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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Creston Health & Rehabilitation	3320 SE Holgate Blvd Portland, OR 97202

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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 0689 Level of Harm - 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 follow care plan interventions to ensure safe transfers and prevent falls for 3 of 4 sampled residents (#'s 2, 48 and 74) reviewed for accidents. This failure resulted in resident 74 having a fall and sustaining an ankle fracture requiring emergency medical services. Findings include: The facility's undated Fall Prevention Program Policy revealed the following: -Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.-Interventions will be monitored for effectiveness, and the plan of care will be revised and needed. -When any resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of injury. 1. Resident 74 was admitted to the facility in 10/2024 with diagnoses including left collarbone fracture with routine healing and unspecified fall. Resident 74's 10/16/24 care plan indicated the resident was a moderate fall risk requiring two-staff participation to use toilet and two-staff participation for transfers. Resident 74's 10/22/24 admission MDS indicated the resident was cognitively intact and dependent on staff for toilet transfers. Review of Resident 74's medical record following the 11/14/24 fall and hospital transfer indicated the resident did not return to the facility. The facility's 11/26/24 Discharge Summary for Resident 74 indicated the resident had a left ankle fracture as her/his final diagnosis. The 11/14/24 10:41 AM Fall Incident Report for Resident 74 indicated Staff 18 (Former Staff CNA) assisted the resident in transferring from the wheelchair to the toilet without assistance from another staff member. Staff 18 reported they attempted to transfer the resident to the toilet; however, the resident's legs gave out and she/he was unable to stand. Staff 18 held the resident from behind and lowered her/him fully onto the floor and turned on the bathroom call light for help. At the time of the incident Resident 74 reported to Staff 18 her/his leg hurt. Staff 19 (Former Staff LPN) responded to Staff 18's call for assistance, assessed Resident 74, and found no injuries at the time of the incident. At approximately 1:00 PM Staff 27 (Nurse Practitioner) assessed Resident 74 at the facility and notified Staff 19 the resident's left ankle was swollen and bruised. The 11/14/24 1:53 PM Nurse Progress Note indicated Staff 27 instructed Staff 19 to send Resident 74 to the Emergency Department. The resident left via medical transportation and Staff 20 (Former (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	DNS) and Witness 2 (Family Member) were notified. Multiple attempts were made to reach Witness 1 (Complainant) for interview but were unsuccessful. On 2/24/26 at 5:16 PM Witness 2 (Family Member) stated Resident 74 was sent to the facility for care and rehabilitation following a fall at home. Witness 2 stated Resident 74 fell in the bathroom at the facility while being transferred to the toilet. Witness 2 stated Resident 74 was unable to bear her/his own weight at the time of the fall and indicated the resident was a two-person transfer. Witness 2 stated Resident 74 was transferred to the hospital following the fall and was found to have fractured her/his left ankle. Witness 2 stated Resident 74 told them the CNA who assisted with her/his toilet transfer had her/him stand without providing support and collapsed because no one was holding onto her/him. Witness 2 expressed they were frustrated Resident 74 had a fall at the facility. Multiple attempts were made to reach Staff 18 for interview but were unsuccessful. On 2/25/26 at 6:08 PM Staff 19 stated they did not remember Resident 74 or the fall and did not recall writing the incident report. No further information was provided by Staff 19. On 2/26/26 at 11:57 AM Staff 20 stated they investigated Resident 74's fall and determined Staff 18 improperly transferred the resident to the toilet, resulting in a fall during which the resident sustained an ankle fracture. The fracture was concluded to be strongly correlated to the fall. Staff 20 stated Resident 74's care plan indicated the resident required a two-person transfer assist for toileting. Staff 20 stated Staff 18 acknowledged they did not review Resident 74's care plan, they were not aware the resident was a two-person transfer and performed a one-person transfer with the resident at the time of the incident. Staff 20 stated Staff 18 was placed on administrative leave following the incident. On 2/26/26 at 4:28 PM Staff 21 (Former Staffing Coordinator) stated they were witness to Staff 18's interview. Staff 21 stated the investigation revealed Resident 74 was improperly transferred for toileting by Staff 18 resulting in a fall and the resident sustained an ankle injury. Staff 21 stated Staff 18 admitted they did not review Resident 74's care plan, they did not know the resident was a two-person transfer for toileting, and they performed a one-person transfer with the resident at the time of the incident. On 2/27/26 at 9:28 AM Staff 2 (DNS) and Staff 16 (Infection Preventionist) stated they expected CNAs to review and follow residents' care plans. Staff 2 and Staff 16 reviewed Resident 74's care plan and Fall Incident Report and acknowledged the care plan was not followed at the time of the fall. 2. Resident 48 was admitted to the facility in 10/2023 with diagnoses including repeated falls. Resident 48's 9/10/25 Fall Risk Care Plan revealed the following interventions:-An orange leaf was to be placed on the resident's name plate outside her/his room to alert staff the resident was at high risk to fall. -The bed was to be kept in the lowest position with the exception of providing care. -Fall mats were to be placed on both sides of the bed at all times with the exception of providing care. -A sign was to be used to remind the resident to use her/his call light and to wear non-skid socks. Resident 48's 1/21/26 Fall Risk Assessment revealed the resident was at moderate risk to fall. Resident 48's 1/25/26 Quarterly MDS revealed the resident experienced short-and-long term memory (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	loss, was severely impaired for decision-making and dependent on assistance from staff for all ADL care. Random observations of Resident 48 from 2/23/26 to 2/26/26 between 5:47 AM and 3:17 PM revealed