STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385259	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holladay Park Plaza	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)
F 0684 Level of Harm - Minimal harm or potential for 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 observation, interview and record review it was determined the facility failed to follow physician orders for 2 of 7 sampled residents (#s 3 and 9) reviewed for unnecessary medications and accidents. This placed residents at risk for adverse medical consequences and lack of mobility needs. Findings include: 1. Resident 3 was admitted to the facility on [DATE] with diagnoses including osteoporosis and a fractured left femur (thigh bone). a. An 8/7/25 physician order indicated Resident 3 was prescribed calcium citrate plus (a dietary supplement to enhance the absorption and function of calcium in the body for better bone health) one time a day. A review of Resident 3's MAR from 8/7/25 through 8/31/25 indicated calcium citrate plus was not administered on 8/7/25, 8/8/25, 8/9/25, 8/10/25 or 8/11/25 and on 8/11/25, the medication was discontinued. Resident 3 missed all prescribed doses. b. An 8/12/25 physician order indicated Resident 3 was prescribed calcium citrate with vitamin D (a dietary supplement to enhance the absorption and function of calcium in the body for better bone health) one time a day. A review of Resident 3's MAR from 8/12/25 through 8/31/25 indicated calcium citrate with vitamin D was not administered on 8/12/25, 8/13/25, 8/14/25, 8/15/25, 8/16/25, 8/17/25, 8/18/25, 8/19/25, 8/20/25, 8/21/25, 8/22/25, 8/23/25 and 8/24/25. Resident 3 missed 13 prescribed doses. On 9/4/25 at 12:09 PM, Staff 4 (LPN Care Manager) reviewed Resident 3's 8/2025 MAR and confirmed all doses of the resident's calcium citrate plus were missed and Resident 3 was not administered 13 doses of calcium citrate with vitamin D. Staff 4 stated she was unaware the resident's medications were not administered until 8/22/25. Staff 4 confirmed the pharmacy was not contacted and the physician was not notified regarding Resident 3's missed doses. On 9/4/25 at 1:28 PM, Staff 2 (DNS) reviewed Resident 3's 8/2025 MARs and confirmed the resident missed doses of calcium citrate plus and calcium citrate with vitamin D. Staff 2 stated when medications were missed, she expected the nurse or CMA to contact the pharmacy and notify the care manager so they could write an SBAR (structured communication method which included situation, background, assessment and recommendation) and update the physician regarding the medication status and resident's condition. On 9/4/25 at 1:36 PM, Staff 12 (CMA) stated she did not call the pharmacy but notified the nurse (continued on next page)

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 - Few	regarding Resident 3's calcium citrate plus and calcium citrate with vitamin D was not available. Staff 12 confirmed she did not administer the prescribed medications because the medications were not available. 2. Resident 9 admitted to the facility in 8/2025, with diagnoses including Parkinson's disease, syncope (loss of consciousness) and collapse (falling or slumping). A Physician's Order dated 8/12/25 indicated bedside rails were to be used to support bed mobility. A Bed Rail Assessment completed on 8/12/25 documented Resident 9 was assessed and approved for use of one-half (1/2) side rails on both sides of the bed. The admission MDS dated [DATE] indicated the resident was cognitively intact. On 9/2/25 at 1:09 PM and on 9/3/25 at 8:13 AM, Resident 9's bed was observed without bed rails. During an interview on 9/3/25 at 8:16 AM Resident 9 stated she/he preferred to have bed rails in place to assist with mobility due to Parkinson's disease. On 9/4/25 at 1:45 PM Staff 4 (LPN Care Manager) stated Resident 9 was assessed and care planned for her/his falls. Staff 4 confirmed Resident 9's fall prevention interventions included the use of bilateral bed rails and acknowledged the bilateral bed rails were not in place. On 9/4/25 at 1:51 PM Staff 2 (DNS) acknowledged Resident 9's bilateral bed rails were not implemented. Staff 2 stated she expected staff to implement physician orders and follow the care plan to assist with bed mobility for Resident 9.

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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 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. **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 residents' environments were free from accident hazards for 1 of 2 sampled residents (# 49) reviewed for accidents. This placed residents at risk for injury. Findings include. The facility's Medication Storage and Accounting Policy, last approved in 2/2025, indicated all medications would be stored in a safe and locked place, not accessible to persons other than employees responsible for the supervision of stored medications. Resident 49 was admitted to the facility on [DATE] with diagnoses including depression. Resident 49's 8/25/25 Cognitive and Communication Care Plan revealed the resident was alert and oriented. Resident 49 required one person staff assistance for mobility. Random observations from 9/2/25 through 9/3/25 between the hours of 12:04 PM and 4:00 PM revealed the following: -Three brown prescription pill bottles labelled with Witness 1's (Family Member) name were visible on the window ledge. The pill bottles contained Farixa (used to treat diabetes, heart failure and chronic kidney disease), Revlimid (used to treat blood cancers) and colchicine (used to treat gout, a painful type of arthritis). The pill bottles were visible from the hallway. -A blue daily pill organizer with unidentified medications stored in each day's compartments was also on the window ledge. The pill organizer was visible from the hallway. -Resident 49's room was in a high traffic area, and her/his door was frequently open. Nursing staff, therapy staff, kitchen personnel, administrative staff, residents and visitors frequently passed by or entered Resident 49's room.-On multiple observations, neither Resident 49 nor Witness 1 were in the room and the medications were left unattended. -Outside vendors such as laboratory personnel were observed entering Resident 49's room. On 9/3/25 at 10:47 AM, Witness 1 stated medications on the window ledge [in Resident 49's room] in pill bottles and a blue pill organizer belonged to him. Witness 1 stated he left his medications in the room and did not take them with him when he left the facility each day. Witness 1 stated he was not offered a lock box to secure his medications, and no one asked him to remove the medications from the room. On 9/3/25 at 11:01 AM, Staff 8 (CNA) stated the brown pill bottles and pill organizer were on the window ledge in Resident 49's room since the resident admitted to the facility on [DATE]. On 9/3/25 at 11:02 AM, Staff 4 (LPN Care Manager) confirmed Witness 1's medications were unsecured in Resident 49's room. Staff 4 stated the medications should not be in the room and no medications were allowed to be in a resident's room unless there was a physician order and the medications were locked up. On 9/5/25 at 8:16 AM, Staff 1 (Administrator) verified there should be no unsecured medications at any resident's bedside.