STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385145	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robison Jewish Health Center	6125 SW Boundary Street Portland, OR 97221

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 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 assistance with bathing for 1 of 3 sampled residents (#4) reviewed for bathing. This placed residents at risk of unmet care needs. Findings include:Resident 4 was admitted to the facility in 5/2025, with a diagnosis including stroke. Resident 4 was unable to be observed or interviewed as she/he no longer resided in the facility.Resident 4's 5/19/25 care plan indicated Resident 4 required maximum assistance with a Hoyer (a mechanical device used to transfer residents with limited mobility) and was dependent on one staff for showering twice weekly and as necessary.A review of Resident 4's 6/2025, 7/2025, and 8/2025 Task Charting revealed on 6/6/25, 6/20/25, 6/26/25, 8/8/25, and 8/15/25, bathing was documented as NA.(not applicable) by Staff 24 (CNA), Staff 25 (CNA), and Staff 26 (CNA). There was no evidence that a make-up shower was provided.On 9/8/25 at 4:17 PM, Staff 25 stated she charted NA for bathing on 8/8/25 for Resident 4 because she wasn't able to find someone to help get Resident 4 up using the Hoyer and bathing was not provided.On 9/4/25 at 12:35 PM, Witness 1 (Family Member) stated Resident 4 was not provided assistance with showers twice weekly.On 9/8/25 at 4:33 PM, Staff 26 stated on 8/15/25 she charted NA because bathing was not completed for Resident 4 due to a lack of assistance from other staff.On 9/9/25 at 9:09 AM, Staff 24 stated that he charted NA on 6/6/25, 6/20/25, and 6/26/25 for bathing because he was unable to complete Resident 4's bathing due to a lack of staff and Hoyer lifts not being available.On 9//9/25 at 1:05 PM, Staff 3 (RNCM) stated she was not surprised Resident 4 was not bathed or showered on the above dates because the facility had difficulties with staffing.On 9/10/24 at 10:14 AM, the findings were reviewed with Staff 1 (Administrator) and Staff 2 (DNS) who stated residents should be bathed in accordance with their care plans and as needed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385145	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 observation, interview, and record review, it was determined that the facility failed to ensure residents received treatment and care according to professional standards of practice related to neurological checks after a fall for 2 of 3 sampled residents (#s 5 and 6) reviewed for falls. This placed residents at risk for unmet care needs. Findings include: The Facility's 2025 Resident Fall Procedure Guidance revealed residents who experienced falls in the facility were to be placed on neurological checks (neuro checks) for 72 hours to monitor any changes of condition or altered cognitive status. Each neuro check was to be documented in the Neuro Check Binder at the nurse's station until the 72-hour mark had been reached.1. Resident 5 was admitted to the facility in 8/2025, with diagnoses including joint replacement surgery. Resident 5's 8/23/25 Care Plan revealed the resident had self-care performance deficits with activities of daily living due to her/his joint replacement surgery. Resident 5's 8/23/25 Fall Risk Evaluation rated Resident 5 as a high fall risk.An Incident Note dated 8/23/25 at 6:00 PM, revealed Resident 5 experienced an unwitnessed fall to the floor when attempting to self-transfer to the restroom. Staff 9 (LPN) was noted to have assessed and administered pain medication to Resident 5 after she/he reported back pain from the fall.A Progress Note dated 8/24/25 at 1:17 PM, revealed Resident 5 began experiencing excruciating pain from the mid back to the left hip. Staff 10 documented in the resident's clinical progress note that Staff 9 failed to complete neuro check assessments and monitor Resident 5 after her/his fall in the facility.On 9/12/25 at 12:13 PM, a review of Resident 5's clinical record found no documented evidence that neuro check assessments were completed after the resident fell on 8/23/25. 2. Resident 6 was admitted to the facility in 7/2025, with diagnoses including right femur fracture and dementia.Resident 6's 8/2025 Care Plan revealed the resident had limited mobility and a self-care performance deficit due to a right femur fracture and dementia.Resident 6's 8/2/25 Fall Risk Evaluation rated Resident 6 as a high fall risk.A Progress Note dated 8/14/25 at 12:19 PM, revealed Staff 12 (LPN) identified a bruise on Resident 6's left hand when being assisted with toileting. Staff 12 stated a documented fall occurred earlier that morning at 3:33 AM. Staff 12 indicated Resident 6 complained of significant pain in the left hip area and was placed on neuro checks after the fall.On 9/12/25 at 12:13 PM, a review of Resident 6's clinical record found no documented evidence that neuro check assessments were completed. On 9/9/25, this surveyor attempted to interview Staff 9 and Staff 12 but was unable to reach them.On 9/8/25 at 2:54 PM, Staff 7 (LPN) stated all residents who experienced a fall in the facility were to be placed on neuro checks to confirm any changes in their condition. Staff 7 indicated staff weren't always able to meet this requirement due to time being spent caring for other residents. On 9/9/25 at 11:58 AM, Staff 4 (Medical Records) confirmed no neuro check documentation was completed for Resident 5 and Resident 6.On 9/10/25 at 10:14 AM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed Staff 9 and Staff 12 did not follow Resident 5 and Resident 6's post-fall procedures related to neuro checks.