| 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 | 04/16/2025 |

| 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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>43691<br><br>Based on interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse for 1 of 1 resident (#2) reviewed for physical abuse. This resulted in physical injury and prolonged pain which required increased pharmaceutical interventions. Findings include:<br><br>Resident 2 was admitted to the facility in 4/2023 with diagnoses including multiple spinal fractures and mild cognitive impairment.<br><br>The 1/9/25 Quarterly MDS, revealed Resident 2 had severe cognitive impairment and was independent with mobility.<br><br>Resident 1 was admitted to the facility in 11/2023 with diagnoses including restlessness and agitation.<br><br>A 8/13/24 Quarterly MDS, revealed Resident 1 had severe cognitive impairment and was independent with mobility.<br><br>An email communication record from 11/30/23 from Staff 19 (Prior Interim DNS) reported Resident 1 was a very violent person with behaviors and provided contact information for Resident 1's probation officer.<br><br>A review of Resident 1's clinical record including her/his care plan revealed no information regarding her/his violent behavior.<br><br>A 3/27/25 Progress Note revealed Resident 2 stopped when walking by Resident 1 in the hallway. Resident 1 was observed pushing Resident 2 to the ground and punching Resident 2. Resident 2 reported pain and numbness in her/his right side after the incident.<br><br>A 3/27/25 Emergency Department Encounter Note reported Resident 2 was determined to have a lumbar spinal fracture, rib pain and difficulty breathing as a result of the incident.<br><br>A review of Resident 2's pain records (pain scale, which rates pain from 1 to 10, to describe how pain affects daily activity. Mild Pain [1-3], moderate pain [4-6] and severe pain [7-10]) from 3/28/25 through 4/9/25 revealed the following:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - 3/28/25 8 out of 10 pain,<br><br>- 3/30/25 8 out of 10 pain,<br><br>- 3/31/25 5 out of 10 pain,<br><br>- 4/1/25 8 out of 10 pain,<br><br>- 4/2/25 8 out of 10 pain,<br><br>- 4/3/25 9 out of 10 pain,<br><br>- 4/4/25 8 out of 10 pain,<br><br>- 4/5/25 10 out of 10 pain,<br><br>- 4/6/25 5 out of 10 pain and<br><br>- 4/9/25 9 out of 10 pain.<br><br>Review of the 3/2025 and 4/2025 MARs revealed the following medications were provided to Resident 2 to address increased and prolonged pain:<br><br>- Acetaminophen at 650 mg was received one to two times a day from 3/28/25 through 4/3/25 with a pain level recorded at moderate to severe pain levels recorded upon administration.<br><br>- Ibuprofen at 600 mg three times a day was received from 3/28/25 through 4/2/25.<br><br>- Oxycodone at 5 mg was received two to four times a day from 3/31/25 through 4/5/25 with moderate to severe pain levels recorded upon administration.<br><br>- Fentanyl Patch at 12 mcg was applied on 4/7/25.<br><br>- Morphine sulfate at .5 ml was provided three times a day on 4/5/25 and 4/6/25.<br><br>- Morphine sulfate at .25 ml was provided twice on 4/9/25.<br><br>A 4/3/25 Facility Investigation Summary reported on 3/27/25 at 3:45 PM Resident 1 called Resident 2 a bitch when walking past her/him. Resident 2 asked Resident 1, What did you say? Resident 1 responded by saying, Fuck you, motherfucker and then pushed Resident 2 causing her/him to lose her/his balance, hit the wall behind her/him and fall to the ground. Staff were required to immediately intervene and separate the two residents.<br><br>A 4/5/25 Progress Note written by Staff 20 (Licensed Vocational Nurse) revealed Resident 2 was experiencing increased confusion and agitation, was refusing to eat, was refusing to take medications and refusing all care.<br><br>Attempts to contact Resident 1 were unsuccessful and Resident 2 passed away.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/15/25 at 10:57 AM Staff 17 (CNA) stated Resident 2 was mostly independent prior to the incident but was bedridden and often screamed out in pain when ADL care and repositioning assistance was provided.<br><br>On 4/15/25 at 11:22 AM Staff 16 (CNA) stated Resident 2 was thriving before the incident. Staff 16 stated Resident 2 did not like to be touched after the incident due to increased pain. Staff 16 stated Resident 2 regularly walked around the facility prior to the incident but did not continue due to increased and prolonged pain for weeks after the incident.<br><br>On 4/15/25 at 11:44 AM Staff 12 (Social Service Director) and Staff 13 (Social Services Assistant) stated they collected information regarding the incident. Staff 12 reported Resident 2 was walking by Resident 1 when Resident 1 made an unknown verbal remark towards Resident 2. Resident 2 was hard of hearing and asked for the statement to be repeated, upon which Resident 1 pushed Resident 2 against the wall. This caused Resident 2 to fall to the floor. Resident 1 was observed to be punching Resident 2 which required staff intervention. Staff 12 reported the police were called and Resident 1 was arrested immediately after the incident. Staff 12 and Staff 13 reported Resident 2 experienced increased pain and remained in bed all day.<br><br>On 4/15/25 at 1:14 PM Staff 11 (RN) stated she witnessed the incident. Staff 11 stated she heard yelling down the hall and observed Resident 1 push Resident 2 down with both hands resulting in a fall to the ground over her/his walker. Staff 11 stated she was required to rush over to separate Resident 1 and Resident 2. Staff 11 stated Resident 2 was on the ground and yelled get me up! get me up, while complaining of pain to her/his ribs. Staff 11 stated Resident 2 appeared in shock immediately following the incident. Staff 11 stated she considered what she observed as assault.<br><br>During an interview on 4/15/25 at 1:54 PM with Staff 10 (LPN-Resident Care Manager) and Staff 7 (LPN-Resident Care Manager), Staff 7 stated Resident 2 was medically stable prior to the incident. Staff 7 and Staff 10 stated Resident 2 changed from being up and walking around to not getting out of bed after the incident. Staff 10 stated Resident 2 had increased pain and decreased ability to hold a conversation after the incident. Staff 10 confirmed the incident was abuse.<br><br>On 4/15/25 at 2:47 PM Staff 1 (Administrator) acknowledged Resident 2 was physically abused by Resident 1 on 3/27/25. |