

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/10/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined the facility failed to report an allegation of verbal abuse within two hours to the State Agency for 1 of 4 sampled residents (#14) reviewed for abuse. This placed residents at risk for ongoing verbal abuse. Findings include: Resident 14 admitted to the facility in 12/2025 with diagnoses including hemiplegia and hemiparesis following a stroke affecting her/his left non-dominant side. Resident 14 no longer resided in the facility and was unable to be observed or interviewed. A 3/22/26 Alleged Abuse Investigation initiated by Staff 15 (LPN) documented Resident 14 reported an allegation of verbal abuse to Staff 9 (CNA) on 3/22/26. Staff 9 reported the abuse to Staff 15 on 3/22/26. The investigation documented the alleged verbal abuse was perpetrated by Staff 16 (LPN) on 3/20/26 and was witnessed by Staff 26 (CNA). On 7/8/26 at 11:41 AM, Staff 16 (LPN) stated she did not verbally abuse Resident 14 on 3/20/26 or any other time. On 7/8/26 at 1:20 PM, Staff 15 (LPN) stated he initiated the Alleged Abuse Investigation documentation on 3/22/26 when he was made aware of the incident, even though the alleged abuse had occurred several days earlier. On 7/8/26 at 2:16 PM, Staff 9 (CNA) stated on 3/22/26 Staff 26 told her that she witnessed Staff 16 verbally abuse Resident 14 on 3/20/26. On 7/9/26 at 12:28 PM, Staff 26 stated she witnessed Staff 16 verbally abuse Resident 14 on 3/20/26 but did not immediately report it because she was an agency staff and did not know who to notify. On 7/10/26 at 11:27 AM, Staff 1 (Administrator) stated a CNA was aware of the alleged abuse on 3/20/26 but did not notify other facility staff until 3/22/26 which caused a delay in reporting to the state agency.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 385141	If continuation sheet Page 1 of 7

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to fully develop a baseline care plan related to falls within 48 hours for 1 of 3 sampled residents (#13) reviewed for care plans. This placed residents at risk for falls. Findings include: Resident 13 admitted to the facility on [DATE] with diagnoses including sacrum fracture and left pubis fracture. Resident 13 discharged on 6/22/26. Resident 13's 6/19/26 Baseline Care Plan indicated the resident was at risk for falls and injury related to impaired mobility, muscle weakness, and decreased balance; however, no fall interventions were developed and implemented. The 6/20/26 Fall Risk Assessment indicated Resident 13 was at risk for falling. Resident 13's 6/20/26 and 9/22/26 Progress Notes indicated she/he sustained a non-injury fall on 6/20/26 and a fall with injury on 6/22/26. On 7/9/26 at 11:04 AM, Staff 2 (DNS) and Staff 4 (RNCM) acknowledged Resident 13's baseline care plan was not fully completed within the required 48 hours to include fall interventions and acknowledged Resident 13 had a second fall on 6/22/26.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review it was determined the facility failed to implement care plan interventions for 1 of 3 sampled residents (#6) reviewed for ADLs. This placed residents at risk for not receiving showers. Findings include: Resident 6 admitted to the facility in 5/2023 with diagnoses including traumatic brain injury. Resident 6's 1/28/19 Behavior Monitoring Care Plan instructed staff to call Resident 6's parents if Resident 6 refused a shower so they could speak to resident regarding the refusal. Resident 6's 5/15/26 Care Conference Note indicated if Resident 6 refused a shower staff should call the resident's family. Resident 6's Point of Care Shower documentation for 12/13/25 through 1/12/26 and 6/7/26 through 7/7/26 revealed Resident 6 refused a shower on 12/25/25, 1/1/26, 1/4/26, 6/14/26, and 6/25/26. Resident 6's clinical record found no evidence Resident 6's family was called on 12/25/25, 1/1/26, 1/4/26, 6/14/26, and 6/25/26 to inform the family of the resident's shower refusals. On 7/9/26 at 10:14 AM, Staff 11 (RN) stated when Resident 6 refused a shower staff were supposed to call the resident's mother, but staff did not always notify the nurses until the end of the shift. On 7/9/26 at 10:46 AM, Staff 9 (CNA) stated when Resident 6 refused a shower staff were supposed to call the resident's mother. Staff 9 stated she was unable to remember if she called Resident 6's mother when she/he refused a shower with her. On 7/9/26 at 10:47 AM, Staff 2 (DNS) and Staff 4 (RNCM) acknowledged staff were to notify Resident 6's family if the resident refused a shower and to document that the call was made in the clinical record. Staff 4 stated she was unable to find any evidence Resident 6's family was notified of the refused showers on 12/25/25, 1/1/26, 1/4/26, 6/14/26, and 6/25/26.		

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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 interview and record review it was determined the facility failed to provide showers or bed baths for 1 of 3 sampled residents (# 11) reviewed for ADLs. This placed residents at risk for not receiving adequate assistance with ADLs. Findings include: Resident 11 admitted to the facility in 2/2026 with diagnoses including orthopedic aftercare and an infection of the skin and subcutaneous tissue. Resident 11 no longer resided in the facility and was unable to be observed or interviewed. Resident 11's current care plan indicated Resident 11 was to receive a bed bath twice a week. Resident 11's CNA task charting documented Resident 11 received a bed bath on one occasion between 4/1/26 and 4/20/26, with no refusals documented. Resident 11 should have received five bed baths during this time frame. On 7/10/26 at 9:24 AM, Staff 21 (CNA) stated residents typically receive two showers or bed bath per week and as needed. Staff stated Resident 11 had wanted showers but had not received them. Staff 21 stated Resident 11 and the resident's family were upset that Resident 11 was receiving assistance for bathing. On 7/10/26 at 10:10 AM, Staff 3 (LPN Unit Manager) stated Resident 11 was care planned to receive bed baths on Tuesday and Friday but did not receive them. On 7/10/26 at 10:11 AM, Staff 2 (DNS) stated all residents were to receive a bed bath or shower at least twice per week and acknowledged that Resident 11 had not received her/his showers or bed bath.		

