

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Rose City Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 11325 NE Weidler 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.			
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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interview it was determined the facility failed to ensure contact information for pertinent State agencies was posted and readily available to residents for 1 of 1 facility observed for required postings. This failure placed residents at risk for not having access to information necessary to file a complaint or contact appropriate oversight or protective agencies. Findings include: Random observations from 6/22/26 through 6/24/26 from 8:00 AM to 5:00 PM revealed no facility required posting containing State agency contact information for reporting complaints or other concerns. On 6/24/26 at 2:30 PM a Resident Council meeting was held and attended by 11 residents. Residents were interviewed regarding awareness of how to contact the State Agency and other protective services, including Adult Protective Services (APS). Multiple residents stated they were not aware of how to contact these agencies or where to locate the information within the facility. On 6/24/26 at 2:54 PM Staff 1 (Administrator) stated he was not aware the required posting was not in place and confirmed the poster had not been posted since the facility opened in 9/2025.		

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, interview and record review it was determined the facility failed to ensure foods were properly labeled, dated, and stored in accordance with safe food storage practices in 1 of 1 kitchen reviewed for food sanitation and storage. This placed residents at risk for foodborne illness. Findings include: The facility's Food and Receiving Storage Policy dated 10/2017 indicated the following:-Foods shall be received and stored in a manner that complies with safe food handling practices. -Food in designated dry storage areas shall be kept off the floor.-All foods stored in refrigerator or freezer will be covered, labeled and dated. On 6/22/26 at 9:35 AM during the initial tour of the facility's walk-in refrigerator, walk-in freezer, and dry storage room, the following observations were made:Walk-In Refrigerator:-One glass of chocolate drink lightly covered with plastic wrap not labeled or dated. -One opened 2-gallon container of strawberry yogurt, not dated and lightly covered with plastic wrap. -One opened container of liquid whole eggs not covered, sealed or dated.-One opened container of beef base not dated and lightly covered with plastic wrap.-One opened container of beef-flavored stew base that was not labeled or dated.-Two small containers of salsa not labeled. -One 12-ounce container of wasabi horseradish with an expiration date of 4/2/26.-One 1-pound container of horseradish with an expiration date of 2/15/26.Walk-In Freezer:-One plastic bag of barbeque chicken breast not labeled or dated.-One container of cucumber salad without a lid and not dated.-One plastic bag of granola stored in a 1-gallon bag not labeled or dated.Dry Storage:-Two boxes of unopened juice mix stored directly on the floor.-Two boxes of pancake flour stored in plastic bags not sealed or dated. -Two containers of chopped walnuts in plastic containers not labeled or dated.-One bag of cornbread in a plastic bag not sealed or dated. On 6/22/26 at 10:04 AM Staff 6 (Dietary Manager) acknowledged the identified food items were not stored, labeled, dated, or covered in accordance with facility policy. On 6/23/26 at 1:13 PM Staff 1 (Administrator) stated his expectation was all food items were to be properly labeled and dated upon opening/preparation and that any expired, unlabeled, or undated items were to be discarded immediately.		

