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	12/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review it was determined the facility failed to promptly respond to grievances and complaints from the resident council for three of four months reviewed. This placed residents at risk for a lack of resolution to voiced concerns. Findings include:An undated facility Resident Council Policy indicated the following:-A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. -The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. -Issues documented on council response forms may be referred to the QAPI Committee, if applicable (i.e., the issue is of serious nature or if there is a pattern, etc.). A review of the 1/2025 through 11/2025 grievance book revealed that there were no grievances submitted by the Resident Council. A review of the Resident Council Minutes from 8/2025 through 11/2025 revealed multiple concerns including but not limited to call light wait times, lack of adequate CNAs on the floor, language barrier and dietary concerns brought up from the resident council which included old and new business. No evidence was found concerns or grievances were addressed.During the 12/3/25 2:30 PM interview with the Resident Council members, seven of the twelve residents in attendance (#s11, 15, 21, 30, 44, 52, and 82) stated concerns and suggestions brought up during Resident Council were not followed up or addressed by the facility beyond talking to the department head.On 12/4/25 at 8:47 AM, Staff 14 (Activity Director) stated, she spoke at Resident Council regarding old business to see if the residents' view had changed or there were changes with the concerns. Staff 14 stated she brought the resident council's concerns and suggestions to the administrator who would go to each department head to speak to them to come up with a plan. On 12/5/25 at 1:57 PM Staff 1 (Administrator) stated concerns from Resident Council were separated, and Staff 15 (Social Services Director) managed grievances. Staff 14 was responsible for documenting concerns, notifying relevant departments, following up on outcomes, and reporting back to the Resident Council. Staff 1 acknowledged the need for a more effective process to address concerns and emphasized the importance of timely communication and updates to the Resident Council and completion of timely grievances. On 12/5/25 1:57 PM Staff 15 stated grievances from Resident Council were on a separate form, and she did not receive any grievances from Staff 14 or Resident Council. She stated Staff 14 followed up on Resident Council grievances and was a separate process. She stated Staff 14 followed up on the Resident Council grievances with a separate process that did not go through the social services department.

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 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** Based on observation, interview, and record review it was determined the facility failed to provide a clean and sanitary environment toilet/shower rooms for 3 of 4 communal resident bathrooms reviewed for homelike environment. This placed residents at risk for unsanitary conditions while using the communal toilet/shower rooms. Findings include:The facility's policy titled Cleaning and Disinfection Environment Surfaces, adopted on 8/1/24 indicated the following: Policy: Environmental surfaces are cleaned and disinfected according to CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes is used in resident care areas where: a. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt) or b. uncertainty exists about the presence of multi-drug-resistant organisms on such surfaces.Resident 11 admitted to the facility on [DATE] for atherosclerosis of the left lower leg with ulceration and right above knee amputation. The MDS dated [DATE] revealed Resident 11's BIMS score was 15, which indicated she/he was cognitively intact. The resident was independent with toilet hygiene and toilet transfers.In an interview with Resident 11 on 12/2/25 9:18 AM she/he stated the communal toilet/shower rooms smelled and often had feces on the toilet seats. Resident 11 stated she/he used multiple communal toilet and shower rooms for toileting and showering.Random observations of communal toilet/shower rooms from 12/2/25 through 12/5/25 revealed the following:*12/2/25 at 10:58 AM a CNA placed a shower chair in the communal shower room across from room [ROOM NUMBER] and room [ROOM NUMBER]. [NAME] material was on the inside edge of the toilet. and a strong urine odor. A crumpled-up paper towel was under the shower chair with bits of paper just outside the shower mat. Multiple staff were in and out of the communal shower without cleaning the area.*12/2/25 at 11:10 AM the communal shower across from room [ROOM NUMBER] had a reclining shower chair with an approximately one-inch smear of brown material on the seat and crevasses where the commode basin would fit.*12/3/25 at 9:16 AM through 9:36 AM the communal shower across from room [ROOM NUMBER] had the same reclining shower chair and the brown material was still on the seat and crevasses. The reclining chair was moved by Staff 18 (CNA) but she did not clean the chair after usage with another resident and the brown material remained.