the resident to be in her/his room in bed. No orange leaf was observed on the resident's name plate outside of her/his room, no fall mats were in place on either side of the resident's bed and no sign was observed in the resident's room to remind her/him to use her/his call light and to wear non-skid socks. The door to the resident's room was either completely shut or slightly cracked open. The privacy curtain that separated Resident 48 from her/his roommate was always pulled as far as it could extend, so the resident was not visible from the hall even when the door was cracked open. On 2/26/26 at 5:13 AM, Staff 23 (CNA) stated Resident 48 was at risk to fall, so the resident's bed was to be in a low position with fall mats placed on both sides once care was complete. On 2/26/26 at 5:40 AM, Staff 32 (Agency LPN) stated Resident 48 was alert but experienced moments of confusion. Staff 32 stated he did not know if the resident was considered at risk to fall. On 2/26/26 at 5:56 AM, Staff 33 (CNA) stated Resident 48 was at risk to fall, and a sticker should be placed outside of the door to the resident's room to indicate she/he was at risk to fall. Staff 33 stated the resident was supposed to have fall mats in place at all times outside of care, the resident's door was to be open at all times and staff were to peak in every time they walked by the resident's room. On 2/26/26 at 10:30 AM, Staff 14 (RN) stated Resident 48's cognition varied, and at times, the resident would kick her/his legs out of bed as she/he believed she/he could get up and walk. Staff 14 stated the resident kicked her/his legs out of bed on 2/26/26 and told the CNAs she/he was going to walk out of the room. Staff 14 stated she had not seen fall mats used for Resident 48 since 6/2025, but she thought the resident was still at risk to fall. Staff 14 reviewed Resident 48's care plan and stated the resident should have an orange leaf placed outside of her/his room to indicate she/he was at risk to fall and confirmed the resident did not have an orange leaf in place. Staff 14 further stated residents who had an orange leaf placed outside of their room should have their door open at all times outside of providing care, and even with Resident 48's door open, the resident was unable to be visualized by staff as the privacy curtain was always fully extended between Resident 48 and her/his roommate. On 2/26/26 at 1:28 PM, Staff 15 (CNA) stated she found fall prevention interventions in resident care plans. Staff 15 stated an orange leaf outside of a resident's door indicated the resident was at risk to fall, and staff were to perform frequent checks on these residents. Staff 15 stated Resident 48 was to have fall mats on both sides of her/his bed in place, her/his door was to be propped open and the resident required frequent safety checks. On 2/27/26 at 10:32 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 24 (MDS Coordinator-RN) were present for an interview. Staff 24 stated an orange leaf outside of a resident room indicated the resident was at risk to fall, and as a result, the door to the resident's room was to be open outside of care, the resident's bed was to be at a low level and staff were to complete frequent safety rounds on the resident. Staff 1, Staff 2 and Staff 24 stated Resident 48 was at risk to fall and confirmed her/his care plan was accurate. Staff 24 stated Resident 48 should have an orange leaf placed outside of the door to her/his room, fall mats should be in place on both sides of the bed outside of care and a sign should be available in the resident's room reminding her/him to use her/his call light. Staff 24 further stated the privacy curtain in Resident 48's room was always pulled, so staff would not be able to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	visualize the resident during safety rounds without going all the way into the resident's room. 3. Resident 2 was admitted to the facility in 5/2024 with diagnoses including diabetes and history of falling. The 1/7/26 Significant Change MDS indicated Resident 2 was unable to complete the BIMS interview and was dependent on staff for mobility, transfers and was unable to ambulate. The 1/7/26 Fall Risk Assessment indicated Resident 2 was a moderate fall risk. The 5/30/24 Fall Care Plan indicated Resident 2 had a goal to be free from avoidable falls. A revision to the Fall Care Plan on 1/7/26 directed staff to ensure Resident 2's bed was kept in the lowest position outside of cares. Observations on 2/24/26 at 11:45 AM and again at 2:34 PM revealed Resident 2 was lying in bed and the bed was not in the lowest position. Resident 2's bed was between knee and waist height (approximately 2-3 feet). On 2/25/26 at 1:24 PM and 2/26/26 at 5:51 AM, Resident 2 was observed lying flat in bed asleep and the bed was not in the lowest position. Resident 2's bed was at waist level (approximately 3 feet). On 2/25/26 at 1:19 PM, Staff 22 (CNA) stated Resident 2 was not a fall risk. Staff 22 was unaware of any fall precautions for Resident 2. On 2/26/26 at 9:48 AM Staff 25 (LPN) stated Resident 2 was not a fall risk. Staff 22 was unaware of any fall precautions for Resident 2. On 2/27/26 at 10:31 AM, Staff 24 (MDS coordinator-RN), Staff 2 (DNS), and Staff 1 (Administrator) confirmed Resident 2's was a moderate fall risk and her/his care plan included intervention for her/his bed to be in the lowest position outside of cares. Staff 2 and Staff 1 both confirmed they would expect Resident 2's care plan to be followed and her/his bed to be in the lowest position. Staff 1 confirmed the lowest position would be at approximately 18 inches.