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 08/16/2024
NAME OF PROVIDER OR SUPPLIER: Porthaven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 5330 NE Prescott Street Portland, OR 97218	

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 47001 Based on interview and record review it was determined the facility failed to involve residents/representatives in the care planning process for 2 of 2 sampled residents (#s 4 and 41) reviewed for care planning and dementia. This placed residents at risk for unmet needs. Findings include: 1. Resident 4 was admitted to the facility in 5/2009 with diagnoses including dementia. A review of Resident 4's medical record revealed the last care conference completed for Resident 4 was on 2/5/24. On 8/15/24 at 10:12 AM Staff 11 (SSD) stated Resident 4 had not had a care conference completed since 2/5/24. On 8/15/24 at 12:54 AM Staff 6 (LPN Resident Care Manager) and Staff 4 (LPN Resident Care Manager) stated care plan revisions and reviews are reviewed with the resident and/or representatives on a quarterly basis during the care conference. Staff 6 stated Resident 4 was overdue for a care conference. 2. Resident 41 was admitted to the facility in 1/2023 with diagnoses including acute respiratory failure. A 6/15/24 Quarterly MDS revealed Resident 41 had moderate cognitive decline. A review of Resident 41's medical record revealed the last care conference completed for Resident 41 was on 1/24/24. On 8/14/24 at 11:22 AM Staff 4 (LPN Resident Care Manager) stated Resident 41 had a care conference completed in June 2024, she was unsure of the date, she was unsure if the resident's representative was invited and she was unable to provide documentation of the care conference being completed in June 2024. On 8/14/24 at 11:48 AM Staff 11 (SSD) stated the last care conference documented for Resident 41 was in 1/2024. Staff 11 stated she was getting caught up and back on track with care conferences. (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: 385045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 12:54 PM Staff 4 and Staff 6 (LPN Resident Care Manager) stated care plan revisions and reviews are reviewed with the resident and/or representatives on a quarterly basis during the care conference.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690 Based on observation and interview it was determined the facility failed to maintain a homelike environment for 3 of 4 halls reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include: Observations of the facility's general environment and residents' rooms from 8/12/24 through 8/16/24 identified the following issues: -A light cover on the annex hall near room [ROOM NUMBER] was cracked with missing chunks of the lighting cover. -One hall light was out on the annex hall near room [ROOM NUMBER]. -Two lights were out in the dining room. -Dirty vent covers in rooms 155, 157, 158, the center hall outside the employee room and outside the RCM office near the west hall. -The east hall near the O2 storage closet had a torn/jagged baseboard to the left of the closet door. -The east hall near the emergency exit had broken pieces of plastic on both wall corners approximately 3 inches in length that were sharp/jagged. -A lower corner wall near the west hall and RCM office was separated with approximately 3 inches of separation with sharp/jagged edges. -A lower corner wall near the center hall and resident bathroom had approximately 6 inches of missing/broken plastic with sharp/jagged edges. -The entrance to the clean laundry area had a wall corner with broken sharp/jagged edges in three different areas on the wall protector. -The entrance to the facility where the directory sign was had a corner with approximately 3-4 inches of missing plastic protector with sharp/jagged edges. -The west hall outside the nurses station had a wall corner with approximately 3-4 inches of missing plastic protector with sharp/jagged edges. On 8/16/24 at 10:24 AM Staff 1 (Administrator) and Staff 18 (Maintenance Director) acknowledged the identified concerns.

