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	12/06/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 47000 Based on interview and record review it was determined the facility failed to ensure a safe discharge for 1 of 2 sampled residents (#210) reviewed for safe discharges. This placed residents at risk for unmet care needs. Findings include: Resident 210 was admitted to the facility in 7/2024 with diagnoses including periprosthetic fracture around other internal prosthetic joint (a bone fracture that occurs near or around a joint replacement implant). Resident 210's 7/31/24 St. Louis University Mental Status Examination (SLUMS) score indicated the resident experienced dementia. Resident 210's 9/5/24 Discharge MDS Assessment revealed the resident was cognitively intact, had an indwelling catheter, was occasionally incontinent of urine, required setup or clean-up assistance with showering and to put on or take off foot wear and required supervision or touch assistance with car transfers and to go up or down a curb or one step. Resident 210's 9/5/24 Physician Orders directed the resident to receive hydralazine (a medication used to treat high blood pressure) three times daily. The medication was to be held for a systolic (the highest pressure in your arteries when your heart beats) blood pressure less than 110. A review of Resident 210's 9/2024 Progress Notes revealed the following: -A 9/2/24 Progress Note revealed Resident 210 continued to experience episodes of dizziness, unstable blood pressures and urine retention. -A 9/3/24 Physician Order directed the resident to be straight catheterized (a procedure that involves inserting a straight catheter into the urethra to drain the bladder) if her/his post void residual (PVR, the amount of urine left in the bladder after urinating) was more than 300 ml every six hours. If the resident continued to have greater than 300 ml PVR, the resident was to be straight catheterized again. If she/he was straight catheterized three times, a foley catheter (a medical device that helps drain urine from the bladder) was to be inserted. If she/he refused the foley catheter, the resident was to be sent to the emergency department. -A 9/3/24 Skilled Charting Note revealed the resident was concerned about her/his ongoing urine retention and decided the safest thing would be to discharge home with a foley catheter. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A 9/3/24 Social Service Note indicated Resident 210 wanted to discharge on 9/5/24. -A 9/5/24 Social Service Note written at 1:28 PM indicated Witness 2 (Family Member) was called per Resident 20's request to notify Witness 2 of her/his discharge. -A 9/5/24 Health Status Note written at 4:15 PM indicated Resident 210 had a foley catheter re-inserted STAT (immediately) prior to her/his discharge from the facility. Resident 210's 9/5/24 Utilization Review Physical Therapy Progress Section revealed the resident lived with family in a one story home with three steps to enter. The resident required a front wheel walker and supervision with transfers. The Discharge Plan Section indicated the discharge plan was for the resident to go home with Witness 2 and with home health but home health had not been ordered. Resident 210's 9/5/24 Planned Discharge Summary revealed the resident discharged from the facility on 9/5/24 at 2:00 PM, went home as planned and was accompanied home by the driver of a transportation company, needed assistance with lower extremity dressing, personal hygiene and with stairs and was moderately independent for making decisions. In the section of the summary entitled Resident Education Materials Provided, there was no check in the boxes for catheter care or monitor blood pressure. Resident 210's 9/5/24 Physician Discharge Summary indicated the resident discharged home with family on 9/5/24 at 2:06 PM. No evidence was found in Resident 210's clinical record to indicate she/he was could independently administer her/his medications or provide her/his own catheter care, the resident was safe to be alone when she/he experienced on-going episodes of dizziness, the resident's family was notified of her/his discharge from the facility prior to her/his day of discharge, confirmation a family member would be at the resident's house to assist the resident with the stairs or care as needed on the day she/he discharged from the facility or that a family member had received instructions on the resident's medications or catheter care. On 12/5/24 at 11:04 AM Resident 210 stated she/he informed the facility she/he intended to discharge from the facility on 9/5/24 weeks in advance of her/his discharge. Resident 210 stated on her/his day of discharge, everyone was running around to get paperwork done at the last minute. Resident 210 stated she/he did not recall reviewing her/his medication list at the time of discharge or care for her/his catheter. (continued on next page)

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 12:15 PM Witness 2 stated Resident 210's discharge from the facility was really confusing and sad and there was no communication regarding a plan to discharge. Witness 2 stated she was initially informed of Resident 210's discharge from the facility on 9/5/24, just two hours prior to when Resident 210 was anticipated to arrive home. Witness 2 stated when she was informed of the discharge, she told the facility she was out of town and did not know if she would be home at the time Resident 210 arrived. Witness 2 stated she was informed at this time that the resident would be returning home with a foley catheter in place and she had not been trained on the care of a foley catheter. Witness 2 stated she was not informed of what medications the resident was discharged with prior to her/his discharge or if she/he had the necessary supplies for her/his catheter. Witness 2 stated the medication card that contained the resident's blood pressure medication did not match the orders the facility sent home with the resident, and when Resident 210's blood pressure dropped, she/he was not cognitively with it. Witness 2 further stated home health was not set up at the time of Resident 210's discharge, and it was the facility's responsibility to make sure we had the resources available when the resident returned home since we live in a small community where access to resources was limited and home health services were over an hour away. On 12/5/24 at 1:48 PM Staff 13 (CNA) stated Resident 210 was confused and forgetful mostly daily. Staff 13 stated Resident 210 could not independently complete her/his own catheter care at the time of her/his discharge. On 12/6/24 at 11:26 AM Staff 15 (RNCM) stated family was to be notified of a discharge three days ahead of time and throughout the stay. Staff 15 stated residents with a foley catheter required education on catheter care and nurses should document resident abilities in the progress notes. Staff 15 stated residents with medication parameters, such as holding a medication dependent on a blood pressure reading, would need to be trained to take their blood pressure. Staff 15 stated if a resident was determined to discharge home with family, a family member would have to be present when going through all of the patient's medications and she would expect a family member present for catheter care instructions as well. Staff 15 stated Resident 210 had a foley catheter placed the day she/he discharged from the facility because the resident could not straight catheterize on [her/his] own. Staff 15 stated Resident 210 experienced intermittent dizziness, the resident's blood pressure was kind of elevated and staff worked with the resident's provider to change her/his cardiac medication to see what would work. Staff 15 stated the plan was for Resident 210 to discharge home with Witness 2 as the resident required assistance with her/his catheter, needed assistance with transfers for safety reasons and was unable to care for her/himself when dizzy. Staff 15 stated Resident 210's foley catheter was placed at the last minute and the family would have needed some kind of training. Staff 15 reviewed Resident 210's clinical record and confirmed there was no documentation to indicate the family was informed of her/his discharge from the facility prior to her/his date of discharge or that the family was provided any education regarding care of the resident's catheter or medication administration. On 12/6/24 at 12:08 PM Staff 5 (Social Services) stated she was aware of Resident 210's plan to discharge a couple of days prior to her/his actual discharge from the facility on 9/5/24. Staff 5 stated she thought she tried to call Witness 2 to inform her of the resident's discharge on 9/4/24 but she did not connect with Witness 2 or leave her a voicemail. Staff 5 stated she spoke with Witness 2 on 9/5/24 about the resident's discharge and was told Witness 2 may not be home when the resident arrived. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 1:26 PM Staff 16 (Physical Therapy Assistant) stated Resident 210 lived with family way far away. Staff 16 stated Resident 210 needed supervision to do the steps at home and needed someone to always be with [her/him] at home. On 12/6/24 at 2:22 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and Staff 2 stated more training and documentation was needed.