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	02/27/2026

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, it was determined the facility failed to effectively respond to resident council concerns expressed at 3 of 3 resident council meetings reviewed for facility response to Resident Council concerns. This placed residents at risk for unmet needs concerning issues of resident care and lessened quality of life. Findings include: The facility's 1/2017 Resident Council Policy revealed the facility was expected to communicate a response and/or decisions to the Resident Council by the next meeting.During the 2/25/26 at 11:08 AM Resident Council meeting the residents stated they did not feel heard about their concerns or suggestions. The Resident Council stated they did not receive a response from administration or departments regarding the concerns or suggestions they reported.A 2/25/26 review of the Resident Council/Family Council Department minutes revealed the following from the Resident Council meetings concerns: -12/12/25, residents expressed concern for food quality, personal money access and no responses were provided to the Resident Council;-1/14/26, residents expressed concern for requested spices for food, laundry return and no responses were provided to the Resident Council;-2/16/26, residents expressed concern for wanting spices for their food and no response was provided to the Resident Council.On 2/25/26 at 12:52 PM Staff 23 (Activity Director) confirmed the lack of responses to the Resident Council concerns. Staff 23 stated she assisted the residents with Resident Council and there was not any form of communication for facility departments with Resident concerns.On 2/25/26 at 1:08 PM Staff 1 (Administrator) acknowledged the lack of response to the Resident Council concerns as a council. Staff 1 acknowledged all Resident Council concerns should be appropriately addressed in written form and given to the Resident Council to review.

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review it was determined the facility failed to have a system in place to deliver mail on Saturdays for 1 of 1 Resident Council reviewed. This placed residents at risk for lack of timely written communications. Findings include:On 2/25/26 at 11:08 AM during the Resident Council group interview, residents stated their mail was not delivered on Saturdays.On 2/25/26 at 12:52 PM Staff 23 (Activity Director) stated the MOD (manager of the day) delivered mail on Saturdays.On 2/25/26 at 1:00 PM Staff 3 (RNCM) stated she sometimes worked on Saturdays as the MOD and she never delivered mail to the residents.On 2/25/26 at 1:04 PM Staff 8 (RN) stated he worked as the MOD on Saturdays at times and never passed mail to residents.On 2/25/26 at 1:15 PM Staff 1 (Administrator) stated he expected the MOD delivered mail on Saturdays and acknowledged there was no other system in place to deliver mail to residents on Saturdays.

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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. Based on interview and record review it was determined the facility failed to monitor residents and follow physician orders for 6 of 13 sampled residents (#'s 37, 48, 55, 62, 63, and 68) reviewed for abuse, staffing, and death. This placed residents at risk for unidentified concerns and unmet care needs. Findings include: 1. The facility's 9/30/25 Abuse Allegation investigation revealed Resident 37 alleged a resident of the opposite sex entered her/his room on 9/29/25 and touched her/his chest and abdominal region. The investigation identified Resident 68 to be the alleged perpetrator, but the facility was not able to collaborate Resident 37's allegation of abuse. a. Resident 37 was admitted to the facility in 9/2025 with a diagnosis of spinal fracture. Resident 10/1/25 admission MDS revealed she/he had severe memory impairment. Resident 37's Progress notes revealed the following:-9/30/25 during a care conference Resident 37 reported an allegation of abuse and was moved to another room to separate her/him from the alleged perpetrator. -10/1/25 (There was no assessment related to the alleged allegation of abuse and Resident 37's psychosocial status).-10/2/25 Resident 37 was assessed to be confused at times and worked with therapy. (There was no assessment related to the alleged allegation of abuse and Resident 37's psychosocial status.)-10/3/25 Resident 37 was assessed for physical, emotional distress and behavioral changes. No changes were identified. -10/4/25 Resident 37 was assessed to be alert and oriented, able to make needs known, and had limited ROM. (There was no assessment related to the alleged allegation of abuse and Resident 37's psychosocial status.) On 2/23/26 at 10:30 AM Resident 37 stated a resident of the opposite sex came into her/his room and lifted her/his shirt. Resident 37 stated the incident scared her/him and she/he stopped eating in the dining room. On 2/26/26 at 9:41 AM Staff 24 (RN) stated if a resident had a change of condition staff were to place a resident on alert charting. Alert charting was to be completed each shift (every eight hours) and the note should address the area of concern being monitored. The alert charting was to be done for at least 72 hours but longer if needed. RN On 2/26/26 at 4:06 PM Staff 2 (DNS) stated he would expect a resident's alert charting to be completed every shift for at least 72 hours, and it was to be specific to the concern identified. b. Resident 68 was admitted to the facility in 9/2025 with a diagnosis of facial fractures. Resident 68's 10/1/25 Montreal Cognitive Assessment revealed she/he had severe cognitive impairment. Resident 68's Progress Notes revealed: -10/1/25 Resident 68's discharge plan was to return home. (There was no assessment to ensure staff monitored Resident 68 to ensure she/he did not enter other resident rooms.)