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NAME OF PROVIDER OR SUPPLIER: Porthaven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 5330 NE Prescott Street, Portland, OR 97218	

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F 0585 Level of Harm - Minimal harm or potential for actual harm 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. 47001 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: Resident 309 was admitted to the facility in 6/2020 with diagnoses including depression. On 7/8/24 a public complaint was received with allegations of missing personal property. 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. 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. An 8/14/24 review of the facility grievance binder revealed no evidence of a grievance from Resident 309 or her/his representatives. 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. 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. 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. 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. 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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	385045	A. Building B. Wing	08/16/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43690 Based on interview and record review it was determined the facility failed to ensure the Office of the State Long Term Care Ombudsman was notified of resident hospitalization s for 1 of 1 sampled resident (# 56) reviewed for hospitalization . This placed residents at risk for lack of advocacy by the Ombudsman's office. Findings include: Resident 56 was admitted to the facility in 5/2024 with diagnoses including urinary tract infection and bacteremia (bacteria in blood). Resident 56's 5/23/24 Discharge MDS indicated the resident was discharged to an acute care hospital. A review of Resident 56's health record revealed no documentation to indicate the state/local Ombudsman was notified Resident 56 was discharged to a hospital. On 8/15/24 at 12:51 PM Staff 1 (Administrator) stated the facility did not notify the Ombudsman of discharged residents.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 43690 Based on interview and record review it was determined the facility failed to provide residents with a written notice of the facility's bed hold policy at the time of transfer to the hospital for 2 of 3 residents (#s 4 and 56) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 4 was admitted to the facility in 5/2009 with diagnoses including epilepsy and dementia. A 1/31/24 Progress Note revealed Resident 4 experienced a change in condition which required increased medical attention and she/he was transferred to a hospital. A review of Resident 4's health record revealed no documentation to indicate a copy of the facility's bed hold policy was provided to Resident 4 when she/he experienced a change in condition and was transferred to a hospital. On 8/15/24 at 1:24 PM Staff 1 (Administrator) confirmed a bed hold policy was not provided to Resident 4 when she/he experienced a change in condition and was required to be transferred to a hospital. On 8/16/24 at 8:52 AM Staff 3 (Interim DNS) confirmed a bed hold policy was not provided to Resident 4 when she/he was transferred to a hospital. 2. Resident 56 was admitted to the facility in 5/2024 with diagnoses including urinary tract infection and bacteremia (bacteria in blood). A 5/23/24 Progress Note revealed Resident 56 experienced a change in condition which required increased medical attention and she/he was transferred to a hospital. A review of Resident 56's health record revealed no documentation to indicate a copy of the facility's bed hold policy was provided to Resident 56 when she/he experienced a change in condition and was transferred to a hospital. On 8/15/24 at 1:24 PM Staff 1 (Administrator) confirmed a bed hold policy was not provided to Resident 56 when she/he experienced a change in condition and was required to be transferred to a hospital. On 8/16/24 at 8:52 AM Staff 3 (Interim DNS) confirmed a bed hold policy was not provided to Resident 56 when she/he was transferred to a hospital.