STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385258	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Post Acute	8643 NE Beech Street Portland, OR 97220

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure mental health services were obtained for 1 of 3 sampled residents (#1) reviewed for behavioral health services. Findings include:Resident 1 was admitted to the facility in 2/2025 with diagnoses including major depression and suicidal ideation. Resident 1's [NAME] Psychiatric Consultant Notes dated 8/20/25 indicated she/he had last spoken to a therapist at that time. The notes indicated Resident 1 requested to discontinue services with the specific therapist. The notes indicated further therapy could be helpful for Resident 1 and the clinician recommended nursing staff and social services to assist Resident 1 with finding ongoing therapy outside the facility. There was no documented evidence in Resident 1's clinical record to indicate the facility followed up on obtaining mental health services for the resident after 8/2025. Resident 1's Care Plan dated 4/10/26 included active suicidal ideations, with interventions including to call 988, to not leave Resident 1 alone and implement one to one monitoring if Resident 1 mentioned wanting to kill herself/himself. Resident 1's care plan did not include mental health services. On 5/13/26 at 2:21 PM, Staff 10 (Social Services Director) stated she was not aware of Resident 1's Psychiatric Consultant Note to assist the resident in obtaining mental health services back in 8/2025. Staff 10 stated it was not her responsibility to follow-up on mental health notes for residents. On 5/14/26 at 12:35 PM, Staff 2 (Interim DNS) stated she was not aware of [NAME] Psychiatric Consultant notes for Resident 1 and would have expected Staff 16 (RCM) to follow up on obtaining mental health services for Resident 1.

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