-10/2/25 there was no progress note documented. -10/3/25 Resident 68 was assessed to be irritable, and her/his medical status was monitored. (There was no assessment to ensure staff monitored Resident 68 to ensure she/he did not enter other resident rooms.) On 2/26/26 at 9:41 AM Staff 24 (RN) stated if a resident had a change of condition, or needed to be monitored, staff were to place a resident on alert charting. Alert charting was to be completed each shift (every eight hours) and the note should address the area of concern being monitored. The alert charting was to be done for at least 72 hours but longer if needed. On 2/26/26 at 4:06 PM Staff 2 (DNS) stated he would expect staff would monitor a potential perpetrator in an investigation. A resident's alert charting to be completed every shift for at least 72 hours and it was to be specific to the concern identified. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. The facility's 10/21/25 Allegation of Sexual Inappropriate Behavior investigation revealed Resident 48 alleged Resident 68 entered her/his room and touched her/his thigh without consent. Resident 48 was placed on 1:1 supervision and Resident 48 was placed on alert charting. Resident 48's 10/14/25 Quarterly MDS and 1/13/26 Annual MDS revealed she/he was cognitively intact. Resident 48's Progress Notes revealed the following:-10/21/25 Resident 48 reported a resident of the opposite sex entered her/his room, asked Resident 48 to touch the intruder's hand, and the other resident touched her/his thigh twice. Staff were immediately notified. -10/22/25 a progress note was not documented-10/23/25 Resident 48 was monitored due to invasion of privacy by another resident. Resident 48 was guarded (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and worried.-10/24/25 Resident 24 was assessed for her/his nationality, language, and need for ADL assistance. (There was no assessment related to the alleged allegation of abuse and Resident 37's psychosocial status.) On 2/23/26 at 10:05 AM Resident 48 stated Resident 68 came in her/his room and Resident 68 rubbed her/his legs. Resident 48 stated it upset her/him for about a month but was now over it. On 2/26/26 at 9:41 AM Staff 24 (RN) stated if a resident had a change of condition, or needed to be monitored, staff were to place a resident on alert charting. Alert charting was to be completed each shift (every eight hours) and the note should address the area of concern being monitored. The alert charting was to be done for at least 72 hours but longer if needed. On 2/24/26 at 1:46 PM and 2/26/26 at 4:06 PM Staff 2 (DNS) stated he completed the investigation related to this incident would expect staff would monitor and document on a resident every shift for at least 72 hours and it was to be specific to the concern identified. 3. Resident 55 was admitted to the facility in 9/2021 with a diagnosis of heart disease. Resident 55's 12/4/25 Order Details report revealed zinc oxide (treats skin irritations) was to be applied every two hours. Resident 55's 12/2025 TAR revealed zinc oxide was applied every two hours on most shifts. Resident 55's 1/2026 and 2/2026 TAR did not include staff were to apply zinc every two hours. On 2/26/26 at 11:19 AM Staff 17 (CNA) stated the CNAs applied barrier cream to Resident 55's skin every two hours. The nurses had to apply the medicated cream. On 2/26/26 at 2:29 PM AM Staff 9 (RN) stated if a resident required zinc oxide cream to be applied it was documented on the TAR. On 2/26/26 at 4:21 PM Staff 2 (DNS) stated Zinc oxide was a medicated cream, and the licensed nurses were to administer the medication. Staff 2 acknowledged the order was not on the current TARs and was not documented as administered. 4. Resident 62 was admitted to the facility in 1/2026 with a diagnosis of seizures. Resident 62's 1/26/26 Progress Note by Staff 3 (RNCM) revealed staff observed her/him at the nurse's station and she/he was shaking and was unresponsive. The note indicated a CNA stated that [she/he] did this again yesterday . Resident 62's clinical record did not have an assessment of shaking or unresponsiveness on 1/25/26. On 2/27/26 at 11:11 AM Staff 3 stated she did not recall the CNA who reported Resident 62 had a shaking and unresponsive event on 1/25/26. Staff 3 stated if a resident had a change in condition the CNA should report to the nurse and the nurse should document an assessment. On 2/27/26at 11:25 AM Staff 2 (DNS) stated if a resident had a change of condition the CNA was to report to the nurse, the physician was to be notified, and the resident was to be monitored. 5. Resident 63 was admitted to the facility in 12/2025 with diagnoses of kidney disease and heart failure. Resident 12/4/25 hospital Physician Discharge Orders included Resident 62 was to be weighed upon admission to the facility and daily. Staff were to call the physician if Resident 63 gained three pounds in more than 24 hours or five pound in five days. Resident 62's weight log revealed the following: -12/625 202 pounds.-12/8/25 209.4 pounds.-12/925 209 pounds.-12/10/25 207 pounds.-12/1125 223 pounds.-12/15/25 200 pounds.-12/16/25 200.2 pounds.-12/17/25 200 pounds.-12/19/25 200.2 pounds.-12/20/25 209.2 pounds.-12/23/25 211.4 pounds. Resident 63's clinical record did not have documentation to indicate her/his physician was notified of weight gains per orders on 12/8/26, 12/11/25, and 12/20/25. On 2/26/26 at 4:26 PM Staff 2 (DNS) stated Resident 63 was on dialysis and weight fluctuations were expected. Staff did not call the physician with weight gain per physician orders but should have clarified the order due to dialysis related weight fluctuations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure medications and biologicals were secured and accessible only to authorized personnel for 2 of 3 facility halls observed for secure medication cart. This placed residents at risk for misappropriation of medications and adverse medication consequences. Findings include:1. On 2/25/26 at 12:16 PM an unattended medication storage cart in the [NAME] Hall was observed to have unlocked drawers. Two staff members and a visitor were observed to walk past the unlocked medication storage cart. On 2/25/26 at 12:20 AM Staff 10 (RN) opened the closed door in room [ROOM NUMBER], approached the unlocked medication storage cart and locked it. Staff 10 confirmed the drawer had been left unlocked and unattended while she was in room [ROOM NUMBER]. The medication storage cart was inspected, and Staff 10 confirmed the cart contained residents' prescribed medications, insulin vials and insulin needles. Staff 10 confirmed the medication carts were to remain locked when left unattended. On 2/25/26 at 2:58 PM Staff 2 (DNS) confirmed medication carts were to be locked when left unattended by the licensed nurse. 