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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. Based on interview and record review it was determined the facility failed to follow physician orders for (1 of 5) sampled residents (#3) reviewed for unnecessary medications. This placed residents at risk for discomfort and delay in treatment. Findings include: Resident 3 was admitted to the facility in 10/2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (motor impairments on one side of the body following a stroke). A review of Resident 3's 4/29/26 Quarterly MDS revealed the resident was cognitively intact. On 6/22/26 at 10:33 AM, Resident 3 stated she/he had recurrent UTIs, but could not recall the details of any recent UTIs. On 6/25/26 at 9:20 AM, Resident 3 stated she/he felt very uncomfortable in her/his private areas when she/he had a UTI. A review of Resident 3's physician's orders on 4/9/26 included to send urinalysis with reflex culture (a two-step urine test used to diagnose UTIs), due to the resident's painful urination. A review of Resident 3's clinical record revealed a sample was not collected until 4/19/26, lab results came back on 4/21/26, and a new medication was prescribed on 4/23/26 (14 days later). On 6/25/26 at 2:46 PM, Staff 7 (Physician) confirmed she ordered a urinalysis with reflex culture on 4/9/26, due to the resident experiencing suprapubic discomfort, dysuria and urgency for a week. Staff 7 stated she directly entered the order into the facility electronic health system and the facility's RCM was to follow up on the order. On 6/25/26 at 3:32 PM, Staff 4 (RCM) stated she was unsure what happened to the order for Resident 3's urinalysis with reflex culture on 4/9/26 and stated the electronic health system did not trigger a way for staff to promptly collect a sample. Staff 4 confirmed a sample was not collected until 4/19/26 and the results did not come back until 4/20/26. On 6/26/26 at 10:48 AM, Staff 2 (DNS) stated she was aware Resident 3 had recurrent UTIs and stated she expected staff to confirm and follow physician's orders in order to prevent a delay in Resident 3's treatment.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 3 sampled residents (#43) reviewed for trauma-informed care. This placed residents at risk for re-traumatization and a decrease in their quality of life. Findings include: Resident 43 was admitted to the facility in 5/2026 with diagnoses including PTSD (post-traumatic stress disorder). Resident 43's 6/1/26 Social Service History, Trauma and Substance Use Disorder Assessment revealed the following:-The resident experienced something bad in their childhood but did not want to discuss the trauma.-The resident had a history of substance abuse and homelessness.-The resident's support system was her/his family.-The resident did not have a history of trauma. Resident 43's 6/4/26 admission MDS indicated the resident was cognitively intact and had an active diagnosis of PTSD. Resident 43's 6/11/26 PASARR (Preadmission Screening and Resident Review) Level II identified the following:-The resident had a history of sexual trauma. -The resident experienced significant anxiety, fear of being alone, touch and falling and did not like the lights turned off. -The resident required constant care and verbal reassurance due to severe anxiety and pain.-The resident reacted to touch as if they were being hurt.-The resident enjoyed bible study and to engage in conversations about family. -Staff were to provide care with a trauma-informed approach and needed to recognize that any touch or request may trigger an anticipatory pain response. Resident 43's 6/16/26 Behavior Care Plan revealed the resident's behaviors included being accusatory, agitated and frustrated, and behavior triggers were the resident's medical condition, prior substance use, the change in their environment and anxiety around life choices. The Care Plan identified the following interventions to address the behaviors:-Calmly explain to the resident what you plan to do and reapproach as needed.-Remind the resident to use the call light instead of yelling.-Set boundaries with the resident. -Call the resident's family. On 6/23/26 at 2:16 PM, Witness 1 (Family Member) stated Resident 43 witnessed and experienced physical abuse as a child and experienced additional trauma as an adult around one of her/his children. Witness 1 stated watching religious television shows, talking about religion and providing reassurance were helpful interventions when the resident felt upset. Witness 1 stated no one at the facility had reached out to her to discuss the resident's trauma history or to identify strategies to help the resident when she/he experienced increased emotions or behaviors. On 6/24/26 at 10:53 AM and on 6/25/26 at 12:02 PM, Resident 43 was observed in their room in bed. The door to the room was open and the lights were on. Resident 43 stated they did not like to talk about previous relationships or their children as these conversation topics were a source of trauma. Resident 43 stated they did not like to be touched, and the door to the room needed to be kept open because they were claustrophobic. Resident 43 stated talking to family or someone else who would listen, watching television and listening to a preacher were helpful interventions when they felt upset. Resident 43 stated they were approached at the time of their admission to the facility about their trauma history, but they did not want to discuss it at that time because it hit wrong, and they had not been reapproached since this time. Resident 43 stated they would love staff to reach out to family to discuss their trauma history as it would be in their best interest. Resident 43 stated they would never request staff to not contact her/his family. On 6/24/26 at 11:17 AM, Staff 12 (CNA) stated she was unaware of any past traumas or potential