*12/3/25 at 9:46 AM Staff 18 pushed a resident out of the communal shower room across from room [ROOM NUMBER] in a shower chair. The shower room door was left open and unclean, with saturated towels, washcloths and brown material on the shower room floor and matted hair on the grab bar. A sign was posted in the shower area which indicated after each shower provided to residents not to leave towels or clothes, empty trash cans, and keep shower room clean and ready for other residents to use. At 9:54 AM Staff 18 returned to the communal shower, sprayed the area with the shower nozzle but did not disinfect the area.*12/3/25 at 10:11 AM Staff 18 walked a resident down to the communal shower across from room [ROOM NUMBER] and closed the door. At 10:40 AM Staff 18 left the shower room and left the door open. The shower had an odor of bowel movement and brown material was on the shower floor. At 10:43 AM Staff 7 (CNA) entered the shower room sprayed the soiled area with water and did not disinfectant the communal shower. At 12:04 PM the shower chair had dried brown material on the seat, and the shower area was unclean.*12/3/25 at 11:00 AM Staff 7 returned to the toilet/shower room across from room [ROOM NUMBER] to finish cleaning. Staff 7 left the communal shower area, and the brown smear remained on the toilet seat and crumpled paper was on the floor.*12/3/25 at 12:04 PM the bath/shower room across from room [ROOM NUMBER] had the same brown smear on the toilet seat and crumpled paper on the floor. The shower chair still had dried brown material on the seat.*12/4/25 at 12:31 PM and at 3:40 PM the toilet/shower room across from room [ROOM NUMBER] was unclean. The toilet seat and bowl had (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brown smears and a shower chair with brown smears was in front of the sink. The door of the room was left open.*12/4/25 at 5:48 PM on and on 12/5/25 at 7:04 AM the toilet in the communal shower room across from room [ROOM NUMBER] had the same brown smears on the toilet seat. On 12/3/25 at 10:46 AM, Staff 7 stated after completing a shower, staff either dressed the resident in the shower room or assisted them back to their room in a shower chair before returning to clean up. Staff 7 stated a disinfectant spray bottle was located in the utility room was available for cleaning the shower chair, but she did not use the disinfectant. She stated the facility had not provided specific guidance for cleaning the floor and mats, so she typically used the shower sprayer and, sometimes added shampoo or soap. Staff 7 confirmed when bowel incontinence occurred, she used a washcloth with soap to wipe surfaces and sprayed feces down the drain. Staff 7 stated staff were expected to disinfect the shower with a chemical spray before the next use, she acknowledged she had not done so. She stated if the bath/shower room was not clean, staff were instructed to close the door to prevent resident use before cleaning.On 12/4/25 at 12:46 PM Staff 23 (Housekeeper) stated there was a problem with CNAs not cleaning the bathroom, between when housekeepers deep cleaned. She stated after CNAs completed showers, they would often only pick up the residents' items and leave everything else. She reported these concerns to management, but nothing happened. She stated it was a safety concern when residents use dirty bathrooms. Staff 23 stated we are supposed to clean it in the moment and housekeeping cleaned the bath/shower rooms at least daily but sometimes multiple times in a day when CNAs asked. She stated the door was supposed to remain closed when unclean and if open, the bathroom was available for resident use. In an interview on 12/4/25 at 1:04 PM Staff 16 (Housekeeping Manager) confirmed the communal toilet/shower rooms were cleaned by housekeeping at least daily, more if needed. She stated CNAs should check the bathroom after independent residents used the bathroom and were expected to clean and sanitize after each resident. Staff 16 stated communal toilet/shower room doors were to stay closed until the room was cleaned but at times residents utilize the communal toilet/shower room before being cleaned and sanitized appropriately. Staff 16 stated if housekeeping staff came to her with complaints, she reported concerns to the nurses. On 12/4/25 at 4:01 PM Staff 19 (CNA) stated when asked about the cleaning process after showers, I am not a housekeeper, I am a CNA. What I bring to the shower room, I bring out and put the shower chairs back in a safe place. Staff 19 stated she would put the yellow sign out to let others know the room was not available and housekeeping had the chemicals to clean the shower rooms. Staff 19 stated she sprayed the shower chairs with water but sometimes used the soap in the room. She stated if the toilet was dirty before she brought a resident into the shower room, she would put on gloves and clean it with hot water, paper towels or a washcloth. She stated housekeeping cleaned the communal toilets once per day or she called them to clean the toilet if they looked unclean.On 12/5/25 at 7:12 AM Staff 2 (DNS) confirmed the communal toilet/shower room across from room [ROOM NUMBER] was unclean with feces on the communal toilet and she acknowledged the communal toilet/shower rooms should not have been left uncleaned. Staff 2 stated CNAs were expected to clean the toilet and shower chairs when they were unclean. She stated staff had access to a disinfectant spray, which they were supposed to use. Staff 2 stated housekeeping rounded and were to clean areas considered high-risk surfaces and clean the communal bath/shower rooms.