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43691 Based on observation, interview and record review it was determined the facility failed to provided nail care services to 1 of 1 resident (# 24) reviewed for ADL care. This placed residents at risk of unmet care needs. Findings include: Resident 24 was admitted to the facility in 2/2020 with diagnoses including a stroke resulting in hemiplegia (partial or complete loss of function of one side of the body). Physician orders from 7/11/22 stated a licensed nurse was to check fingernails and toe nails once a week and trim as needed. A 6/5/24 Care Plan included Resident 24 requiring extensive assistance with ADL tasks including hygiene and grooming. Review of LN Care Records from 6/2024 through 8/2024 revealed nail care was marked as not needed on the following dates: - 6/3/24, - 6/24/24, - 7/1/24, - 7/8/24, - 7/15/24, - 7/22/24, - 7/29/24, - 8/5/24 and - 8/12/24. Review of LN Care Records from 6/2024 revealed Resident 24 refused nail trimming on the following dates: - 6/10/24 and - 6/17/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 12:35 PM Resident 24 stated her/his nails were too long, nail care had not been offered to her/him recently and she/he would not have refused nail care if it was offered. Resident 24's nails were observed to be extended a quarter of an inch and had dirt under each of the nails on both hands. On 8/13/24 at 1:06 PM Staff 4 (RNCM) confirmed Resident 24's nails were dirty and had not been trimmed for an extended period.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to start antibiotic treatment timely or follow physician orders for 2 of 9 sampled residents (#s 4 and 28) reviewed for skin condition and unnecessary medications. This placed residents at risk for unmet needs. Finding include: 1. Resident 28 was admitted to the facility in 8/2023 with diagnoses including heart failure, diabetes with a foot ulcer and cellulitis (a bacterial skin infection) of the left lower limb. a. Resident 28's 5/20/24 Quarterly MDS revealed the resident was cognitively intact, had a total of two venous ulcers (leg ulcers caused by problems with blood flow in a person's leg veins) and arterial ulcers (a painful, deep sore or wound in the skin of the lower leg or foot) and received the application of nonsurgical dressings and ointments/medications other than to her/his feet. A 6/26/24 Progress Note indicated Resident 28 was observed to have three large greenish patches on her/his right lower extremity with a slight odor. The progress note also indicated the resident's on-call provider was notified, a wound culture was ordered and the provider requested the wound nurse obtain the wound culture during her visit on 6/27/24. A 6/27/24 Encounter Note completed by Staff 30 (NP) stated the wound nurse obtained a culture of Resident 28's leg and indicated the wound might be infected and the resident's pain was a little worse than normal. A 6/27/24 United Wound Healing Note completed by Staff 31 (Wound Nurse) indicated Resident 28's leg wounds had heavy serous (clear fluid that leaks out of wounds) to green drainage with odor. The note indicated a wound culture was obtained by Staff 31 and Staff 31 would notify the facility of the results of the culture which was typically in three to five days. A 7/1/24 Wound Culture Report indicated Resident 28's wound culture was positive for multiple bacteria. Resident 28's 7/2024 MAR revealed the resident received vancomycin (a strong antibiotic used to treat infections caused by bacteria) intravenously (by means of a vein) from 7/18/24 through 7/28/24 and levofloxacin (an oral antibiotic) from 7/18/24 through 7/27/24. No evidence was found in Resident 28's clinical record to indicate Staff 30 was informed of the resident's wound culture results prior to 7/18/24. On 8/13/24 at 3:55 PM Staff 21 (RN) stated she recalled the wound culture was completed on 6/27/24 and would have expected to have seen the results by 7/4/24. Staff 21 stated Staff 30 was not notified of the results of the wound culture until 7/18/24 and that was why the resident started on antibiotics late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 11:12 AM Staff 15 (RN) stated a resident's provider typically received results of a wound culture within three days and was unsure why there was a delay in Staff 30 receiving Resident 28's wound culture results. On 8/14/24 at 2:54 PM Resident 28 was observed to sit in her/his room in her/his wheelchair. Both of the resident's lower extremities were covered in bandages. Resident 28 was unable to recall the state of her/his wounds or pain caused by the wounds from the prior month. Resident 28 stated her/his wounds had been bad for so long and they had progressively gotten worse and the pain was the same. On 8/14/24 at 3:18 PM Staff 6 (Infection Preventionist) and Staff 2 (DNS) acknowledged the findings of this investigation. Staff 6 confirmed Resident 28's provider was not notified of the wound culture results until 