STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385112	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hills Health & Rehabilitation	5701 SW Multnomah Blvd Portland, OR 97219

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42270 Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed for safe self-administration of medications for 1 of 1 sampled resident (#293) reviewed for self-administration of medications. This placed residents at risk for unsafe medication administration. Findings include: The facility's Self-Administration of Medications policy, dated 11/20/16, revealed: A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Resident 293 admitted to the facility in 4/2025 with diagnoses including spinal stenosis (a condition were the spaces within the spine narrow). A review of Resident 293's record revealed there was no assessment for Resident 293 to self-administer medications. On 4/21/25 at 9:57 AM Resident 293 was observed alone in her/his room with a small cup on her/his bedside table, the cup contained multiple medications. On 4/21/25 at 12:23 PM Resident 293 was in her/his room, the same cup with medications was on the bedside table. Resident 293 stated she/he was waiting for someone to tell her/him what the medications were. On 4/21/25 at 12:29 PM Staff 39 (LPN) confirmed the medications were on Resident 293's bedside table and stated she passed medications that morning but Resident 293 was in the restroom when the morning medications were delivered to the room. Staff 39 confirmed the following medications were in the cup on Resident 293's bedside table: - Cholecalciferol Oral Tablet (Vitamin D supplement) - Lansoprazole (medication for indigestion and acid reflux) - Docusate Sodium (stool softener) - Duloxetine HCl (an antidepressant) (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Probiotic - Sennoside (a medication used to treat constipation). On 4/24/25 at 11:13 AM Staff 2 (DNS) confirmed Resident 293 was not assessed for self administration of her/his medications and should not have medications left in her/his room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46491 Based on interview and record review it was determined the facility failed to obtain information related to advance directives and health care decisions for 3 of 3 sampled residents (#s 45, 62 & 392) reviewed for advance directives. This placed residents at risk for not having health care decisions honored. Findings include: a. Resident 45 admitted to the facility in 2/2025 with diagnosis including chronic inflammatory demyelinating polyneuritis (an autoimmune disease that leads to weakness). Resident 45's care plan initiated 4/24/25 indicated advance directives are in effect, and they will be carried out in accordance with the wishes on an ongoing basis. A 2/26/25 care conference note indicated an advanced directive was reviewed. A review of Resident 45's clinical record found no advanced directive. During an interview on 04/22/25 11:45am Resident 45 stated she/he had not completed an advanced directive. During an interview on 4/23/24 at 2:31pm Staff 11 (Social Services Coordinator) stated Resident 45 did not have an advanced directive on file, could not remember whether Resident 45 had an advanced directive, and she/he should have followed up with Resident 45 about this, but had not. b. Resident 62 admitted to the facility in 4/2025 with diagnosis including sepsis (an extreme inflammatory response to an infection) and metabolic encephalopathy (a disease that alters brain function). Resident 62's care plan initiated 4/7/25 indicated advance directives are in effect, and they will be carried out in accordance with the resident's wishes on an ongoing basis. An 2/22/24 Care conference note indicated Resident 62's advance directive was reviewed. A review of resident 62's clinical record found no advanced directive. During an interview on 4/22/25 at 11:50am Resident 62 stated she/he was not sure if she had an advance directive completed. An interview with Staff 11 (Social Services Coordinator) on 4/24/25 at 12:02pm confirmed Resident 62 did not have an advanced directive on file. c. Resident 392 admitted to the facility in 3/2025 with diagnoses including stroke. Resident 392's care plan initiated on 3/28/25 indicated advance directives are in effect, and they will be carried out in accordance with the resident's wishes on an ongoing basis. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/31/25 Care conference note indicated Resident 392's advanced directive was reviewed and documentation was needed from the POA. A review of Resident 392's clinicial record found no advanced directive and no evidence a POA was contacted. During an interview on 4/22/25 at 9:50am Resident 392 stated she/he had an advanced directive but wasn't sure if the facility had a copy of it. She/he said it would benefit the facility to know his/her wishes. During an interview on 4/23/25 at 2:31pm Staff 11 (Social Services Coordinator) confirmed Resident 392 did not have an Advanced Directive on file. She/he stated the initial checkmark in the 3/31/25 care conference indicated that it was requested or discussed and that she/he should have followed up with the resident to get the advanced directive since the care conference and had not. During an interview on 4/25/25 at 9:27am Staff 1 (Executive Director) stated during the admission process the facility provided a blank advanced directive in the paperwork and further stated ideally all advance directive follow-up was documented.