

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Friendship Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3320 SE Holgate Blvd Portland, OR 97202	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>27793</p> <p>Based on observation, interview and record review, it was determined the facility failed to assess and conduct weekly wound evaluations for pressure ulcer care for 1 of 3 sampled residents (#3) reviewed for pressure ulcers. This placed residents at an increased risk for delayed healing and inadequate treatment. Findings include:</p> <p>Resident 2 was admitted to the facility in 7/2024, with diagnoses including atherosclerosis of the arteries (build up of plaque in the arteries, narrowing them and reducing blood flow), diabetes, hypertension, chronic heart failure and atrial fibrillation.</p> <p>On 2/27/25 at 9:25 AM, 12:38 PM, and on 2/28/25 at 8:25 AM, Resident 2 was observed sitting in her/his electric wheelchair in her/his room or through the facility. Resident 2 was pleasant, alert and oriented with clear speech.</p> <p>On 2/28/25 at 10:32 AM, RN surveyor observed Resident 2's pressure ulcer located on her/his right buttock, ischial area (lower part of the pelvis) to be closed, smaller than the size of a penny, reddened area.</p> <p>Resident 2's 1/26/25 Weekly Skin Evaluation identified the resident had a right buttock pressure ulcer, 0.25 x 0.25 x 0.0 cm, with no drainage. The stage of the wound was not identified.</p> <p>Resident 2's 1/29/25 Progress Note indicated the resident has open excoriation to the right ischium which has declined and the wound was open., with defined wound edges and measuring 0.4 x 0.5 x 0.0 cm. The wound bed is 100% slough, no serous drainage (a clear, thin, watery fluid that is released from a wound) noted. The open wound appears pressure related and suspected to be an unstageable pressure injury.</p> <p>There was no documented evidence weekly skin evaluations were conducted until 2/16/25, 17 days after 1/29/25. Subsequent weekly skin evaluations on 2/5/25 and 2/12/25 were not conducted.</p> <p>Resident 2's Weekly Skin Evaluations found the following:</p> <p>-2/16/25: Right gluteal fold, pressure. Right buttock pressure injury, clean with wound cleanser, skin prep surrounding skin, cover with a foam dressing every day until resolved.</p> <p>(continued on next page)</p>

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:  385121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Friendship Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3320 SE Holgate Blvd Portland, OR 97202	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-2/23/25: Wound to right buttock. Moisture associated skin damage (MASD) to right and left quadrant. Dressing to right buttock dry and intact.</p> <p>The Weekly Skin assessments for 2/16/25 and 2/23/25 did not identify the stage of the pressure ulcer, include measurements, or provide a description of the wound.</p> <p>On 2/27/25 at 1:54 PM, Staff 2 (RN/Wound Nurse) stated Resident 2 has a Stage 3 on her/his buttocks due to the resident not wanting to get out of her/his electric wheelchair. Staff stated we encourage the resident to get off her/his buttocks, but the resident prefers to be up in her/his wheelchair.</p> <p>On 2/28/25 at 8:31 AM, Staff 4 (CNA) stated Resident 2 was independent with her/his ADLs and was always in her/his electric wheelchair.</p> <p>In an interview on 2/28/25 at 11:06 AM, Staff 1 (DNS), stated she would expect weekly skin assessments to be conducted and to have a wound staged, measured and description provided on the skin evaluations. Staff stated she had ordered a wheelchair cushion for the resident, but she/he removes the cushion and places it in her/his manual wheelchair.</p>		