2. On 2/24/26 at 11:32 AM an unattended medication storage cart in the [NAME] Hall was observed to have an opened drawer. The medication storage cart was locked, but the drawer had not been fully closed which allowed access to the contents of the drawer. The drawer was inspected and found to contain insulin vials and insulin needles. On 2/24/26 at 11:33 AM two staff members were observed walking by the medication storage cart and no action taken by either staff member. On 2/24/26 at 11:39 AM Staff 9 (RN) approached the cart and confirmed the drawer had not been fully closed and therefore was left unlocked while unattended. Staff 9 stated the drawer contained insulins vials, syringes, and glucometers. Staff 9 confirmed medication carts were to remain locked when left unattended. On 2/25/26 at 2:58 PM Staff 2 (DNS) confirmed medication carts were to be locked when left unattended. 3. On 2/26/26 at 1:04 PM a medication cart was observed unlocked on the North Hall. The nurse was not in view of the cart. On 2/26/26 at 1:11 PM Staff 11 (LPN) confirmed the cart was left unlocked and unattended. On 2/25/26 at 2:58 PM Staff 2 (DNS) confirmed medication carts were to be locked when left unattended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to implement Enhance Barrier Precautions for 2 of 2 sampled residents (#s 11 and 48) reviewed for pressure ulcers. This placed residents at risk for cross contamination. Findings include:1. Resident 11 was admitted to the facility in 10/2025 with a diagnosis of pressure ulcer. Resident 11's 2/26/26 Weekly Skin Evaluation revealed she/he had a pressure ulcer to the left buttock which was first observed on 3/27/25. On 2/25/26 at 10:56 AM Staff 4 (RNCM) was observed to begin pressure ulcer care. Staff 4 performed hand hygiene and put on gloves. Prior to removing Resident 11's dressing, this surveyor asked Staff 4 if she/he was to wear a gown. Staff 4 stated she did not need to wear a gown and only needed to use gloves. Resident 11's ulcer was observed to not have signs of infection. On 2/26/26 at 9:11 AM and 2/27/26 at 12:07 PM Staff 8 (Infection Preventionist) stated residents with chronic wounds that did not have significant drainage were on standard precautions (use of gloves, gowns, masks and eye protection based on the anticipated risk of exposure to fluids). Staff 8 stated residents with chronic wounds should be on EBP (Enhance Barrier Precautions) but Resident 11 did not have EBP in place. On 2/26/26 at 3:59 PM Staff 2 (DNS) stated residents with chronic wounds should be in EBP. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. Resident 48's 1/13/26 Annual MDS revealed she/he was cognitively intact. On 2/23/26 at 2:40 PM and 02/25/2026 at 3:25 PM Resident 48's room was observed with no signage and no PPE (Personal Protective Equipment) by her/his room to indicate she/he was on EBP (Enhance Barrier Precautions). Resident 48 stated staff did not use gowns when they performed wound care. Resident 48 declined to have this surveyor observe wound care. On 2/26/26 at 1:50 PM Staff 4 (RNCM) stated Resident 48 was admitted to the facility in 1/2025 with a pressure ulcer. Staff stated she did not wear a gown when she/he did wound care. On 2/26/26 at 9:11 AM and 2/27/26 at 12:07 PM Staff 8 (Infection Preventionist) stated residents with chronic wounds that did not have significant drainage were on standard precautions (use of gloves, gowns, masks and eye protection based on the anticipated risk of exposure to fluids). Staff 8 stated residents with chronic wounds should be on EBP but Resident 48 did not have EBP in place. On 2/26/26 at 3:59 PM Staff 2 (DNS) stated residents with chronic wounds should be in EBP.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to ensure care was provided in a manner that maintained resident dignity for 1 of 7 residents (#67) reviewed for abuse. This placed residents at risk for undignified care. Findings include:Resident 67 was admitted to the facility in 6/2024 with diagnoses including hemiplegia (loss of movement and/or sensation in half of the body), depression, and anxiety.An 8/14/25 Annual MDS assessment determined Resident 67 had normal cognitive function.An 8/6/25 facility investigation report included the following statements from Resident 39, Resident 67, Staff 12 (LPN), and Staff 22 (CNA):- Resident 39 was in a shared room with Resident 67 and witnessed the incident. Resident 39 stated Staff 22 entered and exited Resident 67's room loudly. When confronted about slamming the door, Staff 22 and Resident 67 raised their voices at each other to which Resident 67 became upset.- Resident 67 stated Staff 22 was moving quickly around Resident 67's room and slammed the door upon exit. Resident 67 asked Staff 22 why he slammed the door to which Staff 22 responded and asked, What are you going to do about it?- Staff 12 stated he observed Staff 22 and Resident 67 cursing at each other inside Resident 67's room as well as at the nurse's station when Resident 67 was filling out a grievance form.