STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385044	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menlo Park Post Acute	745 NE 122nd Avenue Portland, OR 97230

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to timely report an allegation of sexual abuse to the State Agency (SA) for 1 of 3 sampled residents (# 60) reviewed for abuse. This placed residents at risk for abuse. Findings include: The facility's 8/2024 Abuse Screening, Training, Identification, Investigation, Reporting and Protection policy directed the following: -Any suspicion of a crime requires notification of law enforcement and the State survey agency immediately by the person who first forms the suspicion of the crime for sexual abuse. -If, with the suspicion of a crime, there is abuse or a serious injury, the staff member must report the incident within 2 hours of forming the suspicion to law enforcement and the State survey agency. Resident 60 was admitted to the facility in 7/2024 with diagnoses including C-difficile infection (a bacterial infection in the colon). Resident 60's 10/15/24 Quarterly MDS indicated the resident had intact cognition. Resident 13 was admitted to the facility in 6/2024 with diagnoses including diabetes and alcohol induced cirrhosis of the liver (damage to the liver due to alcohol abuse). Resident 13's 9/24/24 Quarterly MDS indicated the resident had intact cognition. The facility's 10/27/24 FRI form, completed by Staff 24 (LPN) revealed the following: -Resident 60 alleged Resident 13 touched her/his genital area while she/he slept and upon waking, she/he asked the resident to leave and Resident 13 left the room. -On 10/27/24 around 7:00 AM, Staff 1 (Administrator) was notified by a nurse at the facility that Resident 60 reported being inappropriately touched by Resident 13. -Staff 25 (CNA) confirmed seeing Resident 13 exit Resident 60's room but did not see Resident 13 entering or in Resident 60's room. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Facility security cameras saw Resident 13 in the vacinity of Resident 60's room but did not see Resident 13 enter or exit Resident 60's room. -Resident 13 denied inappropriately touching Resident 60. -The SA was notified of the incident on 10/27/24 at 11:05 AM. On 11/4/24 at 9:54 AM Resident 60 stated she/he was in her/his room waiting for the wound care nurse to come and complete wound care treatment. Resident 60 stated she/he fell asleep and around 11:00 PM on 10/26/24 was awakened because Resident 13 was touching her/his pubic hairs. Resident 60 stated Resident 13 was shocked when she/he woke up and Resident 13 quickly disappeared. Resident 60 stated she/he activated her/his call light and Staff 25 (CNA) responded. Resident 60 stated she/he reported the alleged sexual abuse to Staff 25 who then reported the alleged sexual abuse to Staff 24. On 11/4/24 at 2:51 PM Staff 1 stated he was notified of Resident 60's alleged sexual abuse when he arrived to work on 10/27/24 and began working on the investigation around 7:00 AM. He stated it was his understanding that he had 24 hours to report an allegation of abuse unless there was serious bodily injury so he wanted to complete the investigation prior to notifying the SA. On 11/4/24 at 6:02 PM Staff 25 stated she arrived for her scheduled night shift assignment and was getting report when Resident 60 activated her/his call light. Staff 25 stated she walked towards Resident 60's room and noticed Resident 13 in her/his wheelchair, backing out of Resident 60's room. Staff 25 stated, initially, Resident 60 reported being upset because the wound care nurse had not shown up, so she informed Resident 60 she would notify the night shift charge nurse regarding the resident's concern. Staff 25 stated approximately five minutes later, Resident 60 activated her/his call light again. Staff 25 stated when she arrived in Resident 60's room, the resident told her that Resident 13 had put her/his hand up her/his brief and inappropriately touched her/him. Staff 25 stated she notified Staff 24 between 10:30 PM and 10:50 PM regarding Resident 60's alleged sexual abuse. Staff 25 stated Staff 24 spoke with Resident 60 between 11:00 PM on 10/26/24 and 12:00 AM on 10/27/24. On 11/4/24 at 7:36 PM Staff 24 stated around 12:30 AM on 10/27/24, Staff 25 informed her that Resident 60 wanted to speak with her. Staff 24 reported Resident 60 notified her that Resident 13 had touched her/him inappropriately on her/his upper thigh and private area. Staff 24 stated she attempted to call a nurse manager but they were unreachable so she notified the nurse manager and Staff 1 in the morning. Staff 24 stated she did not report the allegation of sexual abuse to law enforcement or the SA within two hours because she was not familiar with the timeframe for reporting abuse allegations. On 11/6/24 at 11:01 AM Staff 2 (Interim DNS) stated there was some confusion as to the required timeframe for reporting allegations of abuse so the allegation was not reported within the mandated timeframe. Staff 2 stated the expectation was any abuse allegations were reported to the SA immediately but no longer than two hours of the alleged incident.