident 64's name was written in the 11/2025 Resident Council meeting minutes.On 2/13/26 at 11:45 AM Staff 8 acknowledged Resident 64's name was documented on the Resident Council meeting response she wrote. Staff 8 stated she was not aware the responses she wrote were read out loud to residents or that the residents had access to read her responses. On 2/13/26 at 11:32 AM Resident 64 stated she/he was at the 12/2025 Resident Council Meeting and felt angry that she/he heard her/his name read out loud to everyone in the meeting about the facility calling APS about her/him.On 2/13/26 at 12:16 PM Staff 1 (Administrator) stated he expected the Resident Council minutes to not include resident's personal confidential information and it should not have been read out loud to the resident group.

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	385044	A. Building B. Wing	02/13/2026

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review it was determined the facility failed to provide appropriate foot care for 2 of 5 sampled resident (#42 and 45) reviewed for ADL care. This placed residents at risk for complications and discomfort. Findings include: Resident 42 was admitted to the facility in 8/2025 with diagnoses including diabetes. The 11/24/25 Modified Quarterly MDS indicated Resident 42 had a BIMS score of 15 which indicated the resident was cognitively intact. The 9/5/25 Care Plan indicated the nursing staff completed nail trimming for Resident 42 and staff monitored skin conditions when care was provided and staff notified the nurse of any open areas or red skin areas. A review of Resident 42's Physician Orders on 2/2026 indicated the nurses checked fingernails and toenails once a week on bath days and trimmed the residents nails as needed. Resident 42 was scheduled for evening showers on Sunday and Wednesday. The 3/10/25 Skin & Wound Evaluation indicated Resident 42's right plantar foot wound was healed. An attached picture of Resident 42's right plantar foot indicated Resident 42's toenails were trimmed. The 2/2026 Documentation Survey Report indicated Resident 42 showered on 2/11/26. The 2/2026 MAR indicated Staff 29 (LPN) completed nail care on 2/11/26. The 2/2026 MAR indicated Resident 42 was not verbally or physically aggressive to other residents or staff. On 2/9/26 at 11:28 AM, Resident 42 was observed sitting in wheelchair and she/he was not wearing shoes. The resident had a left BKA (below the knee amputation) and on the right foot, the first three toes were amputated. Resident 42's foot was red, swollen and had a white substance around the foot and her/his two toenails were yellow and were overgrown and curved towards the bottom of her/his foot. Resident 42 stated staff didn't assess her/his foot and they didn't perform nail trimming. Resident 42 stated staff didn't care so why should she/he. On 2/12/26 at 9:35 AM, Resident 42 stated she/he showered yesterday evening and staff didn't offer to cut her/his toenails. Resident 42 stated she/he allowed staff to assist during showers and allowed staff to perform nail care when offered. On 2/12/26 at 1:26 PM, Staff 17 (CNA) stated the nurses perform nail care for residents with a diagnoses of diabetes. Staff 17 stated the nurses performed nail care after residents showered. On 2/12/26 at 1:50 PM, Staff 30 (CNA) stated Resident 42 showered, and he noticed Resident 42 had white stuff on her/his foot. Staff stated he tried to scrub it off with a towel, but the white substance didn't come all the way off. Staff 30 stated Resident 42's-foot didn't have too much redness but acknowledged Resident 42's toenails were deformed. Staff 30 stated he didn't report skin concerns because the foot didn't have discharge and open wounds. Staff 30 stated the nurses performed nail care after showers and was unsure if this was completed for Resident 42. (continued on next page)

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	385044	A. Building B. Wing	02/13/2026

