STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385228	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portland Health & Rehabilitation Center	12441 SE Stark Street Portland, OR 97233

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide care in accordance with professional standards and failed to ensure care needs were met for 3 of 3 sampled residents (#s 1, 3 and 5) reviewed for call lights. This placed residents at risk for unmet care needs. Findings include: 1. Resident 5 was admitted to the facility in 2/2024 for diagnoses including congestive heart failure and surgical aftercare.Resident 5's care plan dated 2/26/24 indicated she/he needed moderate assistance with ADLs such as dressing, bathing, toileting hygiene and transfers.On 3/6/24 the State Survey Agency (SSA) received a complaint which stated Resident 5 had waited over 45 minutes the morning of 3/6/24 for help with personal care.On 7/9/25 at 11:21 AM Witness 1 (Complainant) stated when Resident 5 was at the facility, she/he would activate the call light and CNA staff would come in, turn off the call light and ask what she/he needed. Resident 5 made her/his specific request and was told the staff would get the nurse but nobody came. She/he would use the call light again, staff would come back, ask what she/he needed, would leave and the resident would wait even longer, up to one and a half hours.2. Resident 3 was admitted to the facility in 9/2024 with diagnoses including acute transverse myelitis (inflammation of the spinal cord, which causes nerve damage) and diabetes mellitus.Resident 3's care plan revealed she/he needed moderate assistance with ADLs such as dressing, bathing, and toileting hygiene.On 10/25/24, the SSA received a complaint which stated Resident 3's call light was not answered for over 20 minutes on 10/25/24, and CNA staff were never to be found when residents needed assistance.On 7/10/25 at 2:03 PM, Resident 3 stated call light response times varied anywhere from 15 minutes to over an hour and occurred on all shifts. Resident 3 recalled an incident last fall on NOC shift where a cognitively impaired resident came into her/his room and started going through her/his things. She/he stated nobody responded to the call light, so she/he had to start screaming to get a staff into her/his room. She/he stated long call light times had been an issue since she/he was admitted to the facility.3. Resident 1 was admitted to the facility in 3/2025 with diagnoses including hypertension and atrial fibrillation.Resident 1's care plan revealed she/he needed substantial assistance with ADLs such as dressing, bathing, toileting, hygiene and transfers.On 3/11/25, the SSA received a complaint which stated Resident 1's call light was not answered timely, and she/he had to wait over half an hour for assistance.On 7/10/25 at 9:00 AM, Witness 4 (Complainant) stated she was the resident's authorized representative. She stated Resident 1 frequently called her upset because she/he had activated the call light, needed help with incontinence care, and staff would turn her/his call light off and leave the room without assisting the resident. Witness 4 stated she spoke to the DNS about the issue and was told they would work on it.Resident 1's Nursing Note dated 3/12/25 at 2:48 PM noted Staff 2 (DNS) talked to the resident and the resident mentioned long call light response time, especially when she/he wanted to use the bathroom, and that she/he has not been cleared yet to ambulate to the bathroom by herself/himself. Call light response time was addressed with the staff.Review of Resident Council notes from 11/2024 to 5/2025 indicated the following call light concerns: -11/19/24: Call lights taking hours, frequently saying they will return and do not. Seeing staff on phones and not working.-12/18/24: NOC shift call lights. -1/22/25: NOC shift call lights. (Resident name) ostomy bag breaking, waiting 4+ hours on it being changed. Response to call lights are very long. CNAs on phones. CNA's passing off things to next shift and not addressing.-2/19/25: NOC shift nurses/CNAs not answering call lights. Aides on phone, not being responsive. Call light audits to be done.-3/20/25: Call light times.night staff absent. Showers/bed baths not being done.-4/16/25: Call light times NEED TO BE ADDRESSED. 'I'll be right back' is trending.-5/21/25: Call light times still an issue.Interviews with residents revealed the following concerns:On 7/9/25 at 12:43 PM, Resident in room [ROOM NUMBER] stated she/he activated the call light over an hour ago, wanted something to eat, and had not had breakfast or lunch.On 7/10/24 at 12:24 PM, Resident in room [ROOM NUMBER] stated call lights were an ongoing issue. She/he verified the ostomy bag statement from the 1/2025 Resident Council meeting and stated it sometimes took hours for staff to respond to call lights, and it occurred on all shifts. The resident stated she/he had waited two hours for a response time in the past six weeks and stated staff know my situation (bed bound and has an ostomy bag); they should at least come down and tell me they're working on it. It has not improved at all. I shouldn't have to lie in poop for two hours. On 7/11/25 at 10:45 AM, the Resident Council President stated call light times had gotten worse, but had always been an issue at the facility.On 7/11/25 at 12:52 PM, Resident in room [ROOM NUMBER] stated call

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, it was determined that the facility failed to implement care plan interventions for aspiration precautions for 1 of 3 sampled residents (#6) reviewed for respiratory services and aspiration precautions. This placed residents at risk for a lack of nutritional assistance and aspiration. Findings include: Resident 6 was admitted to the facility in 7/2025, with diagnoses including chronic respiratory failure and congestive heart failure.Resident 6's care plan dated 7/4/25 revealed she/he was on aspiration precautions and required one-to-one supervision for all meals.On 7/10/25 at 1:10 PM, Resident 6 was overheard calling out for staff in her/his room. Upon entering the resident's room, a meal tray with partially eaten food was observed on the resident's bedside table. No staff were observed present in the room with Resident 6. After the state surveyor exited the resident's room, Staff 6 (Speech Therapist) was observed to enter the resident's room and assist the resident to her/his care conference.On 7/10/25 at 1:40 PM, Staff 6 stated she was Resident 6's speech therapist. She confirmed the resident was supposed to be a one-to-one supervision while eating and stated she observed the meal tray in Resident 6's room with no staff present.On 7/10/25 at 1:48 PM, Staff 9 (CNA) stated he was Resident 6's assigned CNA. He was unaware of the resident's care plan interventions for supervised eating and stated he had not worked with the resident before that shift.On 7/11/25 at 11:18 AM, Staff 4 (RCM) confirmed Resident 6 was on aspiration precautions and required one-to-one supervision for all meals.