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51845 Based on observation, interview, and record review it was determined the facility failed to ensure proper personal hygiene practices and safe food storage handling techniques for 1 of 1 facility kitchen and 2 of 2 facility ice machines reviewed for kitchen sanitation. This placed residents at risk for cross contamination and foodborne illnesses. Findings include: On 4/21/25 at 9:50 AM, Staff 29 (Cook) was observed to have head and facial hair exposed with no facial and head hair restraints. Staff 30 (Cook) was observed to have with facial hair exposed and no facial hair covering. Staff 29 and Staff 30 were actively prepping the lunch meal. On 4/21/25 at 10:20 AM, Staff 8 (AM Dining Services Director) acknowledged hair and beard nets were to be worn at all times when working in the kitchen. She stated the facility provided hair restraints for all staff. On 4/23/25 at 11:10 AM, Staff 7 (PM Dining Services Director) was observed to pick up a pen off the floor and then changed her gloves without performing hand hygiene. Staff 7 confirmed she did not wash her hands after removing her gloves and putting new gloves on. On 4/23/25 at 11:20 AM, Staff 8 was observed plating food for the lunch meal. Staff 8 did not performed hand hygiene. On 4/25/25 at 9:56 AM, Staff 8 stated there were multiple signs in the kitchen to remind staff to practice proper hand hygiene and agreed hand hygiene was required after the removal of gloves. On 4/24/25 at 2:45 PM, a sealed plastic bag of raw chicken dated 4/21/25 was observed in a gray bin on the bottom shelf of the kitchen refrigerator. An undated plastic container with sliced tomatoes was observed on a shelf in the refrigerator. On 4/24/25 at 2:47 PM, Staff 29 stated frozen food could thaw in the refrigerator for up to five days. Staff 7 stated raw poultry needed to be used within one to two days. Staff 7 confirmed the lack of proper labeling for the chicken and tomatoes and stated undated food items were to be discarded. On 4/25/25 at 9:56 AM, Staff 8 stated all meat and poultry transferred into the refrigerator from freezer to thaw, should be discarded within three days. Staff 8 confirmed staff did not properly label and did not properly perform food storage practices. On 4/23/25 from 2:05 PM to 2:26 PM, observations of the facility's unit refrigerators found the following: - [NAME] unit: an undated banana cream pie and a plastic container of unidentifiable food. - East unit: an undated plastic container with unidentifiable food and decorated Easter eggs on a plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- East Bistro unit: an undated partial eaten container of sushi and a plastic container of unidentifiable food. On 4/23/25 at 2:26 PM, Staff 37 (CNA) was observed placing an undated soup container in the East unit refrigerator. On 4/24/25 at 2:34 PM, Staff 37 (LPN) stated staff were to label food items with the resident's name and opened date. She stated the kitchen staff discarded undated food items. On 4/24/25 at 2:56 PM, Staff 7 stated it was the responsibility of unit staff to discard undated items in the unit refrigerators. On 4/25/25 at 9:56 AM, Staff 8 stated the cook was responsible to discard all undated food items in the unit refrigerators. Staff 8 stated this was an ongoing problem. On 4/24/25 at 9:45 AM, the automatic ice machine, located outside the kitchen entry area, was observed draining condensation into a transparent plastic container which was placed inside the drain area. The plastic container was observed to contain a pool of dirty water from the ice machine. There was also a sealed plastic wrapped food item in the plastic container. The upper inside section of the ice maker was observed to have black spotting. On 4/24/25 at 10:06 AM and at 10:15 AM, Staff 8 stated the Dining Services Director who works in the evening sanitizes the ice machine located in the kitchen. Staff 8 was unable to identify the plastic wrapped food found under the ice machine. Staff 8 discarded the plastic container and unidentified wrapped food item. Staff 8 used a paper towel to wipe the inside of the ice machine lid, and a black substance transferred to the paper towel. Staff 8 confirmed the black spotting on the inside of the ice machine lid. Staff 8 immediately stopped use of the ice machine and proceeded to clean it. On 4/24/25 at 9:15 AM, the drain pipes under the east bistro automatic ice machine was observed to be covered in dark brown and black speckles with slimy substance upon touch. Some areas appeared to have been covered with black mold. The area where the ice maker releases the ice was covered with a pink mold substance that touched the ice when dispensed. On 4/24/25 at 09:38 AM, Staff 34 (CNA) was observed getting ice from the east bistro ice machine and took it to a resident. Staff 34 was asked to remove the cup of ice from the resident's room. On 4/24/25 at 10:00 AM, Staff 32 (Maintenance Director) stated maintenance staff was responsible for sanitizing the ice machine located at the east Bistro. Staff 32 touched the two drain pipes under the ice machine, and she confirmed it was covered with debris and chunks of dark grain. With her left index finger, Staff 32 touched the inside of the dripping pipe, and her finger was covered with slime. On 4/25/25 at 11:09 AM, Staff 1 (Administrator) was informed of the findings and stated it was a great learning opportunity.