

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Secora Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 10435 SE Cora Street Portland, OR 97266	

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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>Based on interview and record review it was determined the facility failed to ensure access to medical records upon oral or written request within the required timeframe for 1 of 3 sampled residents (#801) reviewed for the right to access medical records. This placed residents at risk for uninformed health care needs and delayed access to records. Findings include: The facility's 10/15/22 Medical Record Policy and Procedure revealed the following: -The resident may have access to their medical record upon request to nursing leadership. -The resident and/or responsible party request for medical record documents may be made orally or in writing. It will be provided in the form and format requested, if it is readily producible in such format within two business days. 1. Resident 801 was admitted to the facility in 6/2024 with diagnoses including morbid obesity and chronic pain. The 7/5/25 Annual MDS indicated Resident 801 was cognitively intact. Record review revealed on 4/21/25 Resident 801's attorney's office had requested the facility Please: Provide Medical Records and [NAME] from 12/3/24 to Present. On 7/28/25 a public complaint was received which alleged Witness 1 (Complainant) stated Resident 801's attorney had requested medical records on 4/21/25 and did not receive the completed list of medical records until 7/29/25. On 7/31/25 at 12:24 PM Witness 2 (Case Manager) stated the attorney's office had initially sent the request for Resident 801's medical records to the facility on 4/21/25. Witness 2 stated the facility sent Resident 801's Progress Notes on 4/29/25 but no billing documentation was included. From 5/6/25 through 7/21/25, eight follow-up requests were made for Resident 801's records. All requested records were not released by the facility until 7/29/25, approximately four months later. On 7/31/25 at 2:25 PM Staff 10 (Business Office Manager) stated she had received voicemails and phone calls from Resident 801's attorney's office but had not followed up with the attorney's office because she was too busy. On 7/31/25 at 11:05 AM Staff 1 (Administrator) acknowledged a portion of Resident 801's requested medical records were provided/released to Resident 801's attorney on 4/29/25. Staff 1 acknowledged the requested billing documentation was omitted from the medical records and the billing records were subsequently received by the attorney's office on 7/29/25. On 7/28/25 a public complaint was received which alleged Resident 801 requested her/his medical records on 7/24/25 and had not received them in a timely manner. A review of Resident 801's medical records revealed no documentation indicating the resident received her/his requested medical records. Additionally, there was no evidence found in the medical record of a third-party request for medical records. A Disclosure/Release of Protected Health Information form dated 7/24/25, signed by Resident 801, included a request for her/his history and physical, progress notes, medication list, care plan, all financial data, foot wound care documentation, and notes from a transportation ride to be provided to the resident. On 7/30/25 at 10:10 AM Resident 801 stated she/he had not yet received the records she/he had requested and signed for on 7/24/25, approximately one week earlier. On 7/31/25 at 12:01 PM Staff 1 (Administrator) acknowledged Resident 801 was not provided a copy of her/his medical records which were formally requested on 7/24/24. Staff 1 stated the medical records were not delivered or made available to Resident 801 in the required timeframe.</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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