

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Mt. Tabor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6040 SE Belmont Street Portland, OR 97215	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review it was determined the facility failed to ensure Staff 17 (Former Agency LPN) adhered to professional standards for medication management and licensed nurse oversight of assigned residents. This placed residents at risk for adverse side effects of medication and unmet medical needs. Findings include:</p> <p>The facility initiated an investigation on 3/1/24 regarding Staff 17 for her night shift which started on 2/29/24. Staff 2 (DNS) completed interviews and record reviews for residents which were assigned under Staff 17's supervision. Staff 2 concluded on the evening of 2/29/24 until 3/1/24 at about 6:30 AM, Staff 17 slept in her car in the facility parking lot most of the shift and was not available. Staff 2 concluded seven residents missed ordered medications, opportunities for PRN medications or treatments.</p> <p>On 6/4/25 at 6:39 AM Staff 18 (CNA) confirmed Staff 17 was the charge nurse when she worked in the facility on 3/1/24. Staff 18 stated Staff 17 went missing from the facility and at around 6:00 AM she found Staff 17 asleep in her car and Staff 17 told her she did not think she could finish the shift. Staff 18 stated Staff 17 was a mess.</p> <p>On 6/4/25 at 7:39 AM Staff 19 (LPN) confirmed she worked the night shift when Staff 17 was scheduled to work on 3/1/24. Staff 19 reported Staff 17 was late to her shift on 2/29/24, left the facility sometime during the shift and by the time Staff 17 was found on 3/1/24 at 6:00 AM the morning medications were scheduled to be passed. Staff 19 stated she instructed Staff 18 to inform Staff 17 she needed to return to the facility to count medications before the end of the shift. However, Staff 17 told Staff 18 she was not going to return to the shift.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>On 6/6/25 at 9:50 AM Staff 2 confirmed the investigation for Staff 17 leaving the facility during the night shift of 2/29/24 to 3/1/24 and seven residents were found to have missed medications, opportunities for medications or treatments. Staff 2 stated she expected all licensed nurses to attend to the residents they were assigned and to complete provider orders for the medications and treatments.</p> <p>Refer to F684</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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review it was determined the facility failed to ensure Staff 17 (Former Agency LPN) adhered to medication administration and treatment management for 7 of 7 sampled residents (#s 5, 17, 21, 27, 31, 36, and 155) reviewed for failure to follow physician orders. This placed residents at risk for adverse side effects and unmet medical needs. Findings include:</p> <p>1. Resident 5 admitted to the facility in 2004 with diagnoses including esophageal reflux (stomach contents leak backwards from the stomach into the food pipe) and Cerebral Palsy (affect ability to move, balance and posture).</p> <p>Review of Resident 5's 3/2024 MAR revealed a physician order which directed staff to administer 20 mg of Omeprazole Suspension 2 MG/ML via G-tube (tube to stomach), and eternal feeding (tube delivers nutrients directly to stomach) water flushes on 3/1/24 at 3:00 AM. Resident 5's 3/1/24 MAR revealed she/he was not administered the medication or treatment on 3/1/24 at 3:00 AM.</p> <p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medications for Residents 5 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>2. Resident 17 admitted to the facility in 2022 with diagnoses including chronic gastritis (inflammation and damage to stomach lining) and Gastro-Esophageal reflux (stomach contents flow back up).</p> <p>Review of Resident 17's 3/2024 MAR revealed a physician order which directed staff to administer 40 mg of Pantoprazole Sodium before breakfast for digestion at 6:00 AM. Resident 17's MAR revealed she/he was not administered Pantoprazole Sodium on 3/1/24.</p> <p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medication for Resident 17 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>3. Resident 21 admitted to the facility in 2020 with diagnoses including hypothyroidism.</p> <p>Resident 21's 3/2024 MAR revealed a physician order for Levothyroxine (treats an underactive thyroid) 100 mg to be administered on 3/1/24 at 6:00 AM. Resident 21's 3/1/24 MAR revealed she/he was not administered the Levothyroxine.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medication for Residents 21 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed and medication passed as ordered.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>4. Resident 27 admitted to the facility in 2020 with diagnoses including hypothyroidism.</p> <p>Record review of Resident 27 3/3024 MAR revealed a physician order for Levothyroxine (treats an underactive thyroid) 100 mg to be administered on 3/1/24 at 6:00 AM. Resident 27's 3/1/24 MAR revealed she/he was not administered the Levothyroxine.</p> <p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medication for Resident 27 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed and medication passed as ordered.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>5. Resident 31 admitted to the facility in 2023 with diagnoses including hypothyroidism.</p> <p>Record review of Resident 31's 3/3024 MAR revealed a physician order for Levothyroxine (treats an underactive thyroid) 100 mg to be administered on 3/1/24 at 6:00 AM. Resident 31's 3/1/24 MAR revealed she/he was not administered the Levothyroxine.</p> <p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medication for Residents 31 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed and medication passed as ordered.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>6. Resident 36 admitted to the facility in 2023 with diagnoses including Parkinson's Disease (disorder of central nervous system).</p> <p>Review of Resident 36's 3/3024 MAR revealed a physician order which directed staff to administer Carbidopa-Levodopa (medication for Parkinson's Disease) 0.5 - 1 tablet per resident preference on 3/1/24 at 3:00 AM, Carbidopa-Levodopa one tablet extended release on 3/1/24 at 4:00 AM and she/he was not administered the medication.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medications for Resident 36 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed and medications passed as ordered.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>7. Resident 155 admitted to the facility in 2019 with diagnoses including hypothyroidism and pain.</p> <p>Review of Resident 155's 3/3024 MAR revealed a physician order which directed staff to administer Levothyroxine (treats an underactive thyroid) 100 mg at 6:00 AM and Oxycodone 5 MG for pain on 3/1/24 at 6:00 AM. Resident 155's 3/2024 MAR revealed she/he did not receive Levothyroxine or Oxycodone medications as ordered.</p> <p>On 6/5/25 at 9:50 AM Staff 2 (DNS) confirmed Staff 17 did not administer the prescribed medications for Resident 155 on her scheduled shift on 3/1/24. Staff 2 stated she expected all physician orders to be followed and medications passed as ordered.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p>		