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review it was determined the facility failed to develop and implement a resident-centered activity program for 1 of 2 sampled residents (#42) reviewed for activities. This placed residents at risk for a diminished quality of life. Findings include:The facility's 6/2018 Activity Programs Policy indicated activities offered were based on the comprehensive resident-centered assessment and the preferences of each resident and documented in the resident's medical record. Resident 42 was admitted to the facility in 10/2025 with diagnoses including dementia.Resident 42's 10/29/25 admission MDS revealed the resident was mildly cognitively impaired and listening to preferred music was a very important activity to the resident. The Activities CAA indicated an activity care plan would be created and updated as needed. Resident 42's Activity Task Records from 11/9/25 to 12/8/25 revealed the resident did not participate in any music-themed activities. A review of Resident 42's clinical record revealed no activity care plan was developed for the resident. Random observations of Resident 42 from 12/2/25 through 12/5/25 between 8:44 AM to 2:55 PM revealed the resident was in her/his room in bed. No music was observed to play in the resident's room. On 12/3/25 at 11:12 AM, Resident 42 stated she/he preferred to spend her/his time in her/his room. Resident 42 stated she/he loved to listen to music, especially Christmas music, and had not been able to do so since her/his admission to the facility. On 12/8/25 at 7:11 AM, Staff 11 (CNA) stated she did not know Resident 42's activity interests, including if the resident liked music. Staff 11 stated she looked in the care plan to learn about a resident's activity interests. On 12/8/25 at 7:21 AM and 12:25 PM, Staff 12 (CNA) stated Resident 42 spent all of her/his time in her/his room, and the resident did not have any activity interests. Staff 12 further stated she had never heard music on in the resident's room. On 12/8/25 at 8:01 AM and 12:13 PM, Staff 13 (CNA) stated she did not know Resident 42's activity interests, but she would look in the resident's care plan to find the information. On 12/8/25 at 8:16 AM and 1:00 PM, Staff 7 (CNA) stated she did not know Resident 42's activity interests, and she had never heard music play in the resident's room. Staff 7 stated she was not sure if activity interests were listed in resident care plans.On 12/8/25 at 11:47 AM, Staff 14 (Activity Director) stated she completed activity interest interviews with residents shortly after their admission to the facility and added this information to resident activity care plans. Staff 14 stated music was a big activity for Resident 42, but she did not know which type(s) of music the resident preferred. Staff 14 stated Resident 42 should have an activity care plan in place, which included her/his musical preferences, but acknowledged the resident did not have anything listed on the care plan.

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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. Based on observation, interview and record review it was determined the facility failed to follow physician orders for 1 of 6 residents (#14) reviewed for unnecessary medications. This placed residents at risk for decreased weight loss. Findings include:Resident 14 was admitted to the facility in 10/2025 with diagnoses including an open wound on her/his right foot and morbid obesity.Resident 14's 10/12/25 admission MDS revealed she/he had moderate cognitive impairment and was dependent for bed mobility, transfers and toileting hygiene.Signed physician orders dated 10/14/25 revealed Resident 14 was to receive 0.5ML of Tirzepatide injected subcutaneously every seven days for diabetes mellitus and weight management.A review of Resident 14's medication administration records revealed she/he did not receive an injection of Tirzepatide as ordered on the following days:-11/19/25-11/26/25-12/3/25A progress note created on 11/19/25 revealed Resident 14 was given her/his final weekly dose and a new order was placed for her/his next dose.On 12/3/25 at 9:57 AM Resident 14 stated, she/he started receiving the Tirzepatide as ordered on 10/14/25 and received weekly doses until 11/13/25. Resident 14 stated the medication was important to her/him because it would help her/him lose weight so she/he could participate in therapy and improve her/his strength and overall health. Resident 14 stated she/he did not know why the facility ran out of the Tirzepatide and thought it might be related to the cost of the medication.On 12/4/25 at 9:34 AM Staff 4 (LPN) stated she was aware Resident 14 missed doses of Tirzepatide and the