

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER Belmont Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 812 SE 48th Avenue Portland, OR 97215	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to ensure a registered nurse was available for at least eight consecutive hours for 3 of 46 days reviewed for RN coverage. This placed residents at risk for delayed nursing assessments. Findings include: A review of the Direct Care Staff Daily Reports for 1/31/26 through 3/17/26 revealed the following dates without the required RN coverage:-1/31/26-2/25/26-3/17/26 On 8/6/26 at 3:22 PM Staff 1 (Administrator) acknowledged the identified dates without the required RN coverage.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to ensure an ice machine had the required air gap for 1 of 1 facility ice and water machine reviewed for kitchen sanitation. This placed residents at risk for cross contamination and foodborne illness. Findings include: On 8/6/26 at 11:00 AM a flexible hose drain line was observed coming into the kitchen through a hole in the wall. The drain hose was resting along the edge of the drain and approximately six inches were coiled around and in contact with the bottom of the kitchen drain. The drain line was discolored with splotchy pink areas observed and was connected to the dual ice and water machine on the other side of the wall. On 8/6/26 at 1:17 PM, Staff 13 (Maintenance Director) was observed working on the dual ice and water machine in the dining room. Staff 13 stated he was the person that provided maintenance to the machine and confirmed there was a flexible drain line that went through the shared wall and drained into a kitchen drain. Staff 8 acknowledged the drain hose was in contact with the drain floor and side wall and there was no airgap present (space between a water pipe sink or drain that prevents dirty water from flowing back into the clean water supply). On 8/6/26 at 1:25 PM Staff 12 (Dietary Manager) was informed of the findings.		

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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 appropriate contact precautions for 2 of 3 sampled residents (#s 1 and 32) reviewed for contact precautions. This placed residents at risk for the spread of infection. Findings include 1. Resident 1 admitted to the facility in 2024 with diagnoses including urinary tract infection. A 7/29/26 care plan indicated Resident 1 had a multidrug-resistant organism (type of bacteria resistant to multiple antibiotics) urinary tract infection and staff were to follow Contact Precautions. On 8/3/26 at 12:47 PM a Contact Precautions sign was posted by Resident 1's door, which directed staff to wear gloves and a gown each time they entered the room. On 8/6/26 at 12:12 PM Staff 7 (CNA) entered Resident 1's room and delivered a meal to her/him. Staff 7 did not wear a gown and gloves when she delivered the meal to Resident 1. Staff 7 stated PPE was not required when she delivered a meal to Resident 1. On 8/6/26 at 12:15 PM Staff 2 (DNS) stated staff were to wear required PPE each time they entered Resident 1's room. 2. Resident 32 admitted to the facility in 4/2026 with diagnoses including Crohn's Disease (inflammatory bowel disease). A 7/24/26 Physician Order revealed Resident 32 had an order for vancomycin (an antibiotic) for C. diff (Clostridium difficile, a bacterium which causes an infection of the colon). On 8/3/26 at 12:08 PM a Contact Enteric Precautions sign was posted by Resident 32's door, which directed staff to wash or gel hands prior to entry, wear a gown and gloves, and use soap and water upon leaving the room. On 8/3/26 at 12:08 PM Staff 10 (CNA) exited Resident 32's room and used hand sanitizer before she exited the room. Staff 10 did not wash her hands with soap and water before she exited Resident 32's room. On 8/4/26 at 12:22 PM Staff 9 (CNA) was observed to remove her gown and gloves then sanitize her hands with hand sanitizer when she left Resident 32's room. Staff 9 then walked to the restroom by the nurses station and washed her hands with soap and water. On 8/4/26 at 12:29 PM Staff 9 stated staff were to wash their hands with soap and water after they were in Resident 32's room. Staff 9 stated they could wash their hands in Resident 32's bathroom, but she washed her hands in the restroom at the nurses station restroom. On 8/4/36 at 1:12 PM Staff 10 stated when she exited Resident 32's room she was to sanitize her hands with alcohol-based hand rub and then go to either the soiled linen room or the restroom by the nurses station to wash her hands. On 8/4/26 at 4:10 PM Staff 2 (DNS) stated Resident 32 was on Contact Precautions due to a diagnosis of C. diff and staff were to wash their hands with soap and water before they exited her/his room.