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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. Based on interview and record review it was determined the facility failed to follow physician orders for 3 of 4 sampled residents (#s 2, 4, and 13) reviewed for medications. This placed residents at risk for medication errors. Findings include: 1. Resident 2 admitted to the facility in 2/2026 with diagnoses including metabolic encephalopathy, pneumonia, alcoholic cirrhosis of liver without ascites, acute and chronic respiratory failure with hypoxia. Resident 2 discharged from the facility on 2/11/26. Resident 2's 2/10/26 SNF admission Orders revealed the following medication orders: -Seroquel (an antipsychotic medication) 50 mg two tablets at bedtime. -Xanax (an anti-anxiety medication) 0.5 mg one tablet BID. Resident 2's 2/2026 MAR documented both medications were not administered on 2/10/26. On 7/7/26 at 11:26 AM, Resident 2 stated she requested her/his Seroquel and Xanax on 2/10/26 but was told the facility could not administer them. On 7/10/26 at 10:38 AM, Staff 4 (RNCM) stated the orders were entered incorrectly on the MAR and were not given per physician orders on 2/10/26. On 7/10/26 at 11:18 AM, Staff 2 (DNS) stated physician orders were to be inputted accurately, confirmed by a second nurse and medications were to be given per physician orders. Staff 2 acknowledged Resident 2 did not receive her/his medications per orders. 2. Resident 4 admitted to the facility in 2/2026 with diagnoses including thyroid disorder, stroke, malnutrition and dysphagia. Resident 4's clinical record revealed the following physician orders: -Megestrol (a medication to treat severe weight loss) 20 mg one tablet daily, ordered on 2/16/26.-Creon (a medication for the pancreas) one tablet TID with meals. Resident 4's 2/2026 MAR documented the following: -Megestrol was started on 2/19/26, three days after it was ordered by the physician.-Creon was scheduled by the facility and given at 8:00 AM, 2:00 PM and 8:00 PM from 2/4/26 to 2/18/26, which was not during a meal. On 7/10/26 at 11:18 AM, Staff 6 (LPN/Former Unit Manager) and Staff 2 (DNS) acknowledged Resident 4's medications were not given consistent with the resident's physician orders. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 13 admitted to the facility in 6/2026 with diagnoses including sacrum and left pubis fracture. Resident 13's admission Orders included Haldol (an antipsychotic medication) every 6 hours as needed for agitation or delirium. Resident 13's Progress Notes from 6/19/26 through 6/22/26 indicated Resident 13 was confused and agitated on 6/19/26, 6/20/26, and 6/21/26. Resident 13's 6/2026 MAR indicated Resident 13 had not received Haldol at any time during her/his stay in the facility. Resident 13's clinical record found the resident's Haldol order was not transcribed onto her/his 6/2026 MAR and no discontinue order was received. On 7/9/26 at 11:04 PM, Staff 4 (RNCM) acknowledged Resident 13's order for Haldol was not discontinued, was not transcribed onto Resident 13's MAR, and was not administered as ordered.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, it was determined the facility failed to provide meals according to preferences and according to recommendations made by a clinician for 1 of 3 sampled residents (#12) reviewed for food preferences. This placed residents at risk for weight loss. Findings include: Resident 12 admitted to the facility in 1/2026 with diagnoses including chronic kidney disease stage 5, congestive heart failure and end stage renal disease. On 7/7/26 at 12:48 PM, Resident 12 stated she/he had requested to receive extra-large portions of food based on a recommendation from Resident 12's dietitian at her/his dialysis clinic and stated she/he never received extra-large portions. On 7/7/26 at 12:59 PM, Resident 12's lunch tray was observed and included one portion of quiche, four pieces of asparagus and a slice of cake. The resident's lunch ticket noted extra-large portions. On 7/8/26 at 9:01 AM, Resident 12's breakfast tray delivery was observed and included two pancakes and one piece of bacon. The resident's breakfast ticket noted extra-large portions. On 7/8/26 at 9:01 AM, Staff 22 (CNA) stated two pancakes, and one piece of bacon was a regular portion and not an extra-large portion. On 7/9/26 at 12:11 PM, Witness 14 (Dietician, Fresenius Dialysis Clinic) stated she had faxed an order to the facility on 1/21/26 which included a recommendation for double protein portions as Resident 12 had frequently complained of not getting enough to eat in the facility. This documentation was unable to be located in Resident 12's clinical record. On 7/9/26 at 1:22 PM, Staff 23 (Cook) stated Resident 12 was to receive extra-large portions at each meal as follows:- 7/7/26 lunch tray: two portions of quiche and 8 pieces of asparagus.- 7/8/26 breakfast tray: four pancakes and four pieces of bacon. On 7/9/26 at 1:33 PM, Staff 24 (Dietary Manager) confirmed Resident 12 was to receive extra-large portions at every meal and acknowledged the resident had not received extra-large portions.		