7/18/24, and as a result, did not receive timely treatment for her/his wound infections. b. Resident 28's 8/2024 Physician Orders directed the resident to be weighed daily and for her/his physician to be notified if the resident gained two pounds in two days or five or more pounds in a week. Resident 28's 7/2024 and 8/2024 LN Task Records revealed the following: -On 7/9/24, the resident weighed 240.5 lbs (pounds). -On 7/11/24, the resident weighed 243.5 lbs (a gain of 3.5 lbs). -On 7/26/24, the resident weighed 236.5 lbs. -On 7/28/24, the resident weighed 240 lbs (a gain of 3.5 lbs). -On 8/1/24, the resident weighed 235 lbs. -On 8/3/24, the resident weighed 240 lbs (a gain of 5 lbs). No evidence was found in Resident 28's clinical record to indicate her/his physician was notified of her/his weight gains. On 8/15/24 Staff 3 (Interim DNS) stated Resident 28's provider should have been notified of her/his weight gains on 7/11/24, 7/28/24 and 8/3/24 and was not. 47001 2. Resident 4 was admitted to the facility in 5/2009 with diagnoses including depression. A review of Resident 4's 4/10/23 hospital readmission orders revealed orders for sertraline (a medication used to treat depression). A review of Resident 4's 4/2023 MAR revealed no evidence sertraline was added to her/his MAR as ordered on her/his 4/10/23 hospital readmission orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/4/24 [NAME] Psychiatric Consultant Progress Note revealed Resident 4 continued to have physical and verbal behaviors with care activities and these behaviors had increased in 6/2023 and persisted since. A recommendation were made for Resident 4 to restart previous medication that was stopped in 4/2023. A 4/11/24 Provider Progress Note revealed Resident 4 was having increased behaviors and stated Resident 4 stopped taking sertraline about a year ago. A review of Resident 4's medical record revealed sertraline was restarted on 5/6/24. On 8/15/24 at 1:07 PM Staff 3 (Interim DNS) stated Resident 4's sertraline was ordered and not transcribed on her/his 4/10/23 readmission to the facility. Staff 3 confirmed this was a medication error.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47000 Based on interview and record review it was determined the facility failed to ensure necessary interventions were in place and followed to reduce the risk of falls and to thoroughly investigate the cause of a fall for 2 of 5 sampled residents (#s 37 and 360) reviewed for skin conditions and falls. This placed residents at risk for falls. Findings include: 1. Resident 37 was admitted to the facility in 7/2023 with diagnoses including diabetes, acquired absence of left foot, acquired absence of right toes and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Resident 37's 7/9/23 Morse Fall Scale indicated the resident was at high risk to fall. Resident 37's 3/7/24 At Risk For Falls Care Plan revealed the following: -The resident experienced impaired physical mobility as a result of the surgical amputation of her/his left foot. -The resident had a history of falls. -The resident's call light/personal items were to be within reach. -The resident was to wear nonskid footwear when transferring. -Staff were to remind the resident to use the call light for assistance. -The resident was at low risk to fall. Resident 37's 3/7/24 ADL Care Plan revealed the resident was non-ambulatory and no weight bearing left. Resident 37's 4/13/24 Quarterly MDS indicated the resident was cognitively intact, experienced lower extremity impairment on one side and used a wheelchair. A 5/13/24 Incident Report revealed the following: -Resident 37 experienced an unwitnessed fall in her/his room. -The resident stated she/he attempted to walk as she/he wanted to go back home and she/he had stairs in her/his home. -The resident had no restrictions related to her/his ability to bear weight. -Conclusion: The resident adhered to her/his physician orders when this event occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No evidence was found in Resident 37's health record to indicate the resident's care plan was followed prior to the fall or a thorough investigation was completed after the fall. No detailed information about the resident's fall was obtained, including where in the room the resident was found at the time of the fall, whether or not her/his call light was activated, the last time she/he interacted with staff, whether or not the resident wore nonskid footwear or whether or not the resident's personal items were in reach. On 8/16/24 at 11:30 AM Staff 2 (DNS) and Staff 3 (Interim DNS) acknowledged the findings of this investigation. Staff 3 stated a thorough fall investigation included an evaluation of the events that lead up to the fall, resident and witness statements, a review of the resident's care plan and an interview with the staff person who provided care to the resident prior to the fall. Staff 3 confirmed the investigation of Resident 37's fall on 5/13/24 was not thorough and stated it was unclear if the resident's care plan was followed. Staff 3 further stated the resident's At Risk For Falls Care Plan and the conclusion of the investigation were inaccurate. 