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review it was determined the facility failed to ensure overbed lights were accessible, call lights were within reach and bed preferences were honored for 5 of 6 sampled residents (#s 21, 40, 48, 49 and 53) reviewed for accommodation of needs. This placed residents at risk for lack of independence. Findings include: The facility's undated Accommodation of Needs Policy indicated: -The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, expect when the health and safety of the individual or other residents would be endangered. -The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom, bedroom, and common living areas within the facility. -Facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment. -Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible. 1. Resident 40 was admitted to the facility in 7/2021 with diagnoses including chronic joint disease of the knees and morbid obesity. The 5/25/25 Annual MDS indicated the resident had no cognitive impairment and was dependent for mobility and transfers. A maintenance request dated 1/24/26 completed by Staff 13 (CNA) stated Resident 40 wanted the bed she/he had upstairs because this one is too small. On 2/23/26 at 3:28 PM, Resident 40 stated she/he moved rooms and was told their bed would be moved to the new room. The bed was not moved and she/he was now in a smaller bed. Resident 40 stated she/he preferred the previous bed, because the smaller bed made her/his mobility difficult. On 2/26/25 at 10:05 AM Staff 14 (CNA) stated Resident 40 was in a larger bed prior to moving rooms. Staff 14 stated Resident 40 requested a larger bed and stated maintenance was notified. On 2/26/26 at 12:04 PM, Staff 7 (Director of Facility Services) stated he would expect maintenance requests be completed within 24 hours and was unaware of Resident 40's request dated 1/24/26. He confirmed it was not completed. On 2/26/26 at 2:59 PM, Staff 1 (Administrator) stated Resident 40's previous bed was returned to the rental company. He stated he would expect Resident 40's maintenance request for the larger bed to be completed within 24 hours. 2. Resident 21 was admitted to the facility in 8/2024 with diagnoses including diabetes and left leg abrasion. Resident 21's 6/8/25 Annual MDS indicated the resident had no cognitive impairment and was (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent on staff for mobility, ambulation and transfers. On 2/24/26 at 9:22 AM, Resident 21 was observed in bed and attempted to turn on the overbed light, the resident reached from a lying position in bed, to turn on the overbed light using a butter knife. Resident 21 was unable to reach the light switch with her/his hands and used the butter knife to reach the light. Resident 21 was successful in turning on the light with the butter knife. On 2/24/26 at 9:22 AM, Resident 21 stated there was a toggle like switch to turn the overbed light on, but she/he was unable to reach the switch. Resident 21 stated she/he needed to use the butter knife or had to call staff assistance when she/he needed the light turned on and off. On 2/26/26 at 10:05 AM, Staff 14 (CNA), stated most residents had no way of turning the overbed light on and off without calling for assistance. She stated Resident 21 frequently called for assistance to turn the overbed light on and off. On 2/26/26 at 12:04 PM, Staff 1 (Administrator) and Staff 7 (Director of Facility Services) stated residents with beds equipped with the toggle-like switch had to activate their call light to receive help. Staff 1 stated if residents were physically capable to operate the overbed light, they should have been provided with the means to do so. 3. Resident 49 was admitted to the facility in 10/2025 with diagnoses including a right hip fracture. Resident 49's 1/18/26 Quarterly MDS indicated the resident had no cognitive impairment and was dependent for mobility, transfers and ambulation. Observations from 2/24/26 through 2/26/26 between the hours of 8:00 AM and 4:30 PM revealed Resident 49 had no ability to turn on her/his overbed light unless she/he called staff for assistance. On 2/24/26 at 1:08 PM, Resident 49 stated there was a little button over there that turned on the overbed light, but she/he was unable to reach the light switch and had to call for staff assistance when she/he needed the light turned on and off. On 2/25/26 at 8:42 AM, Staff 4 (CNA) stated some residents were unable to turn their overbed lights on and off because the newer beds no longer had overbed light controls. Staff 4 stated if a resident did not have a pull cord (such as Resident 49) the resident had to get out of bed or call staff to turn their overbed light on and off. On 2/25/26 at 12:29 PM, Staff 6 (CNA) stated Resident 49's bed did not have a pull cord to turn on her/his overbed light, so the resident had to call for staff assistance when she/he wanted the overbed light on or off. On 2/26/26 at 12:03 PM, Staff 1 (Administrator) and Staff 7 (Director of Facility Services) stated some residents had pull cords and were able to turn their overbed light on and off but those who did not had to activate their call light to get help. Staff 1 stated if residents were able to physically turn on the overbed light, they should have a way to do so. 4. Resident 53 was admitted to the facility in 1/2026 with diagnoses including multiple fractures of the spine, multiple fractures of the pelvis, fractures of the right lower leg, multiple fractures of the ribs and a fractured neck. Resident 53's 1/18/26 admission MDS indicated the resident had no cognitive impairment, was dependent for bed mobility and was unable to transfer or ambulate. Observations from 2/24/26 through 2/26/26 between the hours of 8:00 AM and 4:30 PM revealed Resident 53 had no ability to turn on her/his overbed light unless she/he called staff for assistance. On 2/23/26 at 9:48 AM and 2/25/26 at 9:20 AM, Resident 53 stated she/he had no way of turning on the overbed light. Resident 53 stated she/he was unable to walk and had no bed controls, so she/he had to call staff for assistance to turn the overbed light on and off. On 2/25/26 at 8:42 AM, Staff 4 (CNA) stated some residents were unable to turn their overbed lights on and off because the newer beds no longer had overbed light controls. Staff 4 stated if a resident did not have a pull cord (such as Resident 53) the resident had to get out of bed or call staff to turn their overbed light on and off. On (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/25/26 at 12:29 PM, Staff 6 (CNA) stated Resident 53's bed did not have a pull cord to turn on her/his overbed light, so the resident had to call for staff assistance when she/he wanted the overbed light on or off. On 2/26/26 at 12:03 PM, Staff 1 (Administrator) and Staff 7 (Director of Facility Services) stated some residents had pull cords and were able to turn their overbed light on and off but those who did not had to activate their call light to get help. Staff 1 stated if residents were able to physically turn on the overbed light, they should have a way to do so. 5. Resident 48 was admitted to the facility in 10/2023 with diagnoses including Parkinson's disease (a progressive movement disorder of the nervous system). Resident 48's 9/10/25 Care Plan revealed the following interventions:-Staff were to ensure the resident's call light was within reach.-Staff were to remind the resident during encounters to use the call light to request assistance.