STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385045	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Porthaven Healthcare Center	5330 NE Prescott Street Portland, OR 97218

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on observation and interview it was determined the facility failed to have adequate staff available to meet resident care needs in a timely manner for 1 of 1 facility reviewed for staffing and call light response times. This placed residents at risk for delayed and unmet needs and lengthy call light response times. Findings include: On 5/9/24 the facility had a census of 63 residents. On 5/13/24, Staff 2 (DNS) provided a list of residents who: -Required two-person mechanical lift transfers: 12 -Required one or two-person extensive or total assistance for bathing: 58 -Required one or two-person extensive or total assistance for toileting: 22 -Required one or two-person extensive or total assistance for dressing: 39 -Required suctioning due to a tracheostomy (an opening into the trachea from the outside due to obstructed breathing): 2 -Required tube feedings: 4 -Had behavioral healthcare needs: 8 Observations from 5/9/24 through 5/13/24 from the hours of 8:15 AM to 1:30 PM revealed the following concerns: -5/9/24 at 8:36 AM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 9:23 AM for a total wait time of 47 minutes. -5/9/24 at 10:41 AM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 11:10 AM for a total wait time of 29 minutes. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/9/24 at 11:33 AM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 1:15 PM for a total wait time of one hour and 42 minutes. During that time, the resident's spouse was observed, several times, to leave room [ROOM NUMBER] in an attempt to find assistance. On several occasions, multiple staff were observed walking past room [ROOM NUMBER] without responding to the activated call light. -5/9/24 at 12:38 PM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 1:16 PM for a total wait time of 38 minutes. -5/9/24 at 12:43 PM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 1:16 PM for a total wait time of 33 minutes. -5/9/24 at 1:14 PM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 2:25 PM for a total wait time of one hour and 41 minutes. -5/10/24: at 8:15 AM the call light in room [ROOM NUMBER] was activated. The call light was responded to at 8:59 AM for a total wait time of 44 minutes. -5/13/24 at 8:52 AM the call light in the east front hall bathroom was activated. The call light was responded to at 9:17 for a total wait time of 25 minutes. On 5/9/24 at 10:13 AM Witness 1 (Complainant) reported Resident 4 arrived at the facility from the hospital around noon on 2/17/24. Witness 1 stated Resident 4 was taken to her/his assigned room but nobody checked on her/him so Resident 4 activated her/his call light and, still no one came. Witness 1 stated Resident 4 then called a neighbor who came and picked the resident up from the facility and took her/him home. Witness 1 stated Resident 4 left because of the lack of available and timely help. On 5/9/24 at 12:40 PM Witness 2 (Family) reported the call light in room [ROOM NUMBER] was activated since 11:33 AM because Resident 9 wanted to get back into bed after therapy. Witness 2 stated Resident 9 required two-person assistance, using a mechanical lift, to get back into bed so the resident had to wait until the CNAs finished feeding other residents. Resident 9 stated she/he was tired but OK. At 1:14 PM, Witness 2 was observed notifying Staff 11 (RN) that Resident 9 had been sitting up too long and needed to be assisted back to bed. On 5/9/24 at 2:02 PM Staff 12 (CNA) stated the facility was always short staffed. Staff 12 stated she was assigned several high acuity residents, including two residents who took over one hour to feed and another resident who would get up and fall if not watched closely. Staff 12 stated she ran all over the place and it was difficult to get all of the residents' care done in a timely manner. On 5/9/24 at 3:05 PM Staff 14 (CNA) stated as far back as 9/2023, the facility was short staffed. She stated during 1/2024 and 2/2024, she was assigned as many as 12 residents. Staff 12 stated there was an ongoing issue with CNAs being assigned several residents who required a lot of care and a lot of time. Staff 14 stated when the facility was short staffed, CNAs were unable to provide the social interaction that enriches the lives of residents and resident interactions became task-centered instead of person-centered. In addition, Staff 14 stated when staffing was not adequate, showers were missed and resident falls increased. Staff 14 stated she never took a break and often had to stay late to complete resident care and get her charting done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/10/24 at 9:20 AM Staff 15 (CNA) reported over the past year and up until 2/2024, staffing was horrid. Staff 15 stated the facility was always short staffed and CNAs were overloaded. Staff 15 stated she was assigned up to 10 residents, at times, which resulted in a lack of care for the residents. Staff 15 stated when the facility was inadequately staffed, residents had to wait longer to get changed, showers were missed and call light response times were long. On 5/10/24 at 10:22 AM and 5/13/24 at 9:50 AM Resident 9 stated it could take an hour to an hour and a half to be assisted. Resident 9 reported around mealtime there was no CNA assistance available because there were two residents that required total assistance for eating and they each took up to an hour each to eat. Resident 9 stated over the weekend, she/he did not receive a shower because there was not adequate staff to assist her/him. Resident 9 stated, because of her/his medical condition, she/he was scared when staff were not available to answer the call light timely when she/he was alone in her/his room. On 5/13/24 at 10:18 AM Staff 24 (Staffing Coordinator) stated she determined CNA staffing based on the mandatory minimum CNA staffing ratios. Staff 24 stated she did not know the acuity needs of the residents, including the newly admitted residents, unless a CNA or nurse notified her but there was a lack of communication regarding resident acuity. Staff 24 stated the facility was aware of long call light response times but was unsure as to why long call light response times persisted and were an ongoing problem. Staff 24 stated staff were expected to respond to call lights within 15 minutes. On 5/13/24 at 11:52 AM staffing concerns, including long call light response times, were reviewed with Staff 1 (Administrator). Staff 1 stated the facility typically staffed according to the mandatory minimum CNA staffing ratios and he expected call lights to be responded to promptly but within 15 minutes, maximum.