50927 2. Resident 360 was admitted to the facility in 7/2024 with diagnoses including urinary tract infection and acute kidney failure. An Investigation Report dated 8/9/24 indicated on 8/3/24 at about 10:00 PM, Resident 360 was found on the floor by a CNA during rounds and Resident 360 had been sleeping prior to event and had a urinal at bedside. Resident 360 was disoriented and forgot she/he had a urinal when she/he woke up. The resident stated at the time she/he was getting up to go to the bathroom. When questioned later by a facility RCM (Resident Care Manager), Resident 360 did not remember what happened. The investigation did not include witness statements. On 8/15/24 at 3:36 PM Staff 4 (RNCM) stated the only witness to Resident 360's fall was Staff 28 (CNA). Staff 4 stated she tried calling Staff 28 for a follow up, but Staff 28 did not respond. On 8/15/24 at 4:44 PM staff 28 stated she was driving and needed to call back for an interview. She did not call back. On 8/16/24 at 9:34 AM Staff 4 acknowledged that she did not interview Staff 28. Staff 4 was informed this investigation did not include a witness statements, and Staff 4 agreed. On 8/16/24 at 11:26 AM Staff 3 (Interim DNS) stated the RNCM was expected to obtain resident and witness statements, and the investigation should show the whole picture. Staff 2 (DNS) acknowledged abuse or neglect could not be ruled out because the investigation was not thorough.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43690 Based on interview and record review it was determined the facility failed to follow physician orders and provide correct humidity administration for 1 of 1 sampled resident (#17) reviewed for respiratory care. This placed residents at risk for improper humidity administration. Findings include: A Respiratory Treatment Policy and Procedure dated 6/22/22 stated: It is the policy of this center that residents receive respiratory treatments and monitoring per their physician orders, standards of practice and care plan. Resident 17 admitted to the facility in 3/2024 with diagnoses including respiratory failure which included a tracheostomy required to breathe and malnutrition. A 3/13/24 physician order for Resident 17 revealed the resident used humidity mist via her/his tracheostomy with a flow rate of eight liters per minute at all times. The 6/13/24 Quarterly MDS indicated Resident 17 was severely cognitively impaired. On 8/15/24 at 8:50 AM Staff 19 (LPN) observed Resident 17's humidity mist and confirmed it was set at four liters per minute. On 8/15/24 at 10:57 AM Staff 3 (Interim DNS) confirmed Resident 17's humidity mist was to be set a eight liters at all times.

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	08/16/2024

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

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43691 Based on interview and record review it was determined the facility failed to employ a Physical Therapist to provide therapy services to 1 of 1 resident (# 209) reviewed for therapy services. This placed residents at risk of a decline in function and/or a delayed recovery. Findings include: Resident 209 admitted to the facility on [DATE] with diagnoses including multiple left toe fractures. Hospital orders from 8/6/24 included instructions for Resident 209 to receive a PT evaluation and services. Review of therapy records on from 8/6/24 to 8/13/24 revealed Resident 209 had not been evaluated by PT and therefore had not received PT services to assist with her/his transfer safety and mobility. On 8/14/24 at 2:50 PM Staff 20 (Rehabilitation Director) stated the facility had not been able to have a consistent physical therapist who performed evaluations or provided therapy services. Staff 20 stated the frequency and duration of therapy services had to be reduced for all residents due to insufficient therapy staff. Staff 20 stated ideally residents who required therapy would have received one discipline of therapy five times a week and another disciple based on their areas of deficiencies. Staff 20 confirmed Resident 209 had not received physical therapy services from 8/6/24 through 8/13/24.