- Staff 22 stated Resident 67 was talking to Staff 22 with attitude and cursing at him regarding closing the door loudly. Staff 22 stated Resident 67 threatened to hit him to which Staff 22 asked Resident 67 what are you going to do? Resident 67 then stated she/he was going to file a complaint on Staff 22. Staff 22 responded by saying, do what you want. I don't even care. I'm not working with disrespectful residents like [her/him] no more.An 8/11/25 Incident Report concluded the incident between Resident 67 and Staff 22 was a verbal dispute provoked by both Resident 67 and Staff 22.On 2/24/26 at 12:09 PM Resident 67 stated Staff 22 was moving quickly and slamming doors on 8/4/25. Resident 67 stated he told Staff 22 to leave the room. Resident 67 stated Staff 22 said something like, what are you going to do about it. Resident 67 stated her/his [NAME] was hurt more than anything after how Staff 22 interacted with her/him.On 2/24/26 at 12:24 PM Resident 39 stated after Staff 22 had slammed the door, Resident 67 was upset. Resident 39 stated she/he recalled Staff 22 talking back to Resident 67 disrespectfully.On 2/24/26 at 12:37 PM Staff 12 (LPN) stated he witnessed the incident between Resident 67 and Staff 22. Staff 12 stated he overheard two people shouting at each other and he had to intervene. Staff 12 stated Staff 22 was very rude towards Resident 67 who was initially upset but did not appear bothered the following day.On 2/24/26 and 2/25/26 attempts to communicate with Staff 22 were made but were unsuccessful. On 2/27/26 at 11:21 AM Staff 5 (Business Office Manager/Human Resources) stated Resident 67 tended to be explosive and confrontational, but Staff 22 should not have matched Resident 67 behavior and treated Resident 67 disrespectfully. Staff 5 stated Staff 22's behavior was unprofessional.On 2/27/26 at 11:48 AM Staff 2 (DNS) confirmed the incident which occurred on 8/6/25 and Staff 22's behavior with slamming the door and yelling back at Resident 67 was unprofessional and undignified.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to assist residents to formulate and obtain an advance directive for 2 of 3 sampled residents (#s 26 and 48) reviewed for advance directives. This placed residents at risk for healthcare decisions to conflict with resident wishes. Findings include: 1. Resident 26 was admitted to the facility in 1/2026 with diagnoses of esophageal obstruction (blockage of esophagus) and dysphagia (difficulty swallowing). A review of Resident 26's clinical record revealed no documentation of an advance directive and no evidence the resident was provided written information regarding the right to formulate one. On 2/26/26 at 8:30 AM, Resident 26 stated she/he had not completed an advance directive and had not been offered the opportunity to formulate one. On 2/26/26 at 1:44 PM, Staff 5 (Business Office Manager/Human Resources) stated residents without an advance directive were offered a blank advance directive during their initial care conference. Staff 5 confirmed Resident 26 had not been offered the opportunity to complete an advance directive. On 2/26/26 at 4:20 PM, Staff 1 (Administrator) stated it was the facility's responsibility to ensure residents were informed of their right to formulate an advance directive upon admission and the process should be completed in accordance with required guidelines. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. Resident 48's 1/13/26 Annual MDS revealed she/he was cognitively intact. Resident 48's Care Plan revealed she/he did not have an advance directive, and staff were to offer advance directive information at least quarterly. On 2/25/26 at 8:07 AM Resident 48 stated she/he had an advance directive. On 2/26/26 at 1:00 PM Staff 5 (Business Office Manager) stated Resident 48 had an advance directive, but her/his facility did not obtain a copy. On 2/26/26 at 4:20 PM, Staff 1 (Administrator) stated it was the facility's responsibility to ensure residents were informed of their right to formulate an advance directive upon admission and the process should be completed in accordance with required guidelines.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review it was determined the facility failed to ensure residents were not abused for 3 of 7 sampled residents (#s 48, 65 and 66) reviewed for abuse. This placed residents at risk for abuse and diminished psychosocial well-being. Findings include:The facility's update 2022 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation Policy statement included each resident has the right to be free from abuse including verbal, physical and sexual. The abuse definition included the willful infliction of intimidation resulting in mental anguish. 1. Resident 6 was admitted to the facility in 2020 with diagnoses including epilepsy (neurological disorder) and dementia. Resident 65 was admitted to the facility in 2024 with diagnoses including a stroke and depression. Resident 66 was admitted to the facility in 2025 with diagnoses including heart failure and depression. Review of a 9/25/25 incident report documented on 9/25/25 Resident 6, Resident 65 and Resident 66 tried to exit the facility for the smoking break. Resident 6 stated she/he believed Resident 65 bumped her/his wheelchair which led to a confrontation. Review of a written statement on 9/25/25 documented Resident 6 stated in the morning while attempting to exit for the smoking break, she/he felt Resident 65 push her/his wheelchair and said to hurry up. Resident 6 stated Resident 65 yelled at her/him and then she/he yelled back Get away from me, don't touch me you fucking bitch. You touch me again and I'll kill you. Review of a written statement from Resident 65 on 9/25/25 documented she/he stated that morning Resident 6 called her/him a fucking bitch, tried to hit her/him and then Staff 11 (LPN) pulled her/him away just in time. Review of a written statement from Resident 66 on 9/25/25 documented that morning she/he waited to exit for a smoking break when Resident 6 stood up and took a swing at Resident 65 and called her/him a bitch. Resident 6 then turned to Resident 66 and said, You're a little bitch too, I bet I could beat your ass. It was documented Resident 66 stated the incident made her/him afraid. Resident 66 discharged from the facility 9/30/25 and her/his phone was not in service on 2/25/26. On 2/25/26 at 3:35 PM Witness 2 (Family Member) stated Resident 66 was not able to take phone calls. Resident 65 discharged from the facility 1/10/26, calls were placed on 2/24/26 and 2/25/26 but were unsuccessful. On 2/24/26 at 12:14 PM Resident 6 stated she/he did not recall the incident. On 2/26/26 at 12:01 PM Staff 11 recalled the incident between Resident 6, Resident 65 and Resident 66 on 9/25/25. Staff 11 noticed Resident 6 being aggressive towards Resident 65. Resent 6 motioned as if she/he was going to hit Resident 65 so he separated the two residents. Staff 11 recalled them (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yelling at each other but was not able to recall the verbiage used. On 2/26/26 at 12:28 PM Staff 2 (DNS) confirmed his written investigation and conclusion of Resident 6 verbally and physically threatened Resident 65 and verbally threatened Resident 66 on 9/25/25. Staff 2 stated he expected all residents to be free from abuse. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. Resident 48's 10/14/25 quarterly MDS and 1/13/26 Annual MDS revealed Resident 48 was cognitively intact. Resident 68's 10/1/25 Montreal Cognitive Assessment revealed she/he had severe cognitive impairment. The facility's 10/21/25 Allegation of Sexual Inappropriate Behavior investigation revealed on 10/21/25 Staff 27 (CNA) heard Resident 48 call out. Staff 27 entered Resident 48's room and observed Resident 68 in her/his wheelchair. Resident 48 reported to Staff 27 Resident 68 touched her/his thigh inappropriately. Resident 68 denied the interaction. Resident 68 was removed from Resident 48's room and was placed on 1:1 supervision. On 2/23/26 at 10:05 AM Resident 48 stated Resident 68 came in her/his room and Resident 68 rubbed her/his hands on Resident 48's legs. Resident 48 stated it upset her/him for about a month but was now over it. On 2/24/26 at 1:46 PM Staff 3 (RNCM) stated prior to Resident 68 entering Resident 48's room, Resident 68 was usually at the nurse's station and not going into other resident rooms. On 2/24/26 at 6:15 PM and 2/26/26 at 3:31 PM telephone messages were left for Staff 27. A return call was not received. On 2/26/26 at 4:07 PM Staff 2 (DNS) stated Resident 68 touched Resident 48 in a nonconsensual manner.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review it was determined the facility failed to assess the use of a physical restraint for 1 of 2 sampled resident (#12) reviewed for positioning and mobility. This placed residents at risk for inappropriate use of a restraint. Findings include:Resident 12 was admitted to the facility in 1/2021 with diagnoses of stroke and dementia. A 1/14/26 Annual MDS assessment indicated Resident 12 had no physical restraints in place and was able to make herself/himself understood and was able to understand others. A 1/23/26 Morse Fall Scale assessment indicated Resident 12 had a history of falls and exhibited impaired balance while standing. The assessment identified Resident 12 as being at high risk for falls. A 1/28/26 Care Plan indicated Resident 12 had impaired mobility and was at high risk for falls. Planned interventions included placement of the bed against the wall, bed in low position, monitor for seizure activity, and placement of a mattress on the floor next to the bed while the resident was in bed. The Care Plan did not include the use of wedges intended to prevent the resident from exiting or falling out of bed. On 2/23/26 at 3:31 PM and on 2/25/26 at 8:56 AM Resident 12's room was observed with a sign posted above the bed which stated, Please ensure body pillow is in place before leaving room to protect the resident from falling out of bed. Two wedges (positioning cushions described by staff to prevent the resident from rolling or falling out of bed) were observed in her/his room propped up against a wall. Record review did not identify a physician order, documented assessment, evaluation for potential restraint use, informed consent, or care plan interventions addressing the use of wedges to prevent the resident from falling out of bed. On 2/25/26 at 10:13 AM, Staff 14 (CNA) stated it was not a body pillow that was used, it was wedges. Staff 14 stated the wedges were used to keep Resident 12 from falling out of bed and were used each time the resident was in bed. On 2/25/26 at 10:35 AM, Staff 18 (CNA) stated staff provided most cares for Resident 12 and confirmed it was not a body pillow used, but wedges. Staff 18 stated the wedges were used at night to prevent the resident from falling out of bed. On 2/25/26 at 3:23 PM, Staff 10 (RN) stated she was aware staff utilized wedges for Resident 12 while in bed to prevent her/him from rolling out. Staff 10 confirmed there was no physician order, no documented assessment, and no care plan intervention addressing the use of the wedges.On 2/25/26 at 4:03 PM, Staff 4 (RNCM) acknowledged Resident 12 utilized wedges rather than a body pillow and confirmed there was no documented assessment evaluating the devices for potential restraint use, no physician order, and no care plan interventions in place. On 2/25/26 at 4:43 PM, Staff 2 (DNS) acknowledged there was no physician order, no documented evaluation, no informed consent, and no care plan interventions related to the use of wedges. Staff 2 stated it was his expectation that positioning devices are not utilized without proper assessment, consent and care plan documentation.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review it was determined the facility failed to obtain a baseline assessment for 1 of 5 sampled residents (#2) reviewed for unnecessary medications. This placed residents at risk for unidentified adverse medication side effects. Findings include: Resident 2 was admitted to the facility in 11/2025 with a diagnosis of dementia. Resident 2's admission orders included she/he was to be administered Risperdal (antipsychotic medication) and olanzapine (antipsychotic medication).Resident 2's clinical record revealed an AIMS (Abnormal Involuntary Movement Scale) was not completed until 2/18/26, three months after she/he was admitted to the facility and antipsychotic therapy was initiatedOn 2/24/26 at 12:38 PM Resident 2 was observed without abnormal involuntary movements. On 2/26/26 at 1:09 PM Staff 3 (RNCM) stated an AIMS was to be completed when a resident was first started on an antipsychotic medication and then every six months. Staff 3 acknowledged Resident 2's AIMS was not completed timely. On 2/26/26 at 3:56 PM Staff 2 (DNS) sated if a resident was administered an antipsychotic medication, the AIMS was to be completed when the medication was initiated in order to obtain a baseline assessment.

