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	02/24/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide transportation for dialysis treatments for 1 of 3 sampled residents (#1) reviewed for dialysis care. This placed residents at risk for not receiving their dialysis services according to their schedules. Findings include: Resident 1 was admitted to the facility in 12/2025, with diagnosis including acute kidney failure, dependence on renal dialysis and metabolic encephalopathy. Resident 1's Care Plan dated 11/22/25 documented the resident received dialysis, was to be transported to dialysis center three days a week (Tuesday, Thursday and Saturday) and would be free from complications secondary to requiring dialysis. Resident 1's Progress Note dated 12/24/25 noted Resident 1 received a dialysis treatment at the hospital on [DATE] and did not receive treatment on 12/25/25. There was no documentation of her/his treatment on 12/27/25. In an interview on 2/19/26 at 12:22 PM, Staff 11 (Receptionist) stated she or nursing staff will assist with dialysis transportation planning. Staff 11 stated she was unable to set up Resident 1's dialysis transportation over the holiday in December. In an interview on 2/20/26 at 3:11 PM, Witness 1 (Family Member) stated she received a call from the dialysis center on 12/29/25 which inquired why Resident 1 was not at dialysis. Witness 1 stated she went to the facility and requested staff send Resident 1 to the ER for dialysis. Witness 1 stated dialysis was completed on 12/29/25. Witness 1 stated Resident 1 was very sick and had not admitted to the facility in that state. In an interview on 2/24/26 at 11:25 AM, Staff 29 (LPN) stated evening shift staff informed her Resident 1's transportation to dialysis needed to be scheduled. Staff 29 stated Resident 1 missed her/his dialysis treatment. Staff 29 stated Resident 1 was supposed to receive dialysis on 12/27/25 but she/he never received it. In an interview on 2/24/26 at 2:54 PM, Staff 2 (DNS) acknowledged Resident 1 missed dialysis due to no transportation being scheduled.

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