-The resident required prompt response to all requests for assistance. Resident 48's 1/25/26 Quarterly MDS revealed the resident experienced short-and-long term memory loss, was severely impaired for decision-making, experienced upper and lower body impairment on both sides and was dependent on assistance from staff for all ADL care. On 2/23/26 at 10:50 AM, Resident 48 was observed in her/his room in bed. A pressure-activated call light (used by people with limited dexterity or motor skills) was observed wrapped around the top portion of the left upper bed rail across from the resident's left shoulder. The resident was unable to answer any questions about her/his call light at this time. On 2/24/26 at 11:42 AM, Resident 48 stated she/he would use her/his call light if it was within reach. On 2/24/26 at 11:42 AM, 2/25/26 at 8:58 AM and 2/26/26 at 5:47 AM, Resident 48 was observed in her/his room in bed. A pressure-activated call light was observed wrapped around the top portion of the left upper bed rail across from the resident's left shoulder. Resident 48 reached across her/his body with her/his right arm, attempted to activate the call light but was unable to reach it. On 2/26/26 at 10:30 AM, Staff 14 (RN) stated Resident 48 used her/his right arm to activate her/his pressure-activated call light as the resident's left side was more limited. Staff 14 stated Resident 48 would not be able to reach her/his call light if it was placed near her/his left shoulder. On 2/26/26 at 1:28 PM, Staff 15 (CNA) stated Resident 48 did not use her/his left arm for anything and the resident used her/his call light on the days when she/he was more alert. At 1:42 PM, Staff 15 observed the resident in bed with her/his call light wrapped around the left bed rail and stated the resident would probably not be able to access the call light. On 2/27/26 at 10:23 AM, Staff 6 (CNA) stated Resident 48 did better with [her/his] right side, she/he used her/his call light and the call light needed to be positioned by her/his hand. On 2/27/26 at 10:32 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 24 (MDS Coordinator-RN) were present for an interview. Staff 24 stated Resident 48 had very low strength on one side and the call light should be placed in her/his lap to be accessible.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to transmit resident assessments in the required timeframe for 7 of 8 sampled residents (#s 15, 78, 79, 80, 82, 83 and 84) reviewed for late assessments. This placed at risk for untimely assessments, delayed and inaccurate care. Findings include:1. Resident 15 was admitted to the facility in 10/2025 with a diagnosis of a right leg fracture.Resident 15's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 15's health record to indicate the facility transmitted her/his 5-day or Discharge MDS assessments.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 15's missing Medicare 5-day and Discharge MDS assessments and stated she failed to verify their transmittal status after submitting them.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.2. Resident 78 was admitted to the facility in 8/2025 with a diagnosis of a right foot fracture.Resident 78's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 78's health record to indicate the facility transmitted her/his MDS discharge assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 78's missing MDS Discharge assessment and stated she failed to verify its transmittal status after submitting it.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.3. Resident 79 was admitted to the facility in 3/2025 with a diagnosis of a left arm fracture.Resident 79's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 79's health record to indicate the facility transmitted her/his MDS discharge assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 79's missing MDS discharge assessment and stated she failed to verify its transmittal status after submitting it. On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.4. Resident 80 was admitted to the facility in 6/2024 with a diagnosis of a periprosthetic fracture (a break in the bone occurring adjacent to an orthopedic implant) of the left hip joint.Resident 80's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 80's health record to indicate the facility completed and transmitted her/his Entry tracking assessment or her/his Medicare 5-day assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 80's missing MDS Entry and Medicare 5-day assessments and stated she failed to verify their transmittal status after submitting them.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.5. Resident 82 was admitted to the facility in 4/2025 with a diagnosis of other idiopathic peripheral autonomic neuropathy (acquired disorders with unknown causes that disrupt involuntary bodily functions, such as blood pressure, digestion and sweating).Resident 82's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 82's health record to indicate the facility completed and transmitted her/his discharge assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 80's missing Discharge assessment and stated she failed to verify its transmittal status after submitting it.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.6. Resident 83 was admitted to the facility in 4/2025 with diagnoses including stroke and dementia.Resident 83's health record revealed she/he was discharged from the facility on [DATE].No evidence was found in Resident 83's health record to indicate the facility transmitted her/his discharge assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 83's missing Discharge assessment and stated she failed to verify its transmittal status after submitting it.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.7. Resident 84 was admitted to the facility in 3/2025 with a diagnosis of severe protein-calorie malnutrition.Resident 84's health record revealed she/he died in the facility on [DATE].No evidence was found in Resident 84's health record to indicate the facility completed and transmitted her/his Death in Facility discharge assessment.On [DATE] at 4:13 PM Staff 8 (Medical Records) acknowledged Resident 84's missing Death in Facility discharge assessment and stated she failed to verify its transmittal status after submitting it.On [DATE] at 1:47 PM Staff 1 (Administrator) stated MDS assessments were important because they provided information for the development of resident-centered care plans. Staff 1 stated he expected MDS assessments to be completed correctly and submitted in a timely manner.