refill was awaiting approval. Staff 4 stated the delay may have been because the pharmacy ran out or because it was a high-cost medication.On 12/4/25 at 9:48 AM Staff 6 (LPN-Resident Care Manager) stated she was aware Resident 14 missed three doses of Tirzepatide. Staff 6 stated the pharmacy was looking for an alternative because it was a high-cost medication. Staff 6 stated she expected Resident 14 to receive all of her/his medications as ordered by the physician.On 12/4/25 at 10:23 AM Staff 2 (DNS) stated the facility had a contingency plan to call the pharmacy and have medications statted to the facility if they ran out of a resident's medications. Staff 2 also stated she expected staff to call the physician for an alternate medication in the interim, but this plan was not followed. Staff 2 stated she was aware Resident 14 missed doses of Tirzepatide and she expected residents to receive medications as ordered by their physicians.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to prevent further decreases in range of motion for 1 of 1 sampled resident (#42) reviewed for position and mobility. This placed residents at risk for worsening contractures (a permanent tightening of the muscle, tendons and skin causing the joint to shorten and stiffen) and conditions. Findings include: The facility's 7/2017 Resident Mobility and ROM Policy indicated the following:-Residents with limited ROM received treatment and services to increase and/or prevent a further decrease in ROM.-As part of the comprehensive assessment, the nurse identified conditions that placed the resident at risk for complications related to ROM and mobility, including contractures. -The care plan would be developed based on the comprehensive assessment and revised as needed. -The care plan would include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. -Interventions included therapies, the provision of necessary equipment, and/or exercises and would be based on professional standards of practice and be consistent with state laws and practice acts. -The care plan would include the type, frequency and duration of interventions, as well as measurable goals and objectives. Resident 42 was admitted to the facility in 10/2025 with diagnoses including dementia and hemiplegia (paralysis on one side of the body).Resident 42's 10/29/25 admission MDS revealed the resident was mildly cognitively impaired and experienced upper and lower extremity impairment on one side of the body. An 11/11/25 Progress Note revealed Resident 42 experienced significant mobility and ADL impairment and persistent right-sided hemiplegia following a stroke.No evidence was found in Resident 42's clinical record to indicate a care plan was developed to address the resident's right-sided weakness. Random observations of Resident 42 on 12/2/25 and 12/3/25 from 8:44 AM to 2:55 PM revealed the resident to be in her/his room in bed. The resident's four fingers on her/his right hand pressed into the palm of her/his hand and the resident's right thumb pushed tightly into her/his right index finger. On 12/3/25 at 11:12 AM, Resident 42 attempted to open the fingers on her/his right hand with her left hand and was only able to slightly raise the index and middle fingers on her/his right hand. The resident stated the facility had done nothing for her/his hand contracture, and she/he was interested in using a rolled washcloth or a therapy carrot (an orthotic device that positions the fingers away from the palm to protect the skin from excessive moisture, pressure and the risk of nail puncture). On 12/4/25 at 12:51 PM, Resident 42 was observed in her/his room in bed. A small piece of rolled gauze was observed in the resident's right hand between her/his fingers and palm. The resident stated she/he was happy to have something placed in her/his hand. On 12/8/25 at 7:16 AM, Staff 24 (CNA) stated she did not know anything about Resident 42's hand contracture or related interventions. On 12/8/25 at 7:21 AM, Staff 12 (CNA) stated Resident 42 did not use her/his right hand, and it stayed curled up. Staff 12 stated she placed rolled gauze in the resident's right hand because she noticed her/his fingers were curled. Staff 12 stated the resident did not have any care plan interventions related to her/his hand contracture, and she often did not see anything placed in the resident's right hand.On 12/8/25 at 7:25 AM, Staff 25 (Director of Rehabilitation and OT) stated a splint had been ordered to be used for Resident 42's right hand contracture, and staff were to place a hand roll in the resident's contracted hand until the splint arrived at the facility. Staff 25 stated he informed one unidentified CNA of this intervention but did not inform other staff or ensure a care plan was created.On 12/8/25 at 7:47 AM, Staff 26 (LPN) stated she was the nurse assigned to work with Resident 42. Staff 26 stated she was unfamiliar with Resident 42 and her/his right-hand contracture. Staff 26 state she would look in the resident's care plan to find information about her/his contracture. On 12/8/25 at 1:41 PM, Staff 27 (Regional RN) stated she expected a care plan to be created and implemented for residents who utilized orthotic devices.

