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	11/04/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review it was determined the facility failed to ensure a Stage 2 pressure ulcer was identified, assessed, treated and monitored upon admission to the facility for 1 of 3 sampled residents (#1) reviewed for pressure ulcers. As a result, Resident 1 experienced significant damage to her/his penis, which was unrepairable and resulted in the resident no longer being able to urinate from her/his penis. Findings include:Resident 1 admitted to the facility on 8/2025 with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, a foley catheter, and a Stage 2 pressure ulcer located on the resident's penis.Per CMS, a Stage 2 Pressure Ulcer is defined as a partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.Resident 1's admission paperwork from her/his previous facility, which included an admission and Discharge Summary, and an Order Summary dated 8/26/25 indicated the resident had a Stage 2 pressure ulcer located on her/his left lateral meatus (penis). In addition, the resident's Order Summary indicated to apply triple antibiotic ointment every shift with catheter care until resolved. If worsening, consult RCM. Review of Resident 1's clinical record found no documented evidence the facility identified, assessed, treated and monitored the resident's Stage 2 pressure ulcer located on her/his left lateral meatus of the penis. Resident 1's admission Nursing Database Skin assessment dated [DATE] identified no pressure ulcer to the resident's left lateral meatus of the penis. Resident 1's Urinary Incontinence/Indwelling catheter CAA dated 8/29/25 indicated the resident had a catheter in place and was followed by a urologist. There was no documentation of the resident's pressure ulcer located on her/his penis. Resident 1's Care Plan dated 8/29/25 identified she/he had skin impairment to her/his bilateral lower extremities. The resident's care plan did not address her/his Stage 2 pressure ulcer to left lateral meatus of the penis.Resident 1's admission Physician Orders dated 8/30/25 had no orders to address and treat the residents Stage 2 pressure ulcer of the left lateral meatus of the penis.Resident 1's MDS admission assessment dated [DATE] indicated the resident was cognitively intact and the resident had no pressure ulcer/skin injury, no skin tears, however, the resident was at risk of developing pressure ulcers/injuries. Resident 1's 9/2025 and 10/2025 TAR did not identify any Stage 2 pressure ulcer to the resident's penis. Resident 1's progress notes dated 8/29/25 through 10/12/25 revealed no documentation of a penile pressure ulcer, wound, injury, or related treatment.Resident 1's hospital records dated 10/12/25 to 10/20/25 revealed the following: -10/12/25 Emergency Department Visit Summary indicated the Foley catheter had eroded through the penile scrotal junction as well as erosion in the meatus. -10/12/25 Hospital Urology Note indicated Resident 1's penile urethra had eroded from the urethral meatus to the penile junction, attributed to prolonged urethral catheter placement. It was uncertain whether the catheter had ever been replaced while the resident was at the facility. A follow-up appointment with the urology clinic was planned to assess the urethral condition and discuss alternative catheterization options in light of the urethral erosion. -10/13/25 Attending Inpatient Note indicated that upon arrival to the emergency department, Resident 1 was found to have urethral erosion extending through the entirety of the penile shaft. -10/19/25 Attending Inpatient Note indicated Resident 1 was evaluated for bladder outlet obstruction associated with a chronic Foley catheter, which resulted in traumatic hypospadias (a condition caused by urethral injury, often related to prolonged catheterization, leading to abnormal urethral positioning and functional complications). The note further documented that the resident's penis was splayed the entire length of the shaft, and that the resident will never be able to urinate normally again. The attending physician noted that surgical options for penile reconstruction are extremely limited. A urology clinic follow-up was planned to evaluate and develop a plan for suprapubic catheter placement. (A thin, flexible tube used to drain urine from the bladder, which is inserted through a small incision in the lower abdomen, just below the navel, bypassing the urethra). On 10/29/25 at 1:53 PM, Staff 16 (CNA) stated once, while providing perineal care to Resident 1, bleeding was observed below the penis and scrotal area. The bleeding was promptly reported to the nurse. On 10/30/25 at 10:13 AM, Witness 1 (Complainant) stated Resident 1's hospital physician requested a complaint be filed with the state due to concerns regarding the condition of the resident's penis upon arrival to the emergency department on 10/12/25.On 10/30/25 at 10:50 AM, Staff 8 (LPN) stated the first time he worked with Resident 1, a CNA alerted him to a concern regarding the resident's penis. Upon assessment, Staff 8