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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 interviews and record review it was determined the facility failed to report allegations of abuse within the mandated timeframe for 3 of 4 sampled residents (#s 6, 65 and 66) for 1 of 5 FRI reports reviewed for abuse. This placed residents at risk for further abuse. Findings include:The facility's revised 2022 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property and Exploitation revealed it was expected for the facility to immediately report all suspected and/or allegations of abuse in accordance with state and federal law. The policy defined immediately to mean as soon as possible but no later than two-hours after an allegation of abuse was made.On 9/26/25 at 11:09 AM, the state agency (SA) received a FRI for a 9/25/25 at 9:00 AM alleged abuse with Resident 6, Resident 65 and Resident 66.On 2/26/26 at12:28 PM Staff 2 (DNS) stated on 9/26/25 he completed the FRI and sent it to the SA and he was not aware of any other attempts to contact the SA within the required two-hour timeframe.On 2/26/26 at 12:41 PM, Staff 1 (Administrator) confirmed the 9/26/25 FRI for allegations of abuse was submitted to the SA late and he expected all allegations of abuse to be reported to the SA within the required two-hour reporting timeframe.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to provide a bed hold policy for 1 of 1 sampled resident (#62) reviewed for hospitalization. This placed residents at risk for not being informed of their right to return to the facility. Findings include: Resident 62 was admitted to the facility in 1/2026 with a diagnosis of seizures. Resident 62's 1/26/26 Progress Note revealed she/he sat at the nurse's station, was observed to have tremors, and was unresponsive. Resident 62 was transported to the hospital for evaluation and treatment. Resident 62's clinical record did not have documentation to indicate a bed hold policy was provided to Resident 62 or her/his representative. On 2/27/26 at 11:11 AM Staff 3 (RNCM) stated Resident 62 was not stable when she/he was transported to the hospital. Staff 3 stated she did not notify Resident 62's representative of the bed hold policy. On 2/27/2026 at 11:53 AM Staff 1 (Administrator) stated the facility residents were not required to pay to hold their bed. All residents were allowed to return from a hospitalization, even without a bed hold notification.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, interview, and record review it was determined the facility failed to complete a comprehensive assessment for 2 of 7 sampled residents (#s 2 and 48) reviewed for pressure ulcer and unnecessary medications. This placed residents at risk for adverse side effects and worsening wounds. Findings include: 1. Resident 2 was admitted to the facility in 11/2025 with a diagnosis of dementia with behavioral disturbances. Resident 2's 11/2025 MAR revealed she/he was administered olanzapine (antipsychotic medication) for delusions, risperidone (antipsychotic medication) for delusions, and sertraline (antidepressant) for mood disorder. Resident 2's 11/18/25 admission MDS and associated CAA indicated she/he used psychotropic medications but there was no analysis of findings including her/his medical condition, history, and rationale for the continued use of psychotropic medications. On 2/27/26 at 8:59 AM Staff 16 (MDS Coordinator) reviewed the 11/18/26 admission MDS and verified she did not address Resident 2's mental health diagnosis, history or psychotropic medications, and the goal of treatment or did not direct the reader to the documentation to support her rationale for developing a care plan and the goal of treatment. On 2/27/26 at 11:35 AM Staff 2 (DNS) sated the CAAs should have an analysis of the use of the psychotropic medications. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. Resident 48's 1/28/25 hospital Discharge Summary revealed she/he had a sacral pressure ulcer with tunneling with osteomyelitis (bone infection). Resident 48 was discharged to the facility for wound care. Resident 48's 1/13/26 Annual MDS and CAAs revealed she/he was identified to have a pressure ulcer. The analysis of findings included information related to her/his nutrition. there was no information related to Resident 48's pressure ulcer, if the pressure ulcer was chronic and if it was expected to heal. On 2/27/26 at 8:59 AM Staff 16 (MDS Coordinator) reviewed the 1/13//26 admission MDS and CAAs and verified she did not address Resident 48's pressure ulcer or refer to documentation to support the rationale for developing a care plan and the goal of treatment. On 2/27/26 at 11:35 AM Staff 2 (DNS) sated the CAAs should have an analysis of Resident 48's care as related to the pressure ulcer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADL care for 2 of 2 sampled residents (#s 12 and 32) reviewed for ADL care. This placed residents at risk for lack of personal hygiene. Findings include:1. Resident 12 was admitted to the facility in 1/2021 with diagnoses of stroke and dementia.Resident 12's Annual MDS dated [DATE] indicated the resident was dependent on staff for personal hygiene and grooming.A review of Resident 12's care plan dated 1/19/26 revealed no interventions addressing facial hair removal or grooming preferences. Resident 12 was observed on 2/24/26 at 9:14 AM and on 2/25/26 at 8:55 AM with a significant amount of visible chin hair. On 2/24/26 at 9:16 AM, Resident 12 stated she/he did not want to have facial hair and would like staff to take care of her/his unwanted hair. On 2/25/26 at 10:13 AM, Staff 14 (CNA) observed Resident 12 's facial hair and stated her/his facial hair is really long. On 2/25/26 at 10:35 AM, Staff 18 (CNA) observed Resident 12's facial hair and stated her/his chin hair is long and needs to be shaved.On 2/25/26 at 3:09 PM, Staff 10 (RN) stated there were no care plan interventions addressing Resident 12's facial hair and acknowledged she had observed facial hair on Resident 12's chin. On 2/25/26 at 4:27 PM, Staff 2 (DNS) stated he was unaware Resident 12 had long chin hairs and acknowledged it was not proper ADL care. Staff 2 stated the expectation was for residents to be offered grooming on shower days and as needed. 