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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Creston Health & Rehabilitation	3320 SE Holgate Blvd Portland, OR 97202

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 5 of 5 sampled CNA staff (#s 5, 10, 11, 12, and 13) reviewed for sufficient and competent nurse staffing. This placed residents at risk for a lack of competent staff. Findings include:A review of personnel records on 2/26/26 indicated the following employees had not received their annual performance evaluations:-Staff 5 (CNA), hired date was 6/1989 and a performance review was not completed.-Staff 10 (CNA), hired date was 12/2024 and a performance review was not completed.-Staff 11 (CNA), hired date was 5/2024 and a performance review was not completed.-Staff 12 (CNA), hired date was 12/2022 and a performance review was not completed.-Staff 13 (CNA), hired date was 7/2002 and a performance review was not completed.On 2/26/26 at 2:59 PM Staff 29 (HR Assistant) stated she was unable to locate the most recent annual performance reviews for Staff 5, Staff 10, Staff 11, Staff 12, and Staff 13 and was unsure if they were completed for Staff 5, Staff 10, Staff 11, Staff 12, and Staff 13. On 2/27/2026 at 12:30 PM Staff 1 (Administrator) expected the annual performances to completed and confirmed annual performance reviews were not completed for Staff 5, Staff 10, Staff 11, Staff 12, and Staff 13.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for required staff postings. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings include:A review of the Direct Care Staff Daily Reports (DCSDR) from 1/23/26 through 2/23/26 revealed 11 of 30 days when portions of the form were left blank or were inaccurate. The incomplete or inaccurate information included daily census and the number of working staff. The dates included:-1/28/26 -2/4/26 -2/5/26 -2/6/26 -2/9/26 -2/10/26 -2/11/26 -2/14/26 -2/18/26 -2/19/26 -2/20/26 On 2/27/26 at 9:11 AM Staff 15 (Staffing Coordinator) stated the lead CNAs were trained to fill in the DCSDRs and a nurse reviewed and signed the report before it was posted for each shift. Staff 15 acknowledged the DCSDRs were incomplete and inaccurate for the identified dates. On 2/27/2026 at 12:30 PM Staff 1 (Administrator) expected the posted DCSDRs were accurate for each shift.

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	385121	A. Building B. Wing	02/27/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review it was determined the facility failed to ensure medications were properly secured, stored, labeled and expired medications were removed from the cart for 3 of 6 sampled medications carts reviewed for medication storage. This placed residents at risk for misappropriation and reduced medication efficacy. Findings include: The facility's 4/2025 Medication Storage Policy revealed the following: -All drugs and biologicals were to be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medications rooms) under proper temperature controls. -Refrigerated products were to be maintained at temperatures between 36 degrees F and 46 degrees F.-Unused medications that were outdated were to be destroyed. 1. The 2013 insulin lispro (HumaLOG) Kwikpen manufacturer instructions for storage and handling indicated unopened insulin pens should be stored in the refrigerator between 36 degrees F and 46 degrees F, and once opened, the pens should be discarded after 28 days. The 2018 insulin Humulin 70/30 Kwikpen manufacturer instructions for storage and handling indicated unopened insulin pens should be stored in the refrigerator between 36 degrees F and 46 degrees F, and once opened, pens should be discarded after 10 days. On 2/24/26 at 2:01 PM the 100 floor B wing medication cart was observed to have an unopened insulin lispro (HumaLOG) Kwikpen in a drawer. On 2/24/26 at 2:01 PM Staff 30 (LPN) confirmed the unopened insulin pen was in the medication cart and stated it should be refrigerated until it was opened. On 2/25/26 at 9:06 AM the 200 floor D wing medication cart was observed to have an open humulin 70/30 (NovoLOG) Kwikpen without an open date and one bottle of MaxTussin congestion expectorant with an expiration date of 11/2025 in its drawers. On 2/26/26 at 9:06 AM Staff 17 (RN) confirmed the open and undated insulin pen and expired expectorant. Staff 17 stated, once opened, insulin is generally good for 28 days but varied depending on the type of insulin and insulin pens should be labeled with an open date; additionally, Staff 17 stated the expired medication should have been removed and discarded. On 2/26/26 at 10:32 AM Staff 2 (DNS) confirmed unopened insulin was to be refrigerated and should not be stored in the medication carts. Additionally, Staff 2 stated once insulin is opened, it should be dated with an open date, as insulin was generally good for only 28 days after opening, but varied depending on the type of insulin. Staff 2 further stated expired medications should not be stored in the medication carts and should be promptly removed and destroyed. 2. On 2/23/26 at 9:25 AM, Staff 34 (RN) was observed to leave the medication cart in the D Hall unlocked and unattended where multiple staff were present. At 9:29 AM, Staff 34 returned to the cart and stated it should be locked at all times when not in use. Staff 34 revealed the contents of the cart to include all medications for residents in rooms 180 through 188, insulin pens, bowel care medications, prescription inhalers, eye drops, over-the-counter pain medications and supplements. (continued on next page)

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	385121	A. Building B. Wing	02/27/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/26 at 6:00 AM, Staff 32 (Agency LPN) stated the medication cart should always be locked when not in use. On 2/26/26 at 10:32 AM, Staff 2 (DNS) stated she expected medication carts to be locked any time they were unattended.

