STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385190	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gresham Post Acute Care and Rehabilitation	405 NE 5th Street Gresham, OR 97030

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 - 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 ensure residents received treatment and services necessary to prevent constipation for 1 of 3 sampled residents (#100) reviewed for bowel care. This failure resulted in the resident experiencing no bowel movements for seven days, which led to the need for emergency department evaluation and treatment due to a fecal impaction (a severe form of constipation where a large, hard mass of stool becomes lodged in the colon or rectum, preventing normal bowel movements). The facility's Bowel Management policy dated 4/2025 indicated the following: -Resident's bowel movements were recorded daily and reviewed by the licensed nurse. -If a resident had no bowel movement for six 12 hour shifts (three days) or nine eight hour shifts (three days) or within their routine bowel pattern, the facility bowel program would be initiated and the resident would be placed on the laxative list. -If the facility bowel program was not effective within 24 to 32 hours of the resident being placed on the bowel list, the licensed nurse would notify the resident's physician and request further orders. Resident 100 was admitted to the facility on [DATE] with diagnoses including central cord syndrome (an incomplete spinal cord injury which the spinal cord's ability to transmit messages to or from the brain is damaged) and toxic encephalopathy (a neurological disorder characterized by altered mental status, cognitive impairments, memory loss, personality and behavioral changes). Resident 100's 5/23/25 admission MDS indicated the resident had severe cognitive impairments, was incontinent of bowel and required substantial to maximal assistance for toileting. Resident 100's 5/19/25 through 5/31/25 Oral Intake monitor indicated the resident ate between zero to 75% of meals until 5/26/25 when her/his intakes declined consistently to zero to 25%. Resident 100's 5/19/25 through 5/31/25 MAR indicated the resident was prescribed polyethylene glycol (laxative) one time in the morning for constipation and sennosides (stimulant laxative) one time in the morning and at bedtime for constipation. According to Resident 100's MAR, the resident accepted the prescribed polyethylene glycol on 12 out of 12 administration attempts and the sennosides on 18 out of 24 administration attempts. (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 100's 5/19/25 through 5/31/25 Bowel Records indicated the resident had no bowel movements on the following days. -5/25/25; -5/26/25; -5/27/25; -5/28/25; -5/29/25; -5/30/25 and -5/31/25. A review of Resident 100's electronic health record indicated no evidence the resident's medical provider was notified of Resident 100's lack of bowel movements and no new orders for bowel care interventions were prescribed prior to 5/31/25. A 5/31/25 progress note written at 2:29 PM, indicated Resident 100 had not had a bowel movement since 5/24/25 [seven days] and continued to refuse to eat and drink so the resident's on-call provider was contacted and orders were obtained to send Resident 100 to the emergency department for evaluation and treatment. A 5/31/25 progress note written at 11:29 PM, indicated Resident 100 returned to the facility with new prescriptions for a UTI (an infection affecting the urinary system) and constipation. Resident 100's 5/31/25 CT Scan (a diagnostic imaging procedure) of the abdomen and pelvis revealed a large/copious amount of stool seen throughout the colon and rectum with significant rectal distention due to fecal impaction. Resident 100's Emergency Department's After Visit Summary indicated the resident was diagnosed and treated for slow transit constipation, dehydration and a UTI. On 6/16/25 at 9:04 AM, Staff 18 (LPN) reported a resident should not go more than two or three days without a bowel movement. Staff 18 stated three days with no bowel movement was the maximum and after three days the bowel protocol would be initiated. Staff 18 stated if there was no bowel movement after administering the bowel protocol (PRN medication or enema depending on the physician orders) then the medical provider should be contacted for additional instructions and orders. Staff 18 stated the facility was very strict on following the bowel protocol and if a resident did not have a bowel movement for seven days, that would be a very serious issue. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/16/25 at 11:15 AM, Staff 16 (LPN) stated each morning she checked the daily bowel list to determine which residents had not had a bowel movement for three days. Staff 16 stated the resident would be assessed by the nurse and a PRN bowel medication (in addition to the resident's routine bowel medications) would be administered to the resident. Staff 16 stated if there was still no bowel movement, she would contact the medical provider for further direction and interventions. On 6/16/25 at 1:43 PM and 6/17/25 at 2:53 PM, Staff 3 (RNCM) stated on 5/28/25, Resident 100 triggered on the daily bowel list. She reported the resident did not consistently eat or drink and refused her/his bowel medications at times. Staff 3 reported when a resident did not have a bowel movement for three full days, there would be a go to bowel medication depending on the resident's physician order and if the resident still did not have a bowel movement, the medical provider would be called for further orders. Staff 3 stated Resident 100 had no bowel movements since 5/24/25. Staff 3 reviewed Resident 100's bowel records and stated staff should have contacted the resident's medical provider on 5/28/25, 5/29/25 and 5/30/25 since the resident had not had a bowel movement for several days. Staff 3 stated on 5/31/25, Resident 100 was sent to the emergency department for evaluation and treatment. On 6/17/25 at 12:04 PM, Staff 9 (LPN) stated when residents did not have a bowel movement for three days, she would notify the medical provider to get further instructions. Staff 9 stated she cared for Resident 100 on 5/28/25 but was unable to recall if she contacted the resident's medical provider to notify them the resident did not have a bowel movement for four days. On 6/17/25 at 12:25 PM, Staff 8 (LPN) reviewed Resident 100's bowel records and reported on 5/28/25, Resident 100 should have been given a PRN bowel medication and the resident's medical provider should have been notified. Staff 8 stated she had been the assigned day nurse for Resident 100 on 5/29/25 and 5/30/25. She stated the resident's medical provider should have been notified of the resident's lack of bowel movements for the previous five and six days, respectively. However, she was unable to recall whether she had contacted the provider, and there was no documentation in the electronic health record indicating the provider was contacted. On 6/17/25 at 9:58 AM, Staff 4 (Nurse Practitioner) stated he was the primary medical provider for managing Resident 100's medical care. Staff 4 stated he had not been involved much with the resident but she/he had significant cognitive deficits and was sundowning. Staff 4 stated he was also aware Resident 100 was not eating or drinking and refused medications. Staff 4 stated he was unaware Resident 100 had no bowel movements from 5/25/25 through 5/31/25 (seven days). Staff 4 stated nursing staff usually communicated with him via an SBAR (a communication tool which stands for Situation, Background, Assessment and Recommendations) but he was unaware of any communications related to Resident 100's constipation prior to 5/31/25. Staff 4 stated Resident 100 was not eating or drinking much thus he would not have expected the resident to have bowel movements so there would have been no interventions needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/17/25 at 2:53 PM, Staff 2 (Interim DNS) confirmed Resident 100 had no bowel movements from 5/25/25 through 5/31/25. Staff 2 stated nursing staff should have contacted the resident's medical provider on 5/28/25 to notify them of the resident's bowel status and obtained orders for a PRN bowel medication. She confirmed nursing did not contact the medical provider on 5/28/25. Staff 2 reported nursing should have contacted the medical provider on 5/29/25 and 5/30/25, as the resident had gone several days without a bowel movement. She confirmed Resident 100's medical provider was not contacted regarding the resident's lack of bowel movements. Staff 2 further stated on 5/31/25, Resident 100 required emergency evaluation and treatment for a fecal impaction.