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/26 at 3:48 PM, Staff 29, (LPN) stated he didn't assess Resident 42's foot because she/he refused weekly skin checks. Staff 29 stated he was unaware about any skin issues or concerns related to Resident 42's foot. Staff 29 stated he didn't perform nail care because Resident 42 refused. Staff 29 stated he did not report Resident 42's refusal of nail care or weekly skin checks to Staff 6 (RNCM). Staff 30 entered Resident 42's room and asked Resident 42 to assess her/his foot and she/he agreed. Staff 30 described Resident 42's nails overgrown but not having an ingrown nail. On 2/13/26 at 9:36 AM, Staff 6 stated residents had orders for weekly nail care. Staff 6 stated staff were expected to document nail care when it was completed and was unsure Resident 42 refused foot care. On 2/13/26 at 10:14 AM, Staff 2 (DNS) stated residents with a diabetic diagnoses received nail care by the podiatrist and the nursing staff. Staff 2 expected staff performed nail care on shower days. 2. Resident 45 was admitted to the facility in 2021 with diagnoses including peripheral vascular disease. The 12/17/25 Quarterly MDS revealed a BIMS score of 15 indicating Resident 45 had intact cognition. The Care Plan, last reviewed 1/14/26, indicated Resident 45 was seen by podiatry for routine toenail care as needed. No evidence was found in Resident 45's clinical record podiatry care was provided. In an interview on 2/11/26 at 10:18 AM, Resident 45 stated she/he needed podiatry services for toenail care. The resident reported the podiatrist who visited the facility declined to complete toenail care the most recent time they came in due to payor issues. Resident 45 stated her/his toenails were so long she/he worried about breakage and infections. On 2/11/26 at 10:39 AM, Staff 8 (Social Services Director) confirmed the mobile podiatrist used by the facility no longer accepted Resident 45's insurance plan. Staff 8 indicated all residents at the facility with that insurance plan had to begin going to podiatry appointments off site. Staff 8 confirmed on 2/12/26 at 12:18 PM she was unable to find documentation of podiatrist visits for Resident 45 from the past year. On 2/12/26 at 12:38 PM, Staff 34 (CNA) removed Resident 45's shoes and socks at her/his request. Resident 45's toenails on both feet were observed as thick, yellowed, and very long. The approximate length of most toenails was one half inch past the end of the toes. Staff 2 (DNS) acknowledged on 2/23/26 at 2:58 PM podiatry services had not been provided to Resident 45 per the care plan.

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	385044	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure trauma informed care was assessed to ensure proper practices were provided for 2 of 2 resident (#s 3 and 10) reviewed for mood and behavior. This placed residents at risk for triggered responses and re-traumatization. Findings include: A facility Trauma-Informed Care policy dated 8/2024 included the focus of four areas when care interventions are developed and strategies to support resident with trauma history. Those four areas include: -Realize the prevalence of trauma through education and training of care staff, -Recognize how trauma affects individuals through evaluation and identification of triggers, -Responding and 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. 1. Resident 10 was admitted to the facility in 1/2026 with diagnoses including post-traumatic stress disorder (PTSD) and anxiety. An admission MDS dated [DATE] revealed Resident 10 had a BIMS score of 15, which indicated the resident was cognitively intact. A Care Plan dated 1/12/26 stated Resident 14 had a diagnosis of PTSD but did not include resident specific information regarding triggers of her/his PTSD or what prevention techniques to address her/his PTSD if triggered. Review of Resident 10's records from 1/10/26 through 2/9/26 revealed a Trauma Informed Care assessment had not been performed to determine specific and potential triggers for PTSD, techniques to prevent a response if triggers occurred, or care intervention to implement for the resident after her/his PTSD was triggered. On 2/9/26 at 10:18 AM Resident 10 was observed in her/his room and stated she/he had experienced a startled reflex on multiple occasions at the facility due to staff loudly knocking on her/his door and also had experienced night terrors. Resident 10 stated she/he had verbally told staff her/his PTSD was triggered by loud sudden noises like knocking on the door and she/he wished for them to lightly tap on the door before they entered. On 2/10/26 at 2:32 PM a CNA was observed knocking loudly on Resident 10's door prior to entering Resident 10's room. Resident 10 was overheard verbally responding to the knocks in a louder than conversational voice level. On 2/12/26 at 11:23 AM Staff 18 (CNA) stated Resident 10 did not like staff loudly knocking on her/his door. Staff 18 stated this information was gained from talking with Resident 10 and was not (continued on next page)

