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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Porthaven Post Acute	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41453 Based on interview and record review it was determined the facility failed to accurately document wound assessments and dressing change refusals for 1 of 3 sampled residents (# 3) reviewed for accuracy of medical records. This placed residents at risk for inaccurate medical records and risk for injury and/or decreased ability for recovery. Findings include: Resident 3 was admitted to the facility in 1/2025 with diagnoses including acute and subacute infective endocarditis (infection). An undated facility policy pertaining to documentation indicated the following: - all nursing staff must document resident assessments. - Documentation should be timely, complete and entered in the appropriate PCC module. - Refusals of care are to be documented in the progress notes including interventions used, resident response, and any notifications made. Resident 3 had the following weekly wound assessments documented in her/his medical record: 1/20/25, 1/24/25, 1/30/25, 2/6/25, 2/13/25, 2/20/25, 2/27/25, 3/6/25, 3/7/25, 3/20/25, and 4/7/25. There was no documented assessments found between 3/20/25 and 4/7/25. Weekly wound assessments dated 1/20/25, 1/24/25, 1/30/25, 2/6/25, 2/13/25, 2/20/25, 2/27/25, 3/7/25, and 4/7/25 were found to be incomplete. The assessments were missing all or part of the following: - wound measurements; - wound description; - percentage of slough vs granulation vs epithelial; - type of wound. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 7:28 AM, Staff 5 (LPN/Care Manager) stated Resident 3 had refused the last three wound assessments from an outside wound agency. This information was not documented in Resident 3's medical record. On 4/9/25 at 8:03 AM, Staff 3 (RN) stated the nurses were instructed to fill in the assessment form after they had completed their wound assessment. Staff 3 confirmed weekly wound assessments were not fully completed. On 4/9/25 at 8:26 AM, Staff 3 (RN) and Staff 4 (RN) confirmed the weekly wound assessments were incomplete and not all refusals of care were documented appropriately.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41453 Based on observation, interview and record review it was determined the facility failed to follow infection control standards for 1 of 3 residents (# 2) sampled reviewed for infection control. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: Resident 2 was admitted to the facility in 3/2025 with diagnoses including open wound to left foot. A 3/20/25 Admission MDS revealed Resident 2 was cognitively intact. On 4/8/25 at 10:00 AM, during an observation of a chronic wound dressing change, an unidentified female placed an enhanced barrier precaution sign on the door to Resident 2's room. Staff 6 (RN) and Staff 5 (LPN/Care Manager) were observed to then put appropriate PPE on and continue Resident 2's dressing change. There was no documentation found in Resident 2's clinical record indicating she/he had been placed on enhanced barrier precautions for a chronic wound. On 4/8/25 at 10:56 AM, Staff 6 confirmed he had not worn appropriate PPE (gown) when he provided care to Resident 2. On 4/8/25 at 10:59 AM, Resident 2 stated she/he had been in the facility since mid-March. Resident 2 stated today (4/8/25) was the first day she/he had seen staff wear PPE gowns when they provided care for her/his chronic wound. On 4/8/25 at 3:05 PM, Staff 5 (LPN/Care Manager) stated normal procedure was to implement enhanced barrier precautions for a chronic wound, catheter, central line, feeding tube, etc. upon admission. Staff 5 confirmed there should have been an enhanced barrier precautions sign posted and appropriate PPE worn.