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 50927 Based on interview and record review it was determined the facility failed to have a plan in place to coordinate care and document hospice services for 1 of 1 sampled resident (#359) reviewed for hospice. This placed residents at risk for lack of coordination of care. Findings include: Resident 359 admitted to the facility in 7/2024 with diagnoses including failure to thrive and acute kidney failure. Resident's 359's health record indicated the resident was admitted to hospice services on 8/6/24. There was no further documentation including contact information, physican's orders for hospice services, hospice care plan or hospice notes. On 8/13/24 at 2:01 PM Staff 11 (Social Services Director) stated resident 359 began hospice services on 8/6/24 and Staff 11 did not know when they came in to care for the resident. On 8/14/24 at 10:00 AM Staff 23 (CNA) stated she thought the resident received hospice services, but had not seen any hospice providers and had no communication with any hospice staff. On 8/15/24 at 10:17 AM Staff 5 (RNCM) acknowledged there was no hospice documentation in Resident 359's health record.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 2 of 4 halls (East and Annex Halls), 1 of 1 dining room, and 2 of 4 sampled residents (#s 28 and 37) reviewed for dining and skin conditions. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: 1. The Centers for Disease Control and Prevention website, section titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration specified there was an increased risk for exposure to bloodborne viruses through contaminated equipment, such as glucometers, when shared. Using a [glucometer] for more than one person without cleaning and disinfecting it in between uses contributed to transmission of HBV (Hepatitis B virus). [Glucometers] should be cleaned and disinfected after every use. The facility's 4/2019 Disinfection of Point-of-Care Devices/Instrument Policy & Procedure specified all point-of-care devices, including glucometers, will be cleaned and disinfected according to manufacturer recommendation using EPA (Environmental Protection Agency) approved disinfectants. Resident 37 was admitted to the facility in 7/2023 with diagnoses including type II diabetes. Resident 28 was admitted to the facility in 8/2023 with diagnoses including type II diabetes. On 8/14/24 at 12:29 PM Staff 32 (Agency RN) was observed in Resident 28 and 37's shared room. Staff 32 used a glucometer and obtained Resident 28's blood sugar. Staff 32 returned to the medication cart in the hallway, placed the glucometer on the top surface of the cart and disinfected the glucometer with an alcohol prep pad. At 12:35 PM Staff 32 returned to the room with the used glucometer and stated she was going to obtain Resident 37's blood sugar. The State Surveyor requested to speak with Staff 32 prior to obtaining Resident 37's blood sugar. Staff 32 stated she used alcohol wipes to disinfect shared glucometers because the purple top wipes caused a lot of errors and she had seen other nurses use them at the facility. On 8/14/24 at 12:40 PM Staff 6 (Infection Preventionist) stated she was unsure if alcohol wipes were effective against blood borne pathogens. On 8/14/24 at 1:05 PM Staff 6 provided the glucometer's manufacturer instructions which indicated the glucometer was to be disinfected between patient uses by wiping it with a CaviWipe towelette (durable towelettes that offer quick, easy-to-use, time-saving convenience and kill organisms in only three minutes) or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. Review of Resident 28 and Resident 37's health record revealed no diagnoses including viral bloodborne pathogens. On 8/14/24 at 2:33 PM Staff 2 (DNS) stated glucometers were to be disinfected according to manufacturer instructions and alcohol wipes were not to be used to disinfect glucometers as they did not kill blood borne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The facility's 7/2024 Transmission Based Precautions Policy & Procedure specified the following related to Enhanced Barrier Precautions (EBP): -Residents with wounds required EBP. -Personnel was to wear gloves and a gown when dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, therapy and device care/use for a resident on EBP. -EBP applies when a wound is open and/or