| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385133 | A. Building<br>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<br>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.

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690<br><br>Based on observation and interview it was determined the facility failed to ensure a homelike environment for 1 of 2 resident rooms (room [ROOM NUMBER]) reviewed for environment. This placed residents at risk for a lessened quality of life. Findings include:<br><br>An observation on 12/2/24 at 9:56 AM revealed the cloth recliner chair in room [ROOM NUMBER] was stained with an unknown brown dried residue on the seat of the chair and on the arm rests.<br><br>On 12/4/24 at 2:14 PM Staff 10 (CNA) stated the chair in room [ROOM NUMBER] was filthy and did not have a cleanable surface.<br><br>On 12/4/24 at 2:23 PM Staff 3 (Infection Preventionist) stated the chair was very dirty and did not have a cleanable surface.<br><br>On 12/6/24 at 12:54 PM Staff 12 (Housekeeping) stated she had a monthly cleaning schedule for resident recliners but did not clean the one in room [ROOM NUMBER] because it was cloth.<br><br>On 12/6/24 at 2:20 PM Staff 1 (Administrator) confirmed the chair was dirty and had a bad odor. |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053<br><br>Based on observation, interview and record review it was determined the facility failed to ensure safety interventions for fall prevention were followed for 1 of 4 residents (#26) reviewed for accidents. This placed residents at risk for accidents. Findings include:<br><br>Resident 26 was admitted to the facility on [DATE] with diagnoses including age-related osteoporosis with a current pathological fracture of her/his left femur (a chronic disease that causes bones to become brittle and porous, and a broken upper-leg bone) and severe vascular dementia with agitation (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain).<br><br>A review of Resident 26's 9/30/24 Quarterly MDS Assessment revealed she/he had severe cognitive impairment.<br><br>Resident 26's 9/30/24 Quarterly Fall Risk Assessment indicated she/he was at risk for falls related to her/his incontinence, impaired cognition and impaired functional mobility.<br><br>A review of Resident 26's care plan revealed she/he had a low bed and it was to be against the wall and in the lowest position with a fall mat at her/his bedside to minimize her/his risk of injuries from falls.<br><br>On 12/3/24 at 10:01 AM Resident 26 was observed to be in bed with a fall mat at her/his bedside. Her/his bed was elevated to a level for transfers and was not in the low position. There were no caregivers in her/his room.<br><br>On 12/5/24 at 9:24 AM Resident 26 was observed to be in bed, awake and watching television with the head of the bed elevated to approximately 30 degrees. There was a fall mat on the floor beside the bed and the bed was elevated to a height appropriate for wheelchair transfers. The bed was not in the low position and there were no caregivers in the room.<br><br>On 12/5/24 9:59 AM Staff 13 (CNA) stated Resident 26 was part of the facility's Falling Star program which indicated staff were to look inside Resident 26's room whenever they passed it to make sure she/he had not fallen, there was a fall mat at her/his bedside and her/his bed was in the lowest position. Staff 13 confirmed Resident 26 was in her/his bed and the bed was in wheelchair transfer height. Staff 13 stated Resident 26's bed should be in the lowest position when she/he was in it.<br><br>On 12/5/24 at 11:23 AM Staff 15 (RN) stated Resident 26 was assessed to be at risk for falls and had a history of falls. She stated she expected CNAs to follow Resident 26's care plan for her/his safety.<br><br>On 12/6/24 at 10:28 AM Staff 3 (LPN / Infection Preventionist) stated Resident 26 often sat in bed with her/his legs dangling over the edge and it made us nervous. He added this was one of the reasons for Resident 26's fall prevention interventions.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/06/24 at 2:23 PM Staff 1 (Administrator) stated she expected staff to follow care planned interventions because Resident 26 was at risk for falls. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>43691<br><br>Based on observation, interview and record review it was determined the facility failed to follow catheter care orders for 1 of 1 resident (# 53) reviewed for catheter care. This placed residents at risk for unmet care needs. Findings include:<br><br>Resident 53 was initially admitted to the facility in 10/2024 with diagnoses including urine retention (difficulty urinating) with the use of a Foley catheter to remove urine from the bladder.<br><br>A 10/3/24 BIMS indicated Resident 53 had normal cognitive function.<br><br>A 12/3/24 Neurosurgery Postoperative Visit note included instructions for Resident 53's Foley catheter to be changed after she/he returned to the nursing facility.<br><br>A 12/3/24 physician order stated the following: Change Foley ASAP, was not changed during hospitalization .