triggers of re-traumatization for Resident 43. Staff 12 stated she was unaware if conversations about the resident's children or past relationships should be avoided, if the resident experienced any issues related to touch or if conversations about religion were helpful for the resident. Staff 12 stated information on a resident's trauma history, potential (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	triggers and interventions to help were found in the resident's care plan. On 6/24/26 at 11:44 AM, Staff 13 (CNA) stated she looked in the care plan to find information about a resident's trauma history. Staff 13 stated she did not know if Resident 43 had experienced any trauma and was unaware if the resident had any issues related to touch. Staff 13 stated the resident was frantic and in panic mode often, and she did not know why. Staff 13 stated she provided reassurance and offered the resident coffee when they were upset. On 6/24/26 at 12:00 PM, Staff 9 (CNA) stated Resident 43 experienced a lot of anxiety, and the resident told her they had been treated so bad in a previous relationship, but the resident did not further elaborate. Staff 9 stated the resident always wanted the door open but was unsure why. Staff 9 stated she was unaware if Resident 43 had a trauma history, but she would look in the resident's care plan to find information on past traumas and potential triggers for re-traumatization. On 6/24/26 at 12:57 PM, Staff 8 (LPN) stated trauma triggers, including conversation topics to avoid, were listed in a resident's care plan. Staff 8 stated she was unaware if Resident 43 had a trauma history or if the resident experienced any issues related to touch. Staff 8 stated the resident always wanted the door open, and she was unaware if conversations about religion and/or the resident's children should be encouraged or avoided. On 6/24/26 at 1:56 PM, Staff 3 (Social Services Director) stated she reapproached residents who declined to complete the trauma assessment at the time of admission the following day, and if the resident continued to decline but had a history of PTSD, she would continually reapproach. Staff 3 stated she constantly reviewed history and physical notes about a resident in an effort to understand their trauma history and would reach out to family members to gain information about a resident's trauma history if the resident agreed. Staff 3 stated she always created a specific care plan for PTSD that was separate from the resident's behavior care plan which included goals, custom interventions and potential trauma triggers. Staff 3 stated she knew Resident 43 had traumatic events happen but the resident did not really tell me a lot. Staff 3 stated she did not reach out to Resident 43's family about the resident's trauma history because the resident did not want her to. Staff 3 stated she did not ask the resident a lot of questions about their past or potential sources of trauma because the resident was all over the place and she thought asking a lot of questions was a trigger. Staff 3 stated she reviewed the resident's PASARR II but had not had a chance to update the resident's care plan to include the recommendations from this evaluation. Staff 3 stated she knew the resident always wanted the door open but never asked the resident why. On 6/25/26 at 9:19 AM, Resident 43 was heard from across the hall to yell at an unidentified staff member, Don't touch me, I don't want her touching me. They just force themselves on you, and I don't want her touching me. On 6/24/26 at 4:15 PM, Staff 1 (Administrator) stated he expected residents with a diagnosis of PTSD to have a care plan that included potential triggers of re-traumatization and resident-specific interventions to assist the resident if triggered. Staff 1 stated Resident 43 loved to talk, he could tell something happened [to the resident] in the past, and he expected staff to dive a little deeper into the resident's past in order to ensure the trauma care plan was comprehensive.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to develop a system to notify the State Long-Term Care Ombudsman's office of residents' facility transfers for 1 of 1 sampled resident (#55) reviewed for hospitalization. This placed residents at risk for lack of advocacy from the ombudsman's office. Findings include. The facility's Transfer or Discharge-Facility Initiated policy, dated 10/2022, indicated when a resident transferred to the hospital or discharged from the facility, a copy of the notice of transfer was provided to the resident and representative and to the Long-Term Care Ombudsman's office when practicable (in a monthly list of residents that included all notice content requirements). Resident 55 was admitted to the facility in 4/2026 with diagnoses including fusion of the spine at the thoracic region (the middle section of the spinal column). Resident 55's 5/4/26 progress notes indicated the resident was transferred to the hospital on 5/4/26 for emergency spinal surgery. On 6/24/26 at 11:09 AM, Staff 3 (Social Services Director) stated she was not responsible for notifying the Long-Term Care Ombudsman's office of transfers or discharges and stated Staff 2 (DNS) notified the ombudsman's office. On 6/24/26 at 11:19 AM, Staff 2 stated she was not responsible for notifying the Long-Term Care Ombudsman's office of transfers or discharges and stated Staff 3 notified the ombudsman's office. On 6/25/26 at 12:24 PM, Staff 1 (Administrator) and Staff 11 (Director of Operations) confirmed the facility had no system in place to notify the Long-Term Care Ombudsman's office of transfers or discharges and stated the facility had not been notifying the ombudsman's office when a resident was transferred or discharged from the facility. Staff 1 stated he expected the ombudsman's office to be notified when the facility transferred or discharged a resident.		