2. Resident 32 was admitted to the facility in 12/2024 with diagnoses of fracture and legal blindness. Resident 32's annual MDS dated [DATE] indicated Resident 32 was dependent on staff for ADL care related to toileting and hygiene. A review of Resident 32's care plan dated 12/18/25 indicated she/he was dependent on staff for toileting and required assistance with toilet transfers, including setup and clean-up. A 9/2/25 Facility Reported Incident revealed morning staff found Resident 32 on 8/31/25 soiled with a bowel movement. The resident's brief and bed linens were saturated with fecal matter, and the floor surrounding the bed was also soiled.On 2/26/26 at 9:11 AM, Staff 12 (LPN) stated he worked the morning of 8/31/25 and observed Resident 32's bedding and the surrounding floor covered in feces. Staff 12 stated he had never observed Resident 32 in that condition before. On 2/26/26 at 9:27 AM, Staff 13 (Medical Records/CNA) stated on the morning of 8/31/25, she observed Resident 32 with feces present on the bed, floor, sleepwear, and on one of the resident's legs. Staff 13 stated it appeared the resident had been left soiled for an extended period of time. On 2/26/26 at 12:15 PM, Staff 15 (Former CNA) stated he worked the morning shift on 8/31/25. Staff 15 reported when he checked on Resident 32, the resident's bed and surrounding floor were soiled. Staff 15 stated the resident required a full bedding change and a head-to-toe shower. On 2/26/26 at 12:52 PM, Staff 2 (DNS) stated he was aware of the incident on the morning of 8/31/25. Staff 2 acknowledged Resident 32 was found in a soiled condition, with feces on the bed, floor, and on her/his sleepwear, as documented in the Facility Reported Incident. Staff 2 stated it was his expectation residents requiring ADL assistance, received care consistent with their individualized care plans. On 2/27/26 at 9:11 AM, Staff 19 (Former CNA) stated he worked the night shift beginning on 8/30/25. Staff 19 stated he was unaware Resident 32 was incontinent and required assistance with toileting. Staff 19 confirmed he did not provide incontinent care for Resident 32 during his shift or the morning of 8/31/25.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview and record review it was determined the facility failed to provide resident centered activities for 1 of 1 sampled resident (#7) reviewed for activities. This placed residents at risk for diminished psychosocial well-being and quality of life. Findings include: Resident 7 was admitted to the facility in 2019 with diagnoses including anxiety and dysphagia following cerebral infarction (difficulty swallowing following a stroke). The 9/25/25 Annual MDS revealed Resident 7 was cognitively impaired, speech was unclear and rarely understood and she/he was dependent on staff for all ADL and mobility needs. Resident 7 enjoyed watching television, to sit in the lobby, listen to music and individualized visits.Resident 7's 10/25/25 Activity Quarterly Progress Note Review revealed she/he enjoyed listening to music, to go outside for fresh air when the weather was good, to watch birds and staff fill the bird feeder outside her/his room window, make phone calls to family, sensory visits and one to one individualized visits. On 2/23/26 at 1:31 PM Resident 7 was observed to lie in bed with her/his body slightly tilted to the right. Residents 7's television was parallel to the wall, on her/his left side of the bed and playing a Western television program with no volume. Resident 7's room was observed with no music devices, no leisure opportunities or supplies, no family pictures or room decorations were visible.On 2/24/26 at 12:10 PM and 2:13 PM Resident 7 was observed in her/his bed with the room divider curtain pulled around the bed, the television was parallel to the wall and not visible from her/his bed and a Western television program was on but the resident was unable to hear the program. The resident's roommate had on a news program and the news program was heard in the room. No other leisure opportunities were visible.On 2/25/26 at 8:47 AM Staff 25 (CNA) stated she obtained the information to care for a resident from the Kardex (care plan for direct care). She stated Resident 7 did not get up and she/he only liked to watch television.On 2/25/26 at 12:37 PM Resident 7 was observed in bed with her/his room divider curtains slightly split a little. The television had a Western program on, three copied pictures were taped to the resident wall and the pictures were of different sceneries. No music was playing and the resident window blinds were closed.On 2/27/26 at 9:36 Staff 26 (CNA) stated she was aware of Resident 7's activity interest from the Kardex. Staff 26 stated the resident mostly liked to watch television. No other activities or leisure interests were shared.Resident 7's 2/27/26 Kardex revealed she/he preferred activities, enjoyed one-to-one visits, visits, art, music, animals, movies and the outdoors. Resident 7 enjoyed listening to music, go outside when weather is nice, bird watching out her/his window, to call her/his family and sensory visits.On 2/26/26 at 9:23 AM Resident 7 was observed sleeping in her/his bed with the room divider curtains drawn, window blinds were closed, no music opportunities and the television had a Western program playing.On 2/27/26 at 9:29 AM Resident 7 was asked if she/he liked Western television programs and the resident stated No. Resident 7 was asked if she/he was bored and the resident stated yes.On 2/27/26 at 9:45 AM Staff 23 (Activity Director) stated she documented Resident 7's activities on the Record of One-on-One Activities forms. Staff 23 stated she did not have a set schedule to provide one to one visits for Resident 7 but she did have two days a week she scheduled for herself to provide one to one visits to all residents in the facility. Staff 23 acknowledged Resident 7 did not like Western programs and she/he did not have any music or other leisure opportunities in her/his room. Staff 23 confirmed Resident 7 had not attended any group activities in over a year and Resident 7 was dependent on staff to assist with leisure opportunities.Record review of Resident 7's Record of One-on-One Activities documentation on 2/27/26 at 10:17 AM revealed the following activities for 1/2026 and 2/2026:-1/6/26, read her/him part of book;-1/8/26, read her/him part of book;-1/15/26, listened to music and watched birds;-1/20/26, read her/him part of book;-1/22/26 read her/him part of book;-2/5/26, read her/him part of book;-2/10/26, read her/him part of book;-2/12/26, bird watching;-2/17/26 listened to music;-2/19/26, read her/him part of book.On 2/27/26 at 11:24 AM Staff 1 (Administrator) expected Resident 7 to have more opportunities for individual activities designed to meet her/his interests and support her/his physical, mental and psychosocial well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review it was determined the facility failed to ensure pressure ulcer care was provided to promote healing and physician orders were followed for 2 of 2 sampled residents (#s 11 and 48) reviewed for pressure ulcers. This placed residents at risk for delayed healing. Findings include: 1. Resident 11 was admitted to the facility in 10/2025 with a diagnosis of osteomyelitis (bone infection) and pressure ulcer. Resident 11's 2/3/26 Order Details revealed her/his ulcer was to be cleaned with wound cleanser, a full package, one gram of collagen powder was to be applied to the wound bed, a calcium alginate sheet was to be lighted packed, and then covered with a border dressing. On 2/25/26 at 10:56 AM Staff 4 (RNCM) was observed to perform pressure ulcer care to Resident 11's sacral pressure ulcer. The care included:-Wound cleanser was applied to clean gauze.