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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. Based on observation, interview and record review it was determined the facility failed to ensure residents received adequate supervision and smoking materials were properly secured for 1 of 2 sampled residents (#73) reviewed for accidents. This placed residents at risk for accidents. Findings include:The facility's 9/2024 Smoking Policy indicated the following:-Residents who do not meet the established criteria to smoke independently are aided/supervised during smoking activities. -Residents are not allowed to borrow cigarettes or other smoking materials from other residents. -All smoking materials are locked up, including smoking materials for residents who are assessed to be a supervised smoker. Resident 73 was admitted to the facility in 11/2025 with diagnoses including intracerebral hemorrhage (brain bleed). Resident 73's 11/26/25 admission MDS revealed the resident was mildly cognitively impaired and did not use tobacco. Resident 73's 12/1/25 Smoking Assessment revealed the resident was cognitively impaired, smoked cigarettes, could not light her/his own smoking device and required supervision when she/he smoked. Resident 73's 12/1/25 Smoking Care Plan directed the following:-The resident required supervision to smoke.-The resident was to wear a smoking apron when she/he smoked.-The resident's smoking paraphernalia was to be stored per facility procedure.On 12/1/25 at 1:51 PM, Resident 73 was observed in her/his room in bed and held an unlit cigarette in her/his left hand. The resident stated a friend at the facility provided her/him with cigarettes.On 12/4/25 at 6:13 AM, Staff 28 (CNA) stated Resident 73 smoked independently at night. Staff 28 stated she did not know where the resident's smoking material was supposed to be stored. On 12/4/25 at 12:39 PM, Resident 73 was observed in her/his room in bed. The resident stated she/he did not wear an apron when she/he smoked, and staff did not supervise or help her/him when she/he smoked but wished they did. On 12/5/25 at 6:14 AM, Staff 29 (CNA) stated she did not know if Resident 73 required supervision when she/he smoked. Staff 29 stated the resident usually went out to smoke with another resident at the facility. On 12/5/26 at 6:20 AM, Staff 30 (CNA) stated Resident 73 smoked whenever at night, she/he smoked independently and did not wear a smoke apron. On 12/5/25 at 6:32 AM, Staff 31 (RN) stated she knew Resident 73 smoked but did not know if staff supervised her/him when she/he smoked.On 12/5/25 at 7:00 AM, Staff 32 (CNA) stated Resident 73 smoked independently, and the resident kept her/his smoking materials in the drawer of her/his nightstand, in her/his jacket or in the pouch on her/his wheelchair. On 12/5/25 at 11:00 AM, Staff 37 (LPN-Resident Care Manager) stated Resident 73 required supervised when she/he smoked and her/his smoking material was to be locked up.On 12/5/25 at 11:01 AM, Staff 2 (DNS) stated she expected Resident 73's care plan to be followed with regards to smoking and her/his smoking material.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and records review it was determined the facility failed to practice proper food safety techniques for 1 of 4 (#5) residents reviewed for food. The placed residents at risk for consumption of contaminated food. Findings include:The Center for Disease Control 11/24/25 Food Safety guidelines include the following information:Bacteria can multiply rapidly if food is left at room temperature or in the Danger Zone between 40 degrees F and 140 degrees F.Never leave perishable food (meat, dairy, and cut fruit) out for more than two hours.Resident 5 was admitted to the facility in 8/2024 with diagnoses including anxiety disorder and PTSD (Post Traumatic Stress Disorder).A Care Plan updated 8/25/25 included interventions for room cleaning including asking resident if room could be cleaned and ensuring safe/sanitation in the room.Review of records revealed no specific information of education provided to Resident 5 on risks of having meals kept in her/his room for extended periods or alternate techniques attempted to ensure Resident 5's safety with food while accommodating for Resident 5's food preferences.On 12/1/25 at 11:34 AM four food trays were observed in Resident 5's room. Three of those trays had full or partially full glasses of milk. Opened yogurt containers were observed on multiple food trays.On 12/4/25 at 1:50 PM Resident 5 stated she/he requested food trays to be left in her/his room. Resident 5 stated she/he often consumed the food and drinks, including her/his milk and yogurt, several hours after meals were delivered. Resident 5 stated she/he occasionally consumer the milk and yogurt overnight.On 12/5/25 at 9:24 AM Staff 36 (CNA) stated Resident 5 often saved food in her/his room overnight.On 12/5/25 at 12:03 PM Staff 16 (Dietary Manager) stated Resident 5 requested food to be left in her/his room often. When asked if Staff 16 provided education to Resident 5 regarding consuming dairy products left out longer than two hours, Staff 16 was unable to provide any records. On 12/8/25 at 12:42 PM Staff 5 (LPN-Resident Care Manager) confirmed Resident 5 preferences regarding food were being honored with leaving her/his meal tray in her/his room for extended periods, but food safety practices were not followed, and no detailed education was provided to Resident 5 regarding the risk of consuming dairy products exposed to room temperature longer than two hours.On 12/8/25 at 12:58 PM Staff 5 entered Resident 5's room and three food trays were observed in her/his room. One tray contained a dish with meat and a glass of milk. A meal ticket was observed on the tray which indicated the meal was from dinner on 12/7/25.