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review it was determined the facility failed to provide a homelike environment for 1 of 3 sampled residents (#6) reviewed for respiratory care. This placed residents at risk for unsanitary conditions. Findings include: Resident 6 was admitted to the facility in 2022 with diagnoses including dysphagia. Resident 6's 10/25/25 Annual MDS revealed she/he required a feeding tube for nutrition and had a tracheostomy in place. On 8/3/26 at 3:45 PM Resident 6's room was observed to have a small black fan. The small black fan was very dirty and dusty and appeared to not have been cleaned for a long time. On 8/3/26 at 3:57 PM Witness 1 (Family Member) stated the area next to Resident 6's bed was dirty and often had liquid on it from the tube feeding, and it appeared gross. On 8/6/26 at 9:21 AM Resident 6 had a mattress on the floor in her/his room near the bed which appeared dirty with dried clear debris, the oxygen concentrator had dried clear debris and dust on it, the tracheostomy machine had dried white debris all over it, the black fan had dust all over it, and there was a dirty towel on Resident 6's bed. On 8/6/26 at 9:45 AM Staff 3 (LPN Resident Care Manager) observed Resident 6's room, agreed the room was dirty, and needed to be cleaned daily.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure behavior monitoring was in place related to the use of antipsychotic medication for 1 of 5 sampled residents (#8) reviewed for unnecessary medications. This placed residents at risk for receiving unnecessary medications. Findings include: Resident 8 was admitted to the facility on [DATE] with diagnoses including depression and delusional disorders. A 3/27/26 physician order revealed Resident 8 was prescribed Olanzapine 5 MG (an antipsychotic medication) once daily for delusions. A review of Resident 8's 7/2026 MAR and 5/2026 care plan revealed no identification or monitoring of targeted behaviors related to antipsychotic use. The record did not include any other behavioral documentation to support the use/effectiveness of the medication. On 8/7/26 at 11:02 AM, Staff 4 (Social Services Director) stated Resident 8 was not on behavior monitoring. On 8/7/26 at 11:19 AM, Staff 2 (DNS) stated residents receiving antipsychotic medications were placed on behavior monitoring and confirmed Resident 8 did not have behavior monitoring in place.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review it was determined the facility failed to ensure residents received appropriate pain management for 1 of 3 sampled residents (#23) reviewed for pain. This placed residents at risk for uncontrolled pain. Findings include: Resident 23 was admitted to the facility in 12/2025 with diagnoses including idiopathic aseptic necrosis of right femur (a condition where bone tissue dies often causing pain, stiffness, and limited mobility). A review of Resident 23's Physician Orders revealed a 6/19/26 order for PRN oxycodone every four hours for idiopathic aseptic necrosis of right femur. A 6/24/26 Incident Report revealed: Resident 23 last received her/his PRN oxycodone on 6/23/26 at 10:38 PM and was able to receive it again at 2:38 AM. Resident 23 requested pain medication at approximately 3:00 AM on 6/24/26. Staff 14 (Former LPN) was notified by the CNAs, who stated Resident 23's medications were not yet due. At approximately 4:00 AM Resident 23 went to Staff 14's medication cart and again requested pain medication. Resident 23 reported she received the pain medication at about 4:45 AM and was told by Staff 14 she/he did not receive the medication earlier because she/he was asleep. A review of camera data revealed a CNA staff left Resident 23's room at approximately 2:30 AM and went to Staff 14. At 4:30 AM Resident 23 was seen on camera at the nurses station and spoke with Staff 14, Resident 23 then went to her/his room. Staff 14 was observed for an additional 15 minutes at the nurses station and then Resident 23 received medication at 5:02 AM. On 8/4/26 at 9:49 AM Resident 23 stated on 6/24/26 she/he was in pain and Staff 14 did not give her/him pain medications after the CNAs told Staff 14 she/he was in need of the pain medication. Resident 23 stated her/his right hip was in pain at all times and she/he needed to stay on top of the pain and the pain was rated at a seven or eight out of ten. Resident 23 stated she/he went to Staff 14 and asked for the pain medication, and finally received it after 5:00 AM and could have received it around 2:30 AM. On 8/6/26 at 10:23 AM Staff 14 stated Resident 23 requested pain medication too soon and was able to have the medication around 2:30 AM. By the time she offered pain medications Resident 23 was asleep. Staff 14 stated she went into Resident 23's room at approximately 4:00 AM and she/he was asleep. On 8/6/26 at 12:39 PM Staff 2 (DNS) stated the late prn medication concern was investigated and it was determined Staff 14 waited until after an early morning fire drill to provide Resident 23 with her/his pain medication, which resulted in Resident 23 not receiving the PRN pain medication for seven hours when she/he could have them every four hours. Staff 2 stated Resident 23 was in a lot of pain and needed pain medications. On 8/7/26 at 10:54 AM Staff 8 (CNA) stated when Resident 23 complained of pain on 6/24/26 she notified the nurse of the need for pain medication and was told to write the request on a piece of paper. Staff 8 stated she notified the nurse two to three times of the need for pain medications.		