STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385141	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mt. Tabor Health & Rehabilitation	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)
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 follow physician orders for 1 of 3 sampled residents (#1) reviewed for physician orders. This placed residents at risk for adverse health consequences. Findings include: Resident 1 admitted to the facility in 10/2025 with diagnoses including fistula of gallbladder. Resident 1's admission MDS dated [DATE] revealed a BIMS score of 10, indicating moderate impairment. Resident 1's care plan dated 11/10/25 revealed she/he was at risk for weight loss and/or malnutrition. Interventions were to encourage Resident 1 to eat, consult with the Registered Dietitian (RD) and follow a therapeutic diet.Resident 1's Physician Orders dated 10/31/25 were to administer one Phos-Nak (a dietary supplement used for people who cannot get enough phosphorus, needed for strong bones and controlling calcium in the body and urine) packet three times per day, to be taken with meals and at bedtime.Resident 1's 11/2025 MAR revealed the medication was not administered three times per day from 11/1/25 through 11/13/25.Progress notes from 11/1/25 through 11/13/25 indicated the medication was not available and/or was on order from the pharmacy.On 11/14/25 at 3:27 PM, Staff 17 (LPN) stated nursing staff called the pharmacy to request the supplement, but the pharmacy did not send it. Staff 17 stated she left a note for the previous RCM but did not know if the RCM followed up with the pharmacy.On 11/20/25 at 12:30 PM, Staff 24 (Regional Nurse Consultant) confirmed the supplement was not administered to Resident 1 as ordered and should have been followed up by staff.

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review it was determined the facility failed to provide necessary care and services for tube feeding nutrition for 1 of 2 sampled residents (#1) reviewed for tube feedings. This placed residents at risk for dehydration and declining nutritional status. Findings include:Resident 1 was admitted to the facility in 10/2025 with diagnoses including GERD (gastroesophageal reflux disease) and choledochoduodenal fistula (a rare complication often caused by a perforated duodenal ulcer) requiring Resident 1 to have nutrition delivered via tube feedings (the delivery of nutrients through a feeding tube directly into the stomach, duodenum or jejunum).Resident 1's 10/31/25 Physician Orders included the following orders:-Administer free water BID via feeding tube at a rate of 35 ml/hr for 18 hours per day and feeding tube off for six hours per day, and-Enteral feeding BID, administer Peptamen AF (a nutritional formula for individuals with impaired gastrointestinal function) via feeding tube for 18 hours per day to provide 2160 calories over a 24-hour period, and feeding tube off six hours per day.Resident 1's 11/5/25 Progress Note stated the resident's water flush was administered at 100 ml/hr instead of 35 ml/hr as ordered. Resident 1 had a large emesis, and her/his provider was notified. Resident 1's tube feeding was held for 1.75 hours to rest the abdomen, and STAT labs were ordered on 11/6/25.On 11/6/25 at 8:00 AM, Resident 1 was transported to the emergency department due to the concern Resident 1 continued to vomit and the additional water she/he received could alter Resident 1's electrolytes. Resident 1 returned from the hospital in the evening.Resident 1's 11/10/25 Progress Note stated staff ran out of Peptamen AF. Peptamen 1.5 was obtained. The on-call provider was notified and stated not to give this alternative product until it was reviewed by the registered dietician and by the team who initiated the Peptamen AF. Peptamen 1.5 was administered on 11/9/25 without orders. Resident 1 indicated she/he had increased digestive symptoms since receiving the Peptamen 1.5.On 11/17/25 at 11:25 AM, Resident 1 was observed in her/his room, visiting with her/his spouse, and ambulating in the halls after lunch.On 11/17/25 at 4:05 PM, Witness 4 (Former RN) stated Resident 1's water flush ran at 100 ml/hour instead of the ordered 35 ml/hour.On 11/20/25 at 12:10 PM, Staff 25 (LPN) stated he had administered the wrong tube feeding formula to Resident 1. Staff 25 stated the resident was administered Peptamen 1.5, instead of Peptamen AF. Staff 25 stated he should have double checked orders prior to administration. On 11/20/25 at 2:28 PM, Staff 1 (Administrator) and Staff 26 (Regional Director of Operations) confirmed there was a medication error with Resident 1's water flush order, and that Staff 25 had administered the wrong tube feeding formula for Resident 1.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and record review it was determined the facility failed to ensure licensed nursing staff had the necessary competencies to care for residents with feeding tubes for 1 of 1 licensed staff (#25) reviewed for tube feedings. This placed residents at risk for incorrect tube feed and water flush administration. Findings include:Resident 1 was admitted to the facility in 10/2025 with diagnoses including Gastroesophageal Reflux Disease (GERD) and choledochoduodenal fistula (a rare complication often caused by a perforated duodenal ulcer).Resident 1's Physician Orders dated 10/31/25 indicated Resident 1's tube feeding was scheduled for 2:00 PM.On 11/17/25 at 2:40 PM, Staff 25 (LPN) was observed to wash his hands, don gown and gloves and enter Resident 1's room. Staff 25 identified Resident 1's tube feeding port and discovered the connector was missing. Staff 25 removed his gown and gloves and left the room.On 11/17/25 at 3:12 PM, Staff 20 (Interim DNS) and Staff 25 entered Resident 1's room wearing only gloves and handled Resident 1's feeding tube. Both staff verbalized confusion over the connector. Staff 25 stated he was unsure whether the tube should directly connect directly to the port or if an adapter was needed. Staff 20 agreed she did not know. At 3:18 PM, Staff 25 left Resident 1's room to get assistance from Staff 26 (MDS Coordinator, LPN).On 11/17/25 at 3:45 PM, Staff 25 returned to Resident 1's room with Staff 26. Staff 26 assessed the situation, left the room to obtain a connector and returned with connectors that were not compatible with the Resident 1's feeding tube.On 11/17/25 at 4:30 PM, Staff 25 checked for residuals per physician orders and initiated Resident 1's tube feedings, which occurred two and a half hours later than scheduled.On 11/17/25 at 4:35 PM, Staff 26 stated nurses receive a skills checklist for administering tube feedings during orientation. On 11/20/25 at 12:10 PM, Staff 25 stated he had requested additional training on 11/17/25 after working with Resident 1's feeding tube. Staff 25's Skill Checklist, initiated on 11/17//25, indicated he required additional training in tube feeding administration after working with Resident 1's feeding tube. On 11/20/25 at 12:41 PM, Staff 20 and Staff 24 (Regional RN) acknowledged Staff 25 needed further orientation and training regarding feeding tubes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to adhere to Enhance Barrier Precautions related to feeding tubes for 1 of 2 sampled residents (#1) reviewed for infection control. This placed residents at risk for infection. Findings include:Resident 1 was admitted to the facility in 10/2025 with diagnoses including GERD (gastroesophageal reflux disease) and the presence of a gastric tube. According to the Centers for Disease Control and Prevention, Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities for residents with wounds or indwelling medical devices. On 11/17/25 at 10:00 AM, signage was observed outside Resident 1's room indicating Resident 1 required Enhanced Barrier Precautions. On 11/17/25 at 3:12 PM, Staff 20 (Interim DNS) and Staff 25 (LPN) were observed handling Resident 1's feeding tube and assess the pump and the gastric tube on the resident's abdomen while wearing only gloves and no gown. On 11/20/25 2:48 PM, Staff 20 acknowledged that neither she nor Staff 25 wore a gown when they accessed Resident 1's gastric tube.