draining. Resident 28 was admitted to the facility in 8/2023 with diagnoses including heart failure, diabetes with a foot ulcer, cellulitis (a bacterial skin infection) of the left lower limb and acquired absence of the right foot. Resident 28's 5/20/24 Quarterly MDS revealed the resident was cognitively intact, had a total of two venous ulcers (leg ulcers caused by problems with blood flow in a person's leg veins) and arterial ulcers (a painful, deep sore or wound in the skin of the lower leg or foot) and received the application of nonsurgical dressings and ointments/medications other than to her/his feet. On 8/12/24 at 10:20 AM Staff 24 was observed to push Resident 28 in her/his wheelchair from the facility's shower room, down the hall and into the resident's shared room. The resident's legs were not covered and revealed large open wounds with chunks of missing skin and yellowish puss on both legs. A sign outside of Resident 28's room indicated she/he was on EBP. After Staff 24 assisted the resident to her/his side of the room, Staff 24 placed a towel under the resident's left foot and right stump, removed the resident's breakfast tray and exited the room. Staff 24 did not wear gloves or a gown when she pushed the resident in her/his wheelchair or when she placed a towel under her/his foot/stump. Staff 24 was not observed to perform hand hygiene after she pushed the resident in her/his wheelchair and prior to retrieving the towel that was placed under her/his bare foot/stump. At 10:23 AM Resident 28 was observed with her/his bare foot/stump off of the towel and directly on the floor. At this time, the resident's right leg was observed with blood running down. On 8/12/24 at 10:32 AM Staff 24 stated staff were supposed to wear gloves, a mask and a gown whenever they worked with residents who were on EBP. Staff 24 stated Resident 28 was on EBP and she did not wear the appropriate PPE when she transported the resident from the shower room or when providing her/him with a towel. Staff 24 further stated she liked to put a towel under the resident's foot/stump because they leaked water. Observations of Resident 28 on 8/12/24 from 10:23 AM to 10:59 AM revealed Resident 28's foot/stump to rest uncovered on the floor of her/his room. A pool of clear fluid was observed on the ground where the resident's foot/stump had previously rested. At 10:43 AM Staff 15 (RN) entered the resident's room, asked the resident if the towel was underneath her/his foot/stump, said oh, pointed to the towel on the ground and left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/12/24 at 10:59 AM Staff 15 re-entered the resident's room to provide treatments to both of the resident's legs. Prior to completing the treatments, Staff 15 was observed to step in the pool of clear fluid on the floor of the resident's room. At 11:47 AM Staff 15 stated she expected staff to wear gloves when they assisted Resident 28 when her/his wounds were uncovered. Staff 15 stated she thought the resident's foot and stump should be on a towel when uncovered because they wept a lot and I don't know what else to do. On 8/13/24 at 12:45 PM Resident 28 was observed to sit in her/his wheelchair in her/his room. The resident's leg wounds were covered and she/he wore non-skid socks over the bandages on her/his feet. No towel was observed underneath the resident's foot/stump and a wet towel was observed in a clump next to the foot of the resident's bed. Resident 28 stated her/his foot and stump were always leaking but she/he could not tell or feel it when they did. On 8/14/24 at 9:40 AM Staff 10 (CNA) stated she had frequently seen a trail of liquid coming from Resident 28's feet on the floor throughout the facility. Staff 10 stated she had not been instructed on what to do when she noticed the trail of liquid on the floor from the resident's feet but thought housekeeping regularly mopped the floors. Staff 10 further stated she regularly changed the resident's socks and towel as they were often soaked all the way through with liquid from her/his feet. On 8/14/24 at 10:21 AM Staff 29 (CNA) stated she had noticed a couple of times in the hallway liquid trails coming from Resident 28's feet. Staff 29 stated she noticed some staff just put a towel down when they noticed the trail but she would clean it up with a towel and then take the dirty towel to the laundry. On 8/14/24 at 11:53 AM Resident 28 was observed to wheel her/himself down the hall, around a corner and into a shared resident bathroom. A trail of clear liquid was observed on the ground that followed the