STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385133	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairlawn Health and Rehab of Cascadia	3457 NE Division Street Gresham, OR 97030

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on interview and record review it was determined the facility failed to complete a discharge summary for 1 of 3 sampled residents (#1) reviewed for discharge. This placed residents at risk for unmet discharge needs. Findings include: Resident 1 admitted to the facility on ,d+[DATE] with diagnoses including malnutrition. Resident 1's care plan, revised 9/29/23, revealed she/he planned to discharge home and the facility would make referrals for home health, physical and occupational therapy, and other medically related services. On 11/18/24 at 11:05 AM, Staff 4 (Social Services Director) stated she was responsible for resident discharges. She stated she made community referrals including home health, faxed physician orders to community providers and completed discharge summaries as part of the discharge process. She confirmed Resident 1 did not have a discharge summary in her/his clinical record in 2023. On 11/19/24 at 10:16 AM, Witness 1 (Home Health Staff) stated she attended a care conference a couple of days before Resident 1 discharged last year. The facility agreed they would make referrals for home health and send the necessary paperwork to the home health agency. Witness 1 stated she made multiple phone calls to Staff 3 (Previous SSD) requesting physician orders and instructions but did not receive a return call from anyone at the facility. Resident 1's clinical record was reviewed and did not include a discharge summary. Progress notes revealed she/he discharged home on 9/17/23. Staff 3 was no longer working at the facility and unable to be interviewed. On 11/21/24 at 3:30 PM, Staff 1 (Administrator) was informed of the investigative findings and provided no additional information.

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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(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** 42222 Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 3 sampled residents (#s 3 and 4) reviewed for bowel care. This placed other residents at risk for bowel complications. Findings include: On 3/31/24, the Past Noncompliance was corrected when the facility implemented an updated bowel protocol, which included: -Bowel protocol binders are located at each nursing station; -New bowel forms were created for every resident and reviewed daily; -Residents with no documented bowel movement after 72 hours were added to the list, monitored and followed up by nursing staff; -Staff in-serviced on the facility's bowel protocol. -Interviews conducted with nursing staff and confirmed bowel protocol was in place. 1. Resident 3 admitted to the facility in 9/2023, with diagnoses including atrial fibrillation and constipation. Resident 3's physician orders dated 9/28/23 indicated she/he was to be administered bowel medications daily. The bowel protocol on the resident's orders and 10/2023 MAR indicated the following steps were to be taken: -Step 1-Administer 17 grams of Polyethylene Glycol Powder every 48 hours for no bowel movement in two days. -Step 2-Administer Bisacodyl suppository every 72 hours for no bowel movement in three days. If resident refused the suppository, administer two Bisacodyl tablets every 72 hours. -Step 3-Administer a Fleet Mineral Oil enema for no bowel movement in four days. -Step 4-Administer Lactulose Solution, 30 ml every 8 hours as needed if unrelieved by bowel protocols. Resident 3's bowel logs for 10/2023 revealed no bowel movement from 10/22/23 through 10/31/23. Resident 3's 10/2023 MAR revealed she/he was given the following bowel medications and results: -10/25/23 (three days after no bowel movement): Polyethylene Glycol Powder: Results - ineffective -10/25/23: Bisacodyl tablets (3 days after no bowel movement): Results - ineffective (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/30/23: Bisacodyl Suppository (8 days after no bowel movement): Results - ineffective -10/31/23: Fleet Mineral Oil enema (9 days after no bowel movement): Results - ineffective -10/31/23: Lactulose Solution (9 days after no bowel movement): Results - unknown A nursing note dated 11/1/23 stated CMA informed LN that patient is going on day 11 of no BM. Enema was given yesterday with no results. LN performed bowel assessment, abdomen soft and round, bowel tones in all four quadrants. Denies nausea or vomiting, denies any pain, eating and drinking well. Provider aware of lack of bowel movement, per verbal from provider scheduled 30 ml of Lactulose q 8 hrs until BM. Orders updated. Resident 3's 11/2023 bowel log revealed she/he had a large bowel movement on 11/3/23. Resident 3 was not interviewed due to discharging from the facility. On 11/21/24 at 1:08 PM, Staff 2 (DNS) confirmed the resident's bowel protocol was not followed. 2. Resident 4 admitted to the facility in 10/2023 with diagnoses including stroke. Resident 4's physician orders dated 10/20/23 indicated she/he was to be administered bowel medications daily. The bowel protocol on the resident's orders and her/his 10/2023 MAR indicated the following steps were to be taken: -Step 1-Administer 17 grams of Polyethylene Glycol Powder every 48 hours for no bowel movement in two days. -Step 2-Administer Bisacodyl suppository every 72 hours for no bowel movement in three days. If resident refused the suppository, administer two Bisacodyl tablets every 72 hours. -Step 3-Administer a Fleet Mineral Oil enema for no bowel movement in four days. -Step 4-Administer Lactulose Solution, 30 ml every 8 hours as needed if unrelieved by bowel protocols. Resident 4's Nursing Admission assessment dated [DATE] revealed no bowel movement since 10/18/23, when she/he was hospitalized . Resident 4's bowel logs revealed no bowel movement from 10/20/23 through 10/23/23. Resident 4's 10/2023 MAR revealed she/he was not given Polyethylene Glycol Powder from 10/20/23 through 10/23/23 and was not given a Bisacodyl suppository until 10/24/23, six days after her/his last bowel movement. The MAR indicated the suppository administered 10/24/23 was effective. Resident 4 was no longer in the facility and was unable to be interviewed. On 11/21/24 at 3:30 PM, Staff 1 (Administrator) and Staff 2 (DNS) were informed of the investigative findings and provided no additional information.