STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385121	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Creston Health & Rehabilitation	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)
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** Based on interview and record review it was determined the facility failed to ensure physician orders were implemented in a timely manner for 2 of 3 sampled residents (#s 5 and 6), reviewed for medications. This placed residents at risk for a delay in treatment and recovery. Findings include:1. Resident 5 admitted to the facility on [DATE] with diagnoses including an opened wound to his/her left foot and decreased white blood cell count.Resident 5's Progress Notes documented:-On 6/5/26 at 5:59 AM, Resident 5 complained of pain and burning upon urination.-On 6/8/26, a urinalysis was collected from Resident 5.-On 6/10/25, Resident 5 continued to complain of pain and burning with urination, had an active UTI and results of a culture and sensitivity were pending.On 6/15/26 at 12:15 PM, Resident 5 stated she/he first notified the facility of their UTI symptoms about two weeks prior. Resident 5 explained the facility completed a UA about one week prior which was positive and thought she/he would have an antibiotic prescribed but had not yet received one. Resident 5 also complained of ongoing pain with urination.On 6/17/26 at 10:22 AM, Resident 5 stated she/he received the first dose of antibiotics the previous night. She/he explained the results of her culture and sensitivity were sent to an assisted living and not the nursing facility, which caused their treatment to be delayed.On 6/17/26 at 12:01 PM, Staff 1 (Administrator) provided the results of Resident 5's culture and sensitivity test dated 6/12/26 at 2:02 PM because the results were not available in Resident 5's electronic health record. The results included a handwritten note by Staff 13 (RN) indicating an antibiotic was prescribed by the on-call provider on 6/16/26.On 6/17/26 at 3:37 PM, Staff 9 (Nurse Practitioner) stated normally a provider was alerted by phone by the facility for a positive UA and culture and sensitivity test and results are viewable in the electronic health record. Staff 9 stated the UA results and culture and sensitivity were not available in the electronic health record at time of interview, but Staff 13 had called the on-call provider on 6/16/26.On 6/17/26 at 3:49 PM and 6/18/26 at 8:40 AM, attempts to contact Staff 13 were unsuccessful.On 6/18/26 at 9:38 AM, Staff 11 (LPN) stated the lab results are typically posted in residents' electronic health record by the lab for viewing, and stated the lab typically calls the facility for critical labs or culture and sensitivity reports. She stated if she was expecting a result that was not available in the electronic health record, she would call the lab for clarification.On 6/18/26 at 9:43 AM, Staff 12 (RN/Assistant DNS) stated Resident 5's culture and sensitivity results should have been available for viewing in the electronic health record on 6/12/26 but were sent to Resident 5's assisted living facility. Staff 12 stated on 6/16/26 she called Resident 5's assisted living and found the results. She stated Staff 13 then called the on-call provider and got the order for the appropriate antibiotic. On 6/18/26 at 10:01 AM, Staff 2 (DNS) stated normally results are uploaded to residents' electronic health record by the lab when available and the lab also calls to notify staff of the culture and sensitivity results. Staff 2 explained he would have expected the nurses to call the lab for results if they were not available in the electronic health record and to notify the provider of issues so a determination could be made on whether the resident should be sent to the ER for evaluation, which was not done.2. Resident 6 admitted to the facility in 2024 with diagnoses including chronic multifocal osteomyelitis of right ankle and foot, Type II diabetes with diabetic polyneuropathy and pressure injuries on both lower extremities. Resident 6 discharged from (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility in 3/2026.Resident 6's Physician Orders documented a 2/11/26 order for doxycycline (an antibiotic medication) 100 mg tablet BID for 10 days for a skin and soft tissue infection.Resident 6's 2/2026 MAR documented the medication was started on 2/17/26 (6 days after the orders).On 6/17/26 at 2:13 PM, Staff 7 (LPN) stated the facility received orders from Resident 6's provider through a fax number accessible only to certain staff, which caused the orders to be received late.On 6/18/26 at 9:43 AM, Staff 12 (RN/Assistant DNS) stated Resident 6's provider faxed orders to a fax number that was only accessible to admission staff, likely resulting in orders to be received late.On 6/18/26 at 10:01 AM, Staff 12 (DNS) stated normally Resident 6's providers faxed orders and called to ensure the order was received. Staff 12 explained that on 2/17/26 Staff 13 (RN) found an order for Resident 6 and brought it to him as Staff 12 was the charge nurse that day. Staff 12 called the provider to verify the order and the provider stated to start the order and give as directed because Resident 6 had an abscess. Staff 12 stated he should have documented this in a progress note, but could not find the documentation.