

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Holladay Park Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NE 16th Avenue Portland, OR 97232	

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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>43691</p> <p>Based on interview and record review it was determined the facility failed to provide residents with a written notice of the facility's bed hold policy at the time of transfer to the hospital for 1 of 1 resident (# 30) reviewed for hospitalization . This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include:</p> <p>Resident 30 was admitted to the facility in 3/2024 with diagnoses including congestive heart failure.</p> <p>A 3/23/24 at 12:35 PM Progress Note revealed Resident 30 experienced a change in condition which required increased medical attention and she/he was transferred to a hospital.</p> <p>Review of Resident 30's records revealed no indication a physical copy of the facility's bed hold policy was provided to Resident 30 when she/he was transferred to a hospital on 3/23/24.</p> <p>On 6/13/24 at 12:52 PM Staff 2 (DNS) confirmed a bed hold policy was not provided to Resident 30 when she/he experienced a change in condition and was required to be transferred to a hospital.</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to follow physician orders for 1 of 1 sampled resident (#81) reviewed for edema (swelling caused by a collection of fluid in the spaces that surround the body's tissues and organs). This placed residents at risk for adverse effects and unmet needs. Findings include:</p> <p>Resident 81 was admitted to the facility in 5/2024 with diagnoses including heart disease and edema.</p> <p>Resident 81's 5/21/24 Physician Encounter Note directed the resident to be weighed each day before breakfast for four weeks.</p> <p>Resident 81's 5/28/24 Admission MDS indicated the resident was cognitively intact and experienced edema.</p> <p>A review of Resident 81's 5/2024 and 6/2024 Weights revealed the resident was not weighed on 5/22/24, 5/23/24, 5/25/24, 5/26/24, 5/30/24, 5/31/24, 6/1/24, 6/2/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24 or 6/9/24.</p> <p>On 6/10/24 at 11:27 AM Resident 81 was observed in her/his room and sat in her/his wheelchair. Resident 81's right leg was observed to be swollen. Resident 81 stated she/he experienced chronic edema in her/his right leg, and the leg caused her/him a great deal of pain.</p> <p>On 6/12/24 at 2:00 PM Staff 3 (LPN-Resident Care Manager) stated residents who experienced excessive edema were typically weighed daily, which included Resident 81. Staff 3 reviewed Resident 81's health record and stated the physician's order from 5/21/24 for daily weights for the resident was missed.</p>