| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385045 | A. Building<br>B. Wing | 08/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Porthaven Post Acute | 5330 NE Prescott Street<br>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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>47001<br><br>Based on interview and record review it was determined the facility failed to follow up on grievances for 1 of 1 resident (#309) reviewed for personal property. This placed residents at risk for unmet needs. Findings include:<br><br>Resident 309 was admitted to the facility in 6/2020 with diagnoses including depression.<br><br>On 7/8/24 a public complaint was received with allegations of missing personal property.<br><br>On 8/12/24 at 5:25 PM Witness 1 (Complainant) stated Resident 309 was discharged from the facility in 4/2024 and was missing some personal belongings. Witness 1 stated she informed the facility via phone of the missing items but had not received a reply from the facility.<br><br>On 8/13/24 at 9:41 AM Staff 4 (SSD) stated she never received a complaint or grievance related to missing personal items from Resident 309 or her/his representatives.<br><br>An 8/14/24 review of the facility grievance binder revealed no evidence of a grievance from Resident 309 or her/his representatives.<br><br>On 8/14/24 at 11:20 AM Staff 4 (LPN Resident Care Manager) stated she was Resident 309's care manager but had not received any grievances or complaints from Resident 309 or her/his representatives related to missing personal items.<br><br>On 8/15/24 at 10:42 AM Staff 12 (Receptionist) stated she received a call from Witness 1 after Resident 309 discharged . Staff 12 stated Witness 1 reported not all of Resident 309's personal items had transferred with her/him upon discharge. Staff 12 stated she could not remember if she reported this to management.<br><br>On 8/15/24 at 11:29 AM Staff 1 (Administrator) stated he had not received a report of Resident 309 missing any personal items.<br><br>On 8/16/24 at 8:15 AM Staff 11 stated she was the facility grievance officer. Staff 11 stated she expected staff to report all written and verbal grievances to her or the administrator.<br><br>(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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/16/24 at 8:25 AM Staff 1 stated verbal grievances are expected to be treated and followed up on just like written grievances. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>41458<br><br>Based on observation, interview and record review it was determined the facility failed to accurately assess residents for oxygen therapy and wounds for 2 of 6 sampled residents (#s 22 and 37) reviewed for respiratory care and skin conditions. This placed residents at risk for inaccurate assessments and unmet care needs. Findings include:<br><br>1. Resident 22 was admitted to the facility in 1/2023 with diagnoses including heart attack and chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe).<br><br>Resident 22's 12/17/24 through 6/11/24 Physician Order indicated the resident was to receive supplemental oxygen therapy at 2 LPM (liters per minute) per NC (nasal cannula-a non-invasive medical device that provides supplemental oxygen to resident's through their noses) for signs of cyanosis (bluish or purple discoloration of the skin, lips and nail beds caused by lack of oxygen), symptoms of dyspnea (difficulty breathing) or shortness of breath.<br><br>Resident 22's 6/11/24 through 7/30/24 Physician Order indicated the resident was to receive supplemental oxygen therapy at 3 LPM to 5 LPM as needed per NC.<br><br>Resident 22's 7/30/24 Physician Order indicated the resident was to receive supplemental oxygen therapy at 2 LPM to 4 LPM continuously per NC.<br><br>Resident 22's 6/12/24, 7/3/24 and 8/6/24 Significant Change MDSs indicated Resident 22 did not require supplemental oxygen therapy.<br><br>Multiple observations from 8/12/24 through 8/16/24 between the hours of 8:00 AM and 3:30 PM revealed Resident 22 received supplemental oxygen therapy.<br><br>On 8/15/24 at 11:35 AM Staff 4 (RNCM) confirmed Resident 22 received supplemental oxygen therapy and the resident's MDSs should have reflected the resident's need for oxygen.<br><br>47000<br><br>2. Resident 37 was readmitted to the facility in 2/2024 with diagnoses including diabetes, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and an acquired absence of right toes.<br><br>Resident 37's 5/10/24 and 5/17/24 Podiatry Outpatient Notes indicated the resident had a diabetic foot ulcer.<br><br>Resident 37's 7/14/24 Quarterly MDS indicated the resident had a surgical wound and she/he did not have a diabetic foot ulcer.<br><br>On 8/16/24 at 11:46 AM Staff 2 (DNS) and Staff 3 (Interim DNS) acknowledged the findings of this investigation and Staff 3 confirmed Resident 37's MDS was inaccurate. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>41458<br><br>Based on observation, interview and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 2 of 7 sampled residents (#s 22 and 28) reviewed for respiratory care and unnecessary medications. This placed residents at risk for unmet needs. Findings include:<br><br>1. Resident 22 was admitted to the facility in 1/2023 with diagnoses including heart attack and chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe).<br><br>Resident 22's 7/30/24 Physician Order indicated the resident was to receive supplemental oxygen therapy at 2 to 4 LPM (liters per minute) continuously per NC (nasal cannula-a non-invasive medical device that provides supplemental oxygen through the nose).<br><br>Resident 22's 5/14/24 (most current) Care Plan indicated the resident was to receive oxygen per NC at 2 LPM as needed to maintain oxygen saturation levels (a measurement of how well the lungs are working) between 88% and 92%.<br><br>Observations from 8/12/24 through 8/16/24 between the hours of 8:00 AM to 3:30 PM revealed Resident 22 received oxygen therapy at 3 LPM, continuously.<br><br>On 8/14/24 at 2:49 PM Staff 21 (RN) stated Resident 22 received continuous oxygen per NC.<br><br>On 8/15/24 at 12:48 PM Staff 3 (Interim DNS) reviewed Resident 22's oxygen orders and current care plan. Staff 3 stated Resident 22's care plan did not reflect the resident's current supplemental oxygen orders and she expected the resident's care plan and oxygen orders to match.<br><br>47000<br><br>2. Resident 28 was admitted to the facility in 8/2023 with diagnoses including heart failure.<br><br>Resident 28's 5/31/24 Nutrition At Risk Care Plan indicated the resident was to be weighed weekly.<br><br>Resident 28's 8/2024 Physician Orders directed the resident to be weighed daily.<br><br>On 8/15/24 at 9:39 AM Staff 29 (CNA) stated she was unsure if Resident 28 was to be weighed weekly or daily but stated she found this information in the resident's care plan.<br><br>On 8/15/24 at 12:14 PM Staff 3 (Interim DNS) reviewed Resident 28's Physician Orders, stated she/he was to be weighed daily and confirmed the care plan needed to be revised. |