

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Woodside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Ridings Avenue Molalla, OR 97038	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident was safe from elopement for 1 of 1 sampled resident (#9) reviewed for elopement. This failure, determined to be an immediate jeopardy situation, resulted in Resident 9 leaving the facility without appropriate supervision and placed the resident at risk for serious injury or death. Findings include:</p> <p>Resident 9 admitted to the facility on [DATE] with diagnoses including stroke and dementia.</p> <p>The 7/30/24 hospital referral records indicated Resident 9 was withdrawn, and answered most questions with, I don't know. The record indicated, disorientation noted overnight and patient trying to leave, though was redirectable. The record also indicated, At this time the resident does not have the capacity to make decisions regarding leaving the hospital so [she/he] would be placed on elopement precautions.</p> <p>Resident 9's Elopement Risk Evaluations indicated the following:</p> <p>-8/20/24: the resident had poor impulse control and was at risk for elopement.</p> <p>-9/12/24: the resident had two attempts to get out of the side door unattended.</p> <p>-11/5/24: the resident eloped, did not communicate when leaving, and left to the community.</p> <p>The 9/12/24 care plan indicated Resident 9 had impaired cognitive function related to dementia and was an elopement risk due to impaired safety awareness.</p> <p>Progress Notes indicated the following:</p> <p>-8/27/24: Resident unable to communicate wants and needs, has a history of wandering and innocently wandered out of facility about 6:00 PM.</p> <p>-8/28/24: Resident wandered out of the facility about 6:00 PM. The note stated, Located 5 minutes at back entrance of facility.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-9/12/24: Resident Care Manager notified by medication aide that the resident attempted to leave the building out the side door two times yesterday. The resident was easily redirected, but was confused with cognitive impairment. The resident's information was placed in elopement book.</p> <p>-11/3/24 at 1:30 PM: The note indicated staff were notified that Resident 9 absconded from the facility's property, local law enforcement was notified. Administrative staff were notified and were waiting for local law enforcement.</p> <p>-11/3/24 at 2:45 PM: Resident 9 returned to the facility unharmed, and stated, I'm cold. The resident was offered hot chocolate and a snack.</p> <p>-11/5/24: Resident 9 stated she/he would like to leave and go home, staff asked if she/he knew how to get there, and the resident stated, No. Later in the shift the resident was seen at the back door looking up in the doorway to show the nurse she/he knew the door code. The nurse told the resident it was dark and cold and she/he should not go outside. The resident stated, ok. The resident continued to walk around the building but no other attempts to get outside of the door were made.</p> <p>-11/10/24 at 11:56 AM: Resident 9 was found in the parking lot in the morning, was able to be redirected back to the facility, and then asked when she/he would be discharged .</p> <p>No facility investigations were found related to Resident 9's elopements on 8/27/24, 8/28/24, and 11/10/24.</p> <p>The 11/7/24 Facility Investigation of the 11/3/24 elopement indicated on 11/3/24 at 1:30 PM staff became aware Resident 9 was missing and the on duty nurse called local police to notify them that the resident was not able to be located. During this time the facility received a call from the off-duty Activities Director who reported she saw Resident 9 at a convenience store parking lot about ten minutes walking distance from the facility. The resident was quickly redirected back to the facility and was back inside the facility by 2:30 PM. No harm or injuries were noted at the time of her/his return. The resident was fully clothed in a long-sleeved shirt and jeans but did make a statement that she/he was cold. She/he was given a blanket and some hot chocolate to warm up and was content. During the time Resident 9 was gone, staff thought she/he was wandering around the facility or the outdoor courtyard per her/his usual routine.</p> <p>Observations on 11/13/24 from 10:54 AM through 3:06 PM revealed Resident 9 walked independently throughout the facility, participated in activities, and sat on the bed in her/his room.</p> <p>On 11/13/24 at 11:18 AM one of the facility's exit doors was observed to open without entering a code. The outside area led to a set of double gates that were open and led to the road.</p> <p>On 11/13/24 at 11:30 AM Staff 1 (Administrator) was observed to walk out of the identified exit door without entering a code. Staff 1 stated the door was supposed to shut and lock. Staff 1 acknowledged the door leading to the outside area was unlocked and the outside area led to the road and parking lot.</p> <p>On 11/13/24 at 11:36 AM Staff 3 (Maintenance Director) was observed to walk out the identified exit door without entering a code. Staff 3 acknowledged the door was not locked and stated a code should be entered to unlock the door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The immediacy was removed on 11/14/24 after verifying the plan of correction was sufficiently implemented.</p>		