-The ulcer periphery and wound bed was cleaned.-The ulcer was dried with clean gauze.-After gloves were removed, hand hygiene was performed, and new gloves were applied. -A collagen sheet was applied to the ulcer base.-Calcium alginate was placed on top of the collogen sheet.-A border dressing was applied to hold the calcium alginate and collagen in place. On 2/27/26 at 11:04 AM Staff 4 stated the facility had both powder and sheets of collagen. Staff 4 stated the powder was usually used for deeper wounds and the order should be clarified. Staff 4 acknowledged used the sheet and not the powder.On 2/26/26 at 3:59 PM Staff 2 (DNS) stated if orders needed to be changed, the physician was to be notified. 2. Resident 48 was admitted to the facility in 1/2025 with a diagnosis of pressure ulcer. Resident 48's Order Review History Report revealed coccyx (tailbone) wound care orders were last updated on 12/23/26. Resident 48's coccyx Weekly Skin Evaluations revealed the following wound status: -1/6/26 improved-1/13/26 improved-1/20/26 unchanged-1/27/26 unchanged-2/3/26 unchanged-2/10/26 unchanged-2/17-26 unchanged-2/24/26 unchanged On 2/25/26 at 3:25 PM Resident 48 declined to have wound care observed. On 2/26/26 at 1:14 PM Staff 3 (RNCM) stated pressure ulcers were monitored weekly. Standard of practice was to change treatment if the ulcer did not improve over a two-week period of time. On 2/26/26 at 1:50 PM Staff 10 (RN/Wound Nurse) stated Resident 48 was admitted to the facility in 2025 and her/his ulcer was larger. Staff 10 stated she called the physician for change in wound care if the ulcer worsened. Staff 10 stated the ulcer currently had a small opening but was two cm deep. On 2/26/26 at 4:07 PM Staff 2 (DNS) stated the last order change for Resident 48's coccyx ulcer was in 12/2025. Staff 2 stated if there was no change staff should ask for a physician to assess the wound and provide additional recommendations if needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review it was determined the facility failed to perform pre and post dialysis assessments on 1 of 1 resident (#3) reviewed for dialysis. This placed residents at risk for inadequate monitoring. Findings include:The facility's Dialysis Policy from 3/2025 states the facility provides ongoing monitoring of the dialysis access site and utilizes a Dialysis Flow Sheet to document resident specific dialysis care including monitoring of the catheter and fistula.Resident 3 was admitted to the facility in 1/2026 with diagnoses including chronic kidney disease.Physician orders from 1/29/26 included Resident 3 had a fistula (a connection port used to access blood vessels during dialysis) in her/his chest and she/he was to receive dialysis services three times a week.A 2/9/26 admission MDS cognitive assessment determined Resident to have no cognitive limitations.Review of records from 1/2026 and 2/2026 revealed Resident 3 received dialysis treatment on 1/28/26, 2/9/26, and 2/18/26. No record was found of pre or post dialysis assessments being completed for Resident 3 on those dates.On 2/25/26 at 8:45 AM Resident 3 stated staff did not perform any formal checks after she/he returned from dialysis.On 2/25/26 at 11:02 AM Staff 20 (RN) stated when a resident received dialysis treatments, they were assessed and a pre and post dialysis form was completed. This form included full vitals, port site appearance inspection and review of any information provided by the dialysis center.On 2/25/26 at 3:41 PM Staff 3 (RNCM) confirmed pre and post dialysis assessments had not been performed on Resident 3. Staff 3 stated these forms included a guide of specific areas to be inspected and documented to ensure proper dialysis monitoring was performed on Resident 3 prior to and after she/he returned from a dialysis appointment.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review it was determined the facility failed to ensure a resident or representative understood an arbitration agreement before signing for 2 of 3 sampled residents (#s 3 and 21). This placed residents at risk for inability to resolve concerns in court. Findings include: 1. Resident 3 was admitted to the facility in 1/2026 with a diagnosis of kidney disease. Resident 3's 1/29/26 State Arbitration Agreement form revealed on 1/29/26 she/he signed to accept the agreement. Resident 3's 2/3/26 admission MDS revealed she/he was cognitively intact. On 2/25/226 at 10:33 AM Resident 3 stated she/he was really sick when she/he admitted to the facility and did not recall all events. Resident 3 stated she/he did not know what an arbitration agreement entailed. Resident 3 stated if she/he knew the agreement meant she/he waived her/his right to file a lawsuit, she/he would not have signed the agreement. On 2/25/26 at 10:00 AM Staff 5 (Business Office Manager) stated she reviewed an arbitration agreement with a resident if she/he was cognitively intact and as soon after admission to the facility as possible. Staff 5 stated Resident 3 often stated she/he did not understand what she/he was told even after the information was reviewed with her/him. On 2/25/26 at 12:25 PM Staff 21(Regional Admissions Director) stated staff were to ensure residents were cognitively intact prior to signing an arbitration agreement and involve family when needed. Staff 21 also stated staff were to ensure residents understood what an arbitration agreement meant prior to signing. 2. Resident 21 was admitted to the facility in 1/24/26 with a diagnosis of heart failure. Resident 21's clinical record revealed Witness 1 (Family) was her/his emergency contact. Resident 21's 1/30/26 admission MDS revealed she he was moderately cognitively impaired. On 2/25/26 at 9:21 AM Resident 21 stated she/he did not sign admission paperwork, and Witness 1 may have signed an arbitration agreement. Resident 21 called Witness 1 (via phone) and Witness 1 stated the facility was notified Resident 21 was not to sign any papers without his knowledge. Witness 1 stated he did not know what an arbitration agreement meant and stated if it waived Resident 21's right to file a lawsuit, he would not have allowed Resident 21 to sign the agreement. On 2/25/26 at 10:00 AM and 2/25/26 at 12:25 PM Staff 5 (Business Office Manager) stated she reviewed the arbitration with a resident if she/he was cognitively intact and as soon as the resident was available after admission to the facility. Staff 5 stated Witness 1 did not want Resident 21 to sign any paperwork without him first reviewing the information. Staff 5 acknowledged Resident 21 signed the arbitration agreement on 1/26/26 and she/he had moderate cognitive impairment. On 2/25/26 at 12:25 PM Staff 21(Regional Admissions Director) stated staff were to ensure residents were cognitively intact prior to signing an arbitration agreement and involve family when needed. Staff 21 also stated staff were to ensure residents understood what an arbitration agreement meant prior to signing.