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	385044	A. Building B. Wing	02/13/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included in her/his records. On 2/12/26 at 11:38 AM Staff 11 (LPN) stated he learned about Resident 10's PTSD triggers verbally from other staff members but did not have specific information on how to address Resident 10's PTSD. On 2/12/26 at 12:38 PM Staff 8 (Social Services Director) stated assessing a resident with a diagnosis of PTSD was important to know how to manage a resident's triggers and to prevent those triggers from impacting a resident. Staff 8 stated the information gained from a Trauma Informed Care assessment was to be included in a resident's care plan. Staff 8 confirmed a Trauma Informed Care assessment had not been completed on Resident 10. Staff 8 she was unaware of specific trigger related to Resident 10s PTSD. On 2/12/26 at 12:49 PM Staff 6 (RNCM) confirmed a Trauma Informed Care assessment had not been completed on Resident 10 to determine specific triggers and what action to take if Resident 10's PTSD was triggered. Staff 6 stated she was unaware a formal assessment was required to be completed for residents diagnosed with PTSD. 2. Resident 3 admitted to the facility in 3/2023 with diagnoses including Post Traumatic Stress Disorder (PTSD) and anxiety. Reviewed of Resident 3's health recorded revealed a Trauma Screen was completed on 8/22/24 and indicated the resident refused. No other Trauma Screen was found as completed. Resident 3's 3/13/25 Annual MDS assessed her/him as cognitively intact and the medical diagnoses included anxiety and PTSD. Review of Resident 3's health record revealed a 2/11/26 Care Plan with no indications to the PTSD triggers to ensure the resident, who was a trauma survivor, received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for Resident 3. No information was found in the health records to identify. On 2/11/26 at 5:45 AM Staff 36 (CNA) confirmed Resident 3 did not have any indications to triggers for possible re-traumatization or to escalate behaviors. Staff 36 could not provide triggers for the resident but stated Resident 30 would sometimes experience outbursts with yelling and throwing things. On 2/13/26 at 11:51 AM Staff 8 (Social Services Director) confirmed Resident 3 did not have any care plan interventions for possible re- traumatization. She was unaware of the need to assess and document trauma informed care prior to a week ago and had not been able to assess and care plan for all the residents. On 2/13/26 at 1:06 PM Staff 1 (Administrator) acknowledged Resident 3's care plan had not interventions related to her/his PTSD. Staff 1 expected residents care planned and staff to be aware of possible PTSD triggers to residents.