resident from her/his room to the bathroom. An unidentified staff person assisted the resident into the bathroom, closed the door behind the resident and stepped into the liquid left on the floor. From 11:53 AM to 12:15 PM five different staff and two different residents were observed to step in the liquid Resident 28 left behind on the floor. On 8/14/24 at 2:54 PM Resident 28 stated her/his room was cleaned and mopped only once in the morning each day. On 8/15/24 at 9:38 AM Staff 29 was observed to leave the resident shower room with a black garbage bag filled with used towels. Staff 29 did not wear gloves or a gown. At 9:39 AM Staff 29 stated she just gave Resident 28 a shower during which she wore gloves and a mask but not a gown. Staff 29 stated the garbage bag was filled with dirty towels from Resident 28's shower. On 8/15/24 at 11:50 AM Staff 6 (Infection Preventionist) and Staff 17 (RN Consultant) acknowledged the findings of this investigation. Staff 17 stated she expected staff to wear a gown and gloves when with Resident 28 any time her/his wounds were not covered and when assisting her/him with a shower. Staff 17 stated she expected Resident 28's wounds to be covered when out of her/his room and staff should clean the floor as soon as possible if the liquid coming from Resident 28's foot/stump could not be contained. Staff 17 further stated she expected staff to keep on top of changing the resident's dressings and socks. 41458 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The facility's Hand Hygiene Policy, last revised 12/15/21, indicated hand hygiene was the primary means of preventing the transmission of infection. On 8/12/24 between the hours of 12:11 PM and 12:30 PM, during the lunch meal in the main dining room and residents' lunch tray pass on the Annex Hall, the following observations were made: -12:18 PM Staff 26 (CNA) was observed in the main dining area wearing a surgical mask which was below her nose. Staff 26 adjusted her surgical mask and then assisted a resident to prepare and set-up their lunch tray. No hand hygiene was performed. Staff 26 was, again, observed with her surgical mask below her nose, adjusted her mask and then assisted another resident to prepare and set-up their tray, touching the resident's silverware and tray items. No hand hygiene was completed after adjusting her mask or between assisting residents. -12:25 PM Staff 27 (CNA) was observed passing beverages on Annex Hall. Staff 27 entered room [ROOM NUMBER], adjusted the resident's bedside table and moved objects on the table prior to placing the beverage down. Staff 27 was observed repeating this process for residents' in rooms 113, 114, 116 and 119. Staff 27 did not complete hand hygiene after exiting or before entering any of the residents' rooms. On 8/12/24 at 12:22 PM Staff 26 stated she was not supposed to touch her surgical mask but if she did, she was supposed to complete hand hygiene. Staff 26 confirmed she did not complete hand hygiene after touching her mask or between residents. On 8/12/24 at 12:31 PM Staff 27 stated he was supposed to complete hand hygiene after touching something belonging to a resident. Staff 27 stated he tried to do as much hand hygiene as possible but did not always consistently perform hand hyiene. On 8/16/24 at 8:35 AM and 10:01 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (Interim DNS) stated staff were expected to complete hand hygiene each time they went in and out of a resident's room. Staff 1 and Staff 2 stated they also expected hand hygiene to be completed after touching something dirty and before touching something clean. 47001 4. On 8/13/24 at 12:56 PM Staff 13 (CNA) was observed in the east hall picking up dirty food trays. Staff 13 picked up room [ROOM NUMBER]'s dirty tray, placed it in the cart and went into room [ROOM NUMBER], no hand hygiene was completed. Staff 13 exited room [ROOM NUMBER] and went into room [ROOM NUMBER], no hand hygiene was completed. Staff 13 exited room [ROOM NUMBER] with a dirty food tray, placed it in the cart and with into room [ROOM NUMBER], no hand hygiene was completed. Staff 13 was observed in room [ROOM NUMBER] attempting to assist the resident with eating, the resident refused the meal, staff 13 exited room [ROOM NUMBER] with the dirty food tray and placed it in the cart, no hand hygiene was completed. Staff 13 stated she was not taught to clean her hands between picking up dirty food trays. On 8/16/24 at 8:35 AM Staff 3 (Interim DON) stated staff are expected to perform hand hygeine each time they go in and out of rooms.