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	385121	A. Building B. Wing	02/27/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notifications to 1 of 3 sampled residents (#60) reviewed for Beneficiary Notification. This placed residents and their representatives at risk for unknown financial liabilities. Findings include:Resident 60 was admitted to the facility on [DATE] with Medicare A benefits.A 2/2/26 NOMNC (Notice of Medicare Non-Coverage) indicated Resident 60's Medicare Part A benefits ended on 2/4/26.Review of Resident 60's health record indicated the resident remained in the facility and was financially responsible for her/his care from 2/5/26 to 2/26/26. There was no documentation indicating the SNF ABN notification was provided to Resident 60 or their representative to inform them of the resident's daily out-of-pocket costs. On 2/24/26 at 2:27 PM Staff 9 (Social Services Director) acknowledged Resident 60 was not issued a SNF ABN. Staff 9 stated her expectation was residents or their representatives were informed of the resident's daily out-of-pocket costs via a SNF ABN notification form.On 2/27/2026 at 12:30 PM Staff 1 (Administrator) acknowledged Resident 60 was not issued a SNF ABN. Staff 1 stated he expected all residents to be issued a SNF ABN if they stayed in the facility.

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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. Based on observation, interview and record review it was determined the facility failed to ensure dependent residents received dressing assistance for 1 of 4 residents (#48) reviewed for ADLs. This placed residents at risk for unmet care needs and loss of dignity. Findings include: The facility's 9/2024 Activities of Daily Living Policy revealed the following:-A resident who is unable to carry out, or dependent with, activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. -The facility will maintain individual objectives of the care plan and periodic review and evaluation. Resident 48 was admitted to the facility in 10/2023 with diagnoses including Parkinson's disease (a progressive movement disorder of the nervous system).Resident 48's 9/10/25 ADL Care Plan revealed the resident required assistance from one person with dressing.Resident 48's 1/25/26 Quarterly MDS revealed the resident experienced short-and-long term memory loss, was severely impaired for decision-making, dependent on assistance from staff for all ADL care and did not exhibit the behavior of rejecting care.A review of Resident 48's Upper and Lower Body Dressing Task Logs from 2/3/26 to 2/25/26 revealed the resident did not refuse to get dressed. On 2/23/26 at 12:27 PM, Resident 48 was observed in her/his room in bed wearing a hospital gown. Resident 48 stated wearing a hospital gown was not her/his preference, and she/he liked to get dressed. Resident 48 further stated no staff offered to assist her/him to get dressed on 2/23/26. On 2/23/26 at 3:19 PM, Witness 3 (Family Member) stated Resident 48 got dressed every morning prior to her/his admission to the facility. Witness 3 stated the last few times he visited Resident 48 at the facility; the resident was dressed in a hospital gown. On 2/24/26 at 3:17 PM, Resident 48 was observed in her/his room in bed wearing a hospital gown. Resident 48 stated she/he wanted to get dressed in regular clothes, but no staff had offered to assist her/him to do so. On 2/25/26 at 1:42 PM, Resident 48 was observed in her/his room in bed wearing a hospital gown. On 2/26/26 at 5:13 AM, Staff 23 (CNA) stated she was unaware of Resident 48's clothing preferences, but stated all residents were expected to get dressed in the morning unless the resident refused. On 2/26/26 at 5:56 AM, Staff 33 (CNA) stated Resident 48 was cooperative with care and did not refuse anything. On 2/26/26 at 10:30 AM, Staff 14 (RN) stated she had not seen Resident 48 dressed in something other than a hospital gown in the last month. Staff 14 further stated she thought Resident 48 preferred to wear nightgowns during the day and she had never received reports from CNA staff of the resident refusing to get dressed or change clothes. On 2/26/26 at 1:28 PM, Staff 15 (CNA) stated she encouraged all residents to get up and get dressed before breakfast. Staff 15 stated Resident 48 was dependent on staff assistance to get dressed and the resident did not refuse. On 2/27/26 at 10:32 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 24 (MDS Coordinator-RN) were present for an interview. Staff 2 stated she expected all residents to get dressed in the morning unless their care plan specified otherwise. Staff 24 further stated Resident 48's care plan did not specify a preference to wear hospital gowns or that she/he was resistive to care.