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	02/13/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure adequate indications for medication use for 1 of 1 sampled resident (#10) reviewed for unnecessary medications. This placed residents at risk for adverse side effects. Findings include:Resident 10 was admitted to the facility in 1/2026 with diagnoses including paraplegia (paralysis of the legs and lower body) and wounds. The 1/10/26 Care Plan identified Resident's 10's pain would be relieved to a tolerable level as indicated by the resident. A 1/11/26 Physician's Order was in place for Morphine Sulfate 10 MG/5 ML every six hours as needed for pain. The 1/16/26 admission MDS revealed a BIMS score of 14 indicating the resident was cognitively intact. The resident received scheduled and PRN pain medications. The 1/2026 and 2/2026 MARs showed Staff 27 (CMA) administered PRN Morphine with a pain rating of zero seven times in the two-month period on 1/21/26, 1/22/26, 1/28/26, 1/29/26, 2/4/26, and 2/5/26.The 1/2026 and 2/2026 Progress Notes contained no additional assessment or justification for the dates associated with a pain rating of zero or why the morphine was administered to the resident. On 2/11/26 at 9:58 AM Staff 27 stated she was able to administer pain medications with no pain assessment or nursing oversight. She did not recall administering PRN Morphine to Resident 10 with a pain rating of zero. On 2/12/26 at 1:50 PM Staff 6 (RNCM) stated Resident 10 identified a pain level of four or five as tolerable. Staff 6 stated the resident was always in pain and would never be at a pain rating of zero. Staff 6 stated a pain rating assessment should always be conducted and reported to the licensed nurse when a resident requested pain medication. Administering PRN Morphine with a pain rating of zero was not appropriate.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review it was determined the facility failed to provide emergency dental services for 1 of 1 sampled resident (#42) reviewed for dental care. This placed residents at risk for acute dental pain and poor appetite. Resident 42 was admitted to the facility in 8/2025 with diagnoses including diabetes.The 9/5/25 Care Plan indicated Resident 42 had her/his own teeth and required assistance setting up when oral hygiene was performed. The 11/24/25 Modification of Quarterly MDS indicated Resident 42 had a BIMS score of 15 which indicated the resident was cognitively intact and Resident 42 did not have dental pain, discomfort and difficulty chewing. The 11/2025 Documentation Survey Report indicated Resident 42 was not verbally or physically aggressive to other residents or staff. A 11/21/25 Progress Note indicated Resident 42 was verbally aggressive with staff and reported toothache. A 11/25/25 Progress Note indicated Staff 31 (Social Services Assistant) called to make an emergent dental appointment but the clinic advised her to call back the following day and an appointment would be scheduled within 48 hours. On 2/9/26 at 11:28 AM, Resident 42 stated she/he felt neglected and felt the facility didnt care about her/him. Resident 42 stated she/he didnt have teeth on the top part of her/his mouth and had multiple missing teeth at the bottom part of her/his mouth. Resident 42 stated she/he had dental pain and discomfort back in 11/2025 and told staff. Resident 42 stated she/he was unable to chew her/his food. Resident 42 stated staff had not scheduled a dental appointment because they didn't care. Resident 42 stated she/he requested an emergent dental appointment in 11/2025 but staff didn't follow up. On 2/12/26 at 1:26 PM, Staff 17 (CNA) stated emergent dental appointments was scheduled quickly and residents were seen with in a couple of days. Staff 17 was unaware Resident 42 had dental concerns. On 2/12/26 at 1:50 PM, Staff 30 (CNA) stated he didn't provide oral care on 2/11/26 swing shift for Resident 42. 02/12/2026 3:48 PM Staff 29, (LPN) stated he didn't assess Resident 42's mouth to notice any dental concerns. Staff 29 stated Resident 42 had not expressed dental pain, discomfort or difficulty chewing. Staff 29 stated residents reporting dental pain and discomfort were scheduled an emergent dental appointment. Staff 29 stated social services scheduled emergent dental appointments within a couple of days. Staff 29 stated he encouraged oral hygiene and reminded residents to perform oral hygiene throughout the day and was unaware oral hygiene not occurring yesterday. On 2/12/26 at 3:57 PM, Staff 8 (Social Service Director) stated emergent dental appointments were scheduled within 24 hours upon request. Staff 8 stated dental concerns were discussed on a quarterly basis and she was unsure about the emergent appointment Resident 42 requested back in 11/2025. On 2/13/26 at 9:36 AM, Staff 6 (RNCM) stated she was unaware Resident 42 had dental pain and discomfort. Staff 6 stated she was not Resident 42's RCM back in 11/2025 so she didnt know about her/his dental concerns. Staff 6 stated staff helped Resident 42 set up supplies to perform oral hygiene. Staff 6 acknowledged Resident 42's request to see a dentist was not timely. On 2/13/26 at 10:14 AM, Staff 2 (DNS) stated residents who reported dental pain, discomfort and difficulty chewing were scheduled an emergent dental appointment immediately. Staff 2 acknowledged Resident 42's request to see a dentist was not timely.