

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Porthaven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42271</p> <p>Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from sexual abuse by another resident for 1 of 1 sampled residents (#11) reviewed for sexual abuse. This placed residents at risk for psychological harm. Findings include:</p> <p>The facility's Abuse policy, revised 1/2023, stated the facility and staff would protect residents from all types of abuse.</p> <p>The facility's Resident Sexual Consent policy dated 9/2022, stated a resident's consent to engage in sexual activity is not valid if a resident lacks the capacity to consent. Any forced sexual activity with a resident is considered sexual abuse.</p> <p>Resident 10 admitted to the facility 7/2024, with diagnoses including Alzheimer's disease.</p> <p>Resident 10's 8/2024 MDS indicated she/he was cognitively intact. Resident 10 was discharged home on 8/28/24.</p> <p>Resident 11 admitted to the facility 5/2024, with diagnoses including Factor X chromosome (a genetic disorder causing developmental and intellectual disability).</p> <p>Resident 11's Quarterly Minimum Data Set (MDS) indicated the resident had severe cognitive impairment.</p> <p>Review of Resident 10 and Resident 11's clinical record found no evidence a Sexual Consent Form was completed.</p> <p>A Facility Reported Incident (FRI) dated 8/20/24 at 6:30 PM, revealed Resident 10 was observed to be rubbing Resident 11's genitalia in an annexed TV area. Both residents were immediately separated and were assessed for injuries by Staff 5 (LPN) and Staff 6 (RN). No injuries were noted.</p> <p>Observations made on 8/29/24 at 11:05 AM, revealed Resident 10 was discharged . Resident 11 attended meals in the dining room and self-propelled via wheelchair through-out the community.</p> <p>(continued on next page)</p>

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: 385045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Porthaven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/29/24 at 11:05 AM, Resident 11 was observed in the hallway and self-propelled her/himself via wheelchair to the dining room for bingo. Resident 11 stated she/he was not afraid of any other resident at the facility.</p> <p>On 8/29/24 at 11:20 AM, Resident 12, Resident 13 and Resident 14 all stated they had not been inappropriately touched while residing in the facility.</p> <p>On 8/30/24 at 1:03 PM, Staff 6 stated she was notified by Staff 8 (CNA) a resident was being touched inappropriately by another resident in the TV room. Staff 6 stated the residents were immediately separated, management and providers were notified and both residents were brought back to their individual rooms and placed on alert monitoring. Resident 10 was placed on a 1:1 supervision and Resident 11 had a STOP sign placed on their room door.</p> <p>On 8/30/24 at 1:28 PM, Staff 8 stated on 8/20/24 around 6:10 PM, she witnessed Resident 10's hand on Resident 11's genitals and Resident 10 was rubbing aggressively. Staff 8 stated Resident 10 saw her and stopped. Staff 8 separated the two residents and notified Staff 6 immediately.</p> <p>On 8/30/24 at 4:45 PM, Staff 1 (Administrator) acknowledged Resident 11 had been sexually abused and will continue to monitor the resident for any psychological impact.</p>