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	385121	A. Building B. Wing	02/27/2026

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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 provide an ongoing person-centered activities program for 1 of 3 sampled residents (#48) reviewed for activities. This placed residents at risk for a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's Activities Policy revealed residents would be encouraged to participate in scheduled activities, and special considerations would be made for developing meaningful activities for residents with dementia and/or special needs. Resident 48 was admitted to the facility in 10/2023 with diagnoses including Parkinson's disease (a progressive movement disorder of the nervous system).Resident 48's 9/10/25 Activity Care Plan revealed the following:-The resident's preferred activities included visiting with family and friends, watching the Hallmark Channel and the morning and evening news on television, listening to rock and roll, classical, '70s and '80s music and playing bingo. -The resident would inform staff if she/he wanted to participate in activities.-The resident was able to self-direct her/his activity program. Resident 48's 11/2/25 Annual MDS revealed the resident was severely cognitively impaired, dependent on assistance from staff for all ADL care and her/his activities of importance included listening to music and doing her/his favorite activities. Resident 48's 2/17/26 Activity Assessment revealed the resident participated in independent activities of choice and a one-to-one program, rarely initiated conversations and was dependent on others for wheelchair transportation. A review of Activity Progress Note Documentation from 11/1/25 through 2/23/26 revealed Resident 48 received a one-to-one visit on 11/21/25 and 2/2/26. No evidence was found in Resident 48's clinical record to indicate she/he participated in out-of-room activities, including socializing with others or playing bingo. On 2/23/26 at 10:50 AM, Resident 48 was observed in her/his room in bed. No music played and the television that the resident shared with her/his roommate was off. Resident 48 was unable to answer any questions about her/his activity preferences at this time. On 2/23/26 at 3:19 PM, Witness 3 (Family Member) stated Resident 48 did not enjoy watching television, but she/he liked to listen to music, especially soothing music, being around others and visiting with friends. Witness 3 stated the resident experienced a decline in functioning, and as a result, needed help to make decisions. On 2/24/2026 at 8:48 AM, Resident 48 was observed awake in her/his room in bed. The resident's shared television was off. Resident 48 stated she/he wanted to get out of bed to attend activities and to go outside but staff did not help her/him to do so. Resident 48 further stated she/he enjoyed listening to music, especially '80s music, but she/he rarely had the opportunity to listen to this genre of music. On 2/24/26 at 11:42 AM, Resident 48 was observed awake in her/his room in bed. '70s music played on the resident's shared television. Resident 48 stated she/he was usually bored and she/he was interested in getting out of bed, but no staff had offered her/him the opportunity to do so. After this interaction, Resident 48 thanked the state surveyor for the visit. On 2/24/26 at 3:17 PM, Resident 48 was observed in room in bed. The resident's shared television played '70s music. Resident 48 stated she/he received a hand massage today, she/he enjoyed it and it had been a while since she/he last received one. Resident 48 asked the state surveyor to turn off the music as she/he was unable to do so independently. Random observations of Resident 48 on 2/25/26 from 8:58 AM to 2:38 PM revealed the resident to be awake in her/his room in bed. The shared television was off and no music played. On 2/26/26 at 10:06 AM, Resident 48 was observed in her/his room and sat in her/his wheelchair. Rock music played loudly from the resident's shared television. Resident 48 stated she/he did not like the music. On 2/26/26 at 5:13 AM, Staff 23 (CNA) stated Resident 48 was not able to use the television remote independently, and she/he usually watched whatever program her/his roommate selected on their shared television. On 2/26/26 at 5:40 AM, Staff 32 (Agency LPN) stated he was unaware of Resident 48's activity preferences but would look in the resident's care plan to find this information. Staff 32 further stated he had seen the resident out of her/his room once or twice.On 2/26/26 at 5:56 AM, Staff 33 (CNA) stated Resident 48 was usually in bed and she had (continued on next page)

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	385121	A. Building B. Wing	02/27/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not seen the resident out of her/his room for any activities. Staff 33 stated the resident was cooperative with care and did not refuse anything.On 2/26/26 at 10:30 AM, Staff 14 (RN), stated Resident 48 got up in her/his wheelchair today for the first time in a long time. Staff 14 stated the resident did not really do much, the resident's cognition varied, she/he was not able to express her/his wants or needs or self-initiate any activities. Staff 14 stated the resident's roommate picked which programs played on their shared television, the resident enjoyed being around others when alert, and she was unaware of any reports of the resident refusing care, including getting out of bed. On 2/26/26 at 1:28 PM, Staff 15 (CNA) stated Resident 48's alertness was on-and-off. Staff 15 stated she was unsure if the resident liked music but thought the resident liked to have the television on, not to watch, but as background. Staff 15 stated she did not know if the resident enjoyed being around others and she was unaware of any activity participation for the resident. On 2/27/26 at 10:23 AM, Staff 6 (CNA) stated Resident 48 alternated between days when she/he would sleep a lot and other days when she/he would be very alert and laughing. Staff 6 stated the resident was cooperative with care on the days she/he was alert but staff did not typically get [the resident] out of bed. On 2/27/26 at 10:32 AM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 