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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385222 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/12/2024 |
| NAME OF PROVIDER OR SUPPLIER Meadow Park Care | | STREET ADDRESS, CITY, STATE, ZIP CODE 75 Shore Drive Saint Helens, OR 97051 | |

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) |
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| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>46054</p> <p>Based on interview and record review it was determined the facility failed to provide a written discharge notice to the resident and failed to notify the resident's representative of a discharge for 1 of 1 sampled resident (#2) reviewed for discharge. This placed residents at risk for lack of information regarding discharge and for their representatives being notified. Findings include:</p> <p>Resident 2 was admitted to the facility in 9/2024, with diagnoses including encephalopathy (a condition that affects the brain) and dementia.</p> <p>A review of Resident 2's clinical record revealed Resident 2 was not provided a written notice to the resident or the resident's representative regarding discharge from the facility on 10/26/24.</p> <p>On 10/30/24 at 1:23 PM, Staff 6 (LPN) stated Resident 2 was not provided a written discharge notification prior to discharge.</p> <p>On 10/30/24 at 3:23 PM, Witness 1 (Resident Representative) stated she/he was not notified or provided with written documentation of Resident 2's 10/26/24 discharge.</p> <p>On 11/4/24 at 1:31 PM, Staff 2 (DNS) confirmed the findings and stated the discharge paperwork for Resident 2 was not completed or provided to Resident 2 prior to her/his 10/26/24 discharge.</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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| (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 - Minimal harm or potential for actual harm</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>46054</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received adequate supervision to prevent an elopement for 1 of 3 sampled residents (#2) reviewed for accidents. This placed residents at risk for elopement from the facility. Findings include:</p> <p>Resident 2 was admitted to the facility in 9/2024, with diagnoses including encephalopathy (a condition that affects the brain) and dementia.</p> <p>Resident 2's 9/5/24 Care Plan revealed the resident as a fall risk due to visual and sensory communication issues including the inability to see at night, hearing loss due to a history of tinnitus, and vertigo. Facility interventions included monitoring and reporting any changes in Resident 2's cognition, decision making abilities, recall, and awareness of her/his surroundings.</p> <p>On 10/30/24 at 1:13 PM, Staff 4 (CNA) stated she and Staff 5 (CNA) identified Resident 2 was missing from the building and located Resident 2 approximately one mile away from the facility.</p> <p>On 10/30/24 at 1:25 PM, Staff 6 (LPN) confirmed Resident 2 had eloped from the facility without staff's awareness.</p> <p>On 10/31/24 at 11:51 AM, Staff 5 (CNA) reported that she saw Resident 2 on the side of the highway on her way to work. Staff 5 stated upon arriving to work, she reported the incident and Staff 4 and her went to look for Resident 2. Staff 5 confirmed Resident 2 was found on the side of the highway 30 minutes later after being initially spotted by staff. Staff 5 stated Resident 2 reported feeling lost and confused after she/he was found. Staff 5 reported Resident 2's elopement was a result of the facility being short staffed with CNAs. Staff 5 indicated the facility was short 2 CNAs for Day Shift on 10/26/24 prior to Resident 2's elopement earlier that morning.</p> <p>On 10/31/24 at 1:33 PM, Staff 7 (Assigned CNA) stated Resident 2 eloped from the facility as a result of the facility being short staffed. Staff 7 confirmed the facility was short 2 CNAs during Resident 2's elopement on 10/26/24 and could not safely monitor residents to prevent an elopement.</p> <p>A review of the facility's 10/2024 Direct Care Daily Staff Report revealed the facility was short 2 CNAs on 10/26/24.</p> <p>On 11/4/24 at 1:31 PM, Staff 2 (DNS) confirmed the findings and stated the lack of CNA staff attributed to Resident 2's elopement from the facility.</p> | | |