<br><br>On 12/4/24 at 9:53 AM Resident 53 stated she/he returned to the facility after a surgical procedure at the hospital and had orders to have her/his catheter changed immediately. Resident 53 stated her/his Foley catheter was not changed on 12/3/24.<br><br>On 12/5/24 at 9:50 AM Resident stated her/his Foley catheter was not changed on 12/4/24.<br><br>Review of the 12/2024 TAR on 12/5/24 revealed Resident 53's Foley catheter change was not completed on 12/3 or 12/4.<br><br>On 12/5/24 at 10:28 AM Staff 20 (RCM/LPN) stated Resident 53's catheter should have been changed as soon as possible and confirmed that change was not performed as ordered on 12/3/24 or 12/4/24.<br><br>On 12/5/24 at 11:13 AM Staff 18 (RN) stated she provided care to Resident 53 on 12/3/24 and confirmed she did not change Resident 53's Foley catheter. Staff 18 stated she intended to contact Resident 53's physician for clarification of catheter change orders, but did not contact the physician.<br><br>On 12/5/24 at 12:03 PM Staff 19 (LPN) stated she provided care to Resident 53 on 12/4/24 and confirmed the Foley catheter change was not completed because she ran out of time.<br><br>On 12/5/24 at 11:37 AM Staff 2 (DNS) confirmed Resident 53's catheter was not changed as ordered. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>46053<br><br>Based on observation, interview and record review it was determined the facility failed to ensure food and beverages were labeled and stored in a manner to minimize spoilage and cross contamination for 1 of 1 kitchen reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include:<br><br>1. The facility's 4/2018 Food Storage: Cold Foods Policy Statement specified, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.<br><br>The facility's 9/2017 Food Storage: Dry Goods Policy Statement specified, All packaged and canned food items will be kept clean, dry, and properly sealed.<br><br>On 12/2/24 at 9:43 AM during the initial tour of the facility's kitchen, the following was observed:<br><br>-Three trays of unlabeled and undated cups of milk and juice on the top shelves of the middle and right refrigerators in the food preparation area;<br><br>-An uncovered and unlabeled large plastic bin of dry oat cereal sitting on the top shelf of a wheeled cart in the dry storage room;<br><br>-An opened and undated five-pound plastic tub of peanut butter with peanut butter smeared on the top and edge of the lid and on the sides of the tub on the top shelf of a wheeled cart in the dry storage room. The tub was slick and unclean;<br><br>-An opened and undated bag of salad greens on the top shelf of the refrigerator in the dry storage room; and<br><br>-A plastic bin containing four eggs, one with a broken shell, on the bottom shelf of the refrigerator in the dry storage room.<br><br>On 12/2/24 at 9:55 AM Staff 14 (Dietary Manager) stated the lettuce shouldn't be left open as it was observed. She added, It needs to be closed up and wrapped with plastic and labeled with a date. She acknowledged the cracked shell and stated she expected staff to throw out any eggs with broken shells. She added, The peanut butter is definitely not clean like that. It should be wiped down during the process if it gets messy. Staff 14 also stated the bin of oat cereal should was not be uncovered in dry storage storage. She expected the bin to be emptied and taken to the dishwashing station rather than left uncovered in the dry storage room.<br><br>2. The facility's 9/2017 Equipment Policy Statement specified, All non-food contact equipment will be clean and free of debris<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/2/24 at 10:06 AM the gaskets on the interiors of the refrigerator doors were observed to be grimey with solid and liquid food debris collected in the plastic flanges. The gaskets were observed to be pulling away from doors which created an incomplete seal. Staff 14 (Dietary Manager) stated she cleaned the gaskets regularly but they got dirty again because they are old and they don't close well. Stuff drops from above. Staff 14 stated she expected her staff to keep it clean because It shouldn't be like this. Staff 14 stated the facility needed a new refridgerator.<br><br>3. On 12/2/24 at 10:07 AM the kitchen was observed to have multiple dirty in-floor drains. The drain opposite the food preparation and steam table area had black grime caked around the inset grate.<br><br>The drain adjacent to the ice machine was also observed to be caked with so much black grime it was not possible to see the inset grate. Additionally, food debris and other kitchen waste was observed on the floor adjacent to the drain next to the ice machine.<br><br>Staff 14 (Dietary Manager) confirmed these observations and stated the drains were dirty and needed to be cleaned.<br><br>On 12/6/24 at 2:14 PM Staff 1 (Administrator) acknowledged these findings and stated she expected the kitchen staff to keep the kitchen clean and sanitary and items should be covered, labeled and dated to prevent spoilage and cross-contamination. |