24 (MDS Coordinator-RN) were present for an interview. Staff 24 stated Resident 48 needed to be offered the opportunity to get out of bed as the resident did not request to do so, and they had never been made aware the resident refused to get out of bed. Staff 24 further stated the resident was such a social butterfly and she/he enjoyed being around people and around the building. Staff 1 stated the resident was very much a people person.On 2/27/26 at 11:44 AM, Staff 1 and Staff 26 (Activity Director) were present for an interview. Staff 26 stated residents who were able to self-initiate activities were residents who were very cognitive, outspoken and could self-advocate. Staff 26 stated residents identified to receive one-to-one visits were those residents who could not self-initiate activities and/or did not attend group activities. Staff 26 stated her goal was to visit with residents who were identified as needing one-to-one visits a few times a week, and worse case, one time a week. Staff 26 stated one-to-one visits were documented in the resident's progress notes when they occurred. Staff 26 stated Resident 48 was to receive one-to-one visits and she thought she visited with the resident maybe two-to-three times a month. Staff 26 stated Resident 48 enjoyed watching crime shows on television but did not know how often she/he was able to do so as she was unsure if her/his roommate enjoyed these types of shows. Staff 26 stated the resident enjoyed '70s and '80s music but her/his roommate was not excited about it, so she provided Resident 48 with a personal radio on 2/27/26. Staff 26 stated Resident 48's cognition was not super, and her/his care plan was in need of revision. Staff 26 stated Resident 48 used to get up to play bingo and come out of her/his room, but she had not seen the resident do either in a while. Staff 26 stated she did not think the resident refused to get out of bed and the last time she invited the resident to an activity was around Christmas.

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	385121	A. Building B. Wing	02/27/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview and record review it was determined the facility failed to ensure treatment and services to maintain hearing abilities were provided for 1 of 1 sampled resident (#1) reviewed for hearing. This placed residents at risk for social isolation and decreased quality of life. Findings include:The facility's 4/9/25 Hearing Services Policy revealed the following:-The facility was to ensure all residents had access to hearing services and received adaptive equipment as indicated. -The social worker/designee was responsible for assisting residents in locating and utilizing any available resources for the provision of hearing services. -Once the need for hearing services was identified, the social worker/designee was to assist the resident to make appointments and arrange for transportation. Resident 1 was readmitted to the facility in 1/2025 with diagnoses including congestive heart failure. A 2/19/25 Audiogram (a graph that plots hearing thresholds to determine the type, degree and configuration of an individual's hearing loss) recommended Resident 1 receive a hearing aid consultation and her/his hearing to be retested in three months. Resident 1's 5/6/25 Care Plan revealed the following:-The resident was hard of hearing and did not wear hearing aids.-Conversations with the resident were best in a low volume environment. -Staff were to use a loud and clear voice. -The resident would ask the speaker to repeat as needed. -The resident preferred to keep the volume of her/his television loud as she/he was hard of hearing. A 7/23/25 and 10/16/25 Care Conference Meeting Note revealed Resident 1 expressed she/he could not hear out of her/his left ear and she/he wanted hearing aids. Resident 1's 1/11/26 Annual MDS revealed the resident was moderately cognitively impaired but was able to communicate with others without difficulty. A 1/8/26 Care Conference Meeting Note revealed Resident 1's left ear was fading and she/he needed hearing aids. No evidence was found in Resident 1's clinical record to indicate her/his hearing was retested or she/he received a hearing aid consultation. On 2/23/26 at 10:04 AM, Resident 1 was observed in her/his room in bed. The resident's television was on and could be heard from the hallway even with the door to her/his room closed. Resident 1 turned off the television and stated she/he could partially hear out of her/his right ear but could not hear at all out of her/his left ear. Resident 1 further stated she/he saw an audiologist about a year ago who recommended hearing aids but nothing was done with this recommendation. On 2/25/26 at 1:47 PM, Staff 31 (CNA) stated Resident 1's hearing was partial and that was why the resident's television volume was always up so high. On 2/26/26 at 5:10 AM, Staff 23 (CNA) stated Resident 1 could not hear on one side, so staff had to yell in order for her/him to hear. Staff 23 stated the volume of the resident's television was always over 100, and staff would ask the resident to reduce the television's volume during interactions in order for the resident to hear better. On 2/26/26 at 5:35 AM, Staff 32 (Agency LPN) stated Resident 1 was very hard of hearing, so much so, that the resident's television could be heard in the kitchen down the hall. Staff 32 stated he frequently repeated his communications to the resident because she/he could not hear. On 2/26/26 at 8:26 AM, Staff 14 (RN) stated Resident 1 always had complaints about her/his hearing. On 2/26/26 at 11:06 AM, Staff 9 (Social Services Director) stated hearing appointments were scheduled for residents as soon as possible after a hearing need was identified. Staff 9 stated she was unaware Resident 1 had an audiogram in 2/2025 and did not know the resident was interested in receiving hearing aids until 1/2026. Staff 9 stated the resident was on a list to be seen by a hearing provider but confirmed the resident had not received any follow up hearing appointments since her/his audiogram in 2/2025. On 2/26/26 at 11:49 AM, Staff 2 (DNS) stated hearing aid referrals should be followed up on as soon as possible, and Resident 1's hearing should have been retested in 5/2025.