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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385237	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernhill Rehabilitation and Care	5737 NE 37th Avenue Portland, OR 97211

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42222 Based on observation, interview, and record review it was determined the facility failed to implement the plan of care for 1 of 3 sampled residents (#1) reviewed for resident safety and elopement. This placed residents at risk of an unsafe elopement. Findings include: Resident 1 admitted to the facility in 5/2024, with diagnoses including schizophrenia and dementia. Resident 1's 8/23/24 MDS Quarterly revealed a BIMS score of 0, indicating severe cognitive impairment. An elopement risk evaluation dated 8/23/24, revealed Resident 1 was a high elopement risk and she/he frequently stood by the entrance door, stating she/he wanted to leave. Resident 1's care plan dated 10/15/24 revealed she/he was an elopement risk/wanderer with a history of attempts to leave the building unattended and she/he had impaired safety awareness. Interventions were to distract the resident by offering diversions, activities, food, conversation, television or a book. On 12/3/24 at 11:39 AM, Staff 10 (CNA) stated she was Resident 1's assigned CNA. She stated staff was aware to watch the resident from leaving and to re-direct the resident. She was not able to describe how to re-direct Resident 1 and stated she had been assigned to Resident 1 twice. On 12/3/24 at 11:43 AM, Staff 11 (CNA) stated she knew Resident 1 had a history of attempting to leave the building and staff was to re-direct the resident and encourage the resident to write in her/his notebook. On 12/3/24 at 11:57 AM, Staff 12 (CNA) stated staff was supposed to watch Resident 1 because she/he liked to escape. (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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NAME OF PROVIDER OR SUPPLIER Fernhill Rehabilitation and Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5737 NE 37th Avenue Portland, OR 97211	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 from 11:22 AM through 12:07 PM, Resident 1 was observed in the South Hall. The resident was seated on an inoperable heating unit which was located right by the front door. Resident 1 was observed writing in a notebook and watching staff as they came into the facility and left the facility. The door was locked and required a security code to be opened from the inside, but no code was required for visitors or staff entering the facility. During the observation period, several CNAs, a Physical Therapist and other facility staff was observed in the South Hall where Resident 1 was seated. During the observation period, no staff attempted to distract or provide a diversion to Resident 1 as care planned. At 12:07 PM, Staff 18 (Activities Director) approached Resident 1 and offered her/him a drink in the Activity Director's office which the resident accepted and left her/his position at the front door. During the survey period, Resident 1 was observed seated by the front door several times writing in a notebook but was not observed attempting to leave the building. On 12/5/24 at 3:15 PM, Staff 1 (Administrator) was informed of the findings of staff not implementing Resident 1's care plan interventions and provided no additional information.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42222 Based on observation, interview, and record review it was determined the facility failed to provide adequate supervision and failed to thoroughly evaluate and analyze an elopement for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for an unsafe elopement. Findings include: a. Resident 1 was admitted to the facility in 5/2024, with diagnoses including schizophrenia and dementia. Resident 1's 8/23/24 Quarterly MDS revealed a BIMS score of 0, which indicated severe cognitive impairment. An elopement risk evaluation dated 8/23/24 revealed Resident 1 was a high elopement risk and she/he frequently stood by the entrance door, stating she/he wanted to leave. Resident 1's most recent care plan dated 10/15/24 revealed she/he was an elopement risk/wanderer with a history of attempts to leave the facility unattended and she/he had impaired safety awareness. Interventions were to distract the resident by offering diversions, activities, food, conversation, television or a book. On 11/25/24 the facility submitted a Facility Reported Incident (FRI) report to the State Survey Agency (SSA) which revealed Resident 1 eloped from the facility on 11/23/24 at approximately 6:50 PM. The FRI stated staff in the facility initiated a search in the neighborhood and Resident 1 was found a block away at a bus stop. The resident returned to the facility with staff at approximately 7:50 PM. On 12/3/24 at 11:39 AM, Staff 10 (CNA) stated she was Resident 1's assigned CNA. She stated staff was aware to watch the resident from leaving and to re-direct the resident. She was not able to describe how to re-direct Resident 1 and stated she had been assigned to Resident 1 twice. On 12/3/24 at 11:43 AM, Staff 11 (CNA) stated she knew Resident 1 had a history of attempting to leave the building and staff was to re-direct the resident and encourage the resident to write in her/his notebook. On 12/3/24 at 11:57 AM, Staff 12 (CNA) stated staff was supposed to watch Resident 1 because she/he liked to escape. On 12/3/24 at 3:20 PM, Staff 13 (RN) stated he worked the day shift on 11/23/24. He stated he saw Resident 1 most of the day and found out she/he eloped the next day. Staff 13 stated Resident 1's exit seeking behaviors was common and the resident walked around the facility most of the time and she/he didn't talk to anyone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 9:33 AM, Staff 14 (CNA) stated she was Resident 1's assigned CNA for the evening shift on 11/23/24. She returned from her break at approximately 6:30 PM and went to Resident 1's room to check on her/him. Staff 14 stated she was unable to locate the resident and notified the charge nurse. Staff 14 stated she and two other CNAs searched the neighborhood for the resident and she/he was found by Staff 16 (CNA) a short time later. Staff 14 stated previous interventions for the resident was to sit down in a chair right next to the resident if she/he was seated by the front door, which resulted in the resident returning to her/his room every time. On 12/5/24 at 9:40 AM, Staff 15 (CNA) stated she was not assigned to Resident 1's hall on 11/23/24, but heard about Resident 1's elopement and decided to search for her/him, along with Staff 14 and Staff 16. Staff 15 stated she observed Resident 1 headed west on a busy street and [resident name] had walked a long way and was waiting for the bus. Staff 15 attempted to talk to Resident 1 to get into her car but Resident 1 refused. Staff 15 stated Staff 16 was on foot and walked with the resident back to the facility. On 12/5/24 at 2:15 PM, Staff 16 stated he was working on the other hall and was informed by the charge nurse Resident 1 was missing. He stated let's go look for [her/him] and immediately walked along the street. Staff 16 stated he walked into a couple of businesses and did not find the resident. He continued to walk and saw Resident 1 standing at the bus stop. He stated he ran across the street to stop her/him from boarding the bus and if it would have been two minutes later, [resident name] would have been gone. Staff 16 stated he walked with Resident 1 back to the facility and the resident had no injuries, had worn a coat and boots and was fine. Observations were made of the bus stop on 12/3/24 at 4:40 PM. The intersection where Resident 1 was located was densely populated, with several businesses, pedestrians and a large amount of motor vehicles observed on both roads. The intersection was several blocks from the facility's location and not one block away, as the facility report indicated. Resident 1 was observed at the facility from 12/3/24 through 12/5/24. She/he was observed seated by the front door several times writing in a notebook but was not observed attempting to leave the facility. Resident 1 was approached by the surveyor on 12/5/24 at 2:45 PM and refused to talk to the surveyor. On 12/5/24 at 3:15 PM, Staff 1 (Administrator) was informed of the findings related to the resident's elopement. No additional information was provided. b. The facility's undated Investigation and Conclusion Report revealed Resident 1 was noted absent from the facility on 11/23/24 at 6:30 PM. A Code Yellow elopement protocol was activated, 911 was contacted and administrative staff were notified. The report only contained a statement from an unnamed nurse regarding the investigative activities. The investigation's conclusion revealed staff began searching for the resident and she/he was found at a bus stop near the facility. The findings noted it is uncertain if [resident name] let [herself/himself] out or if a visitor let [her/him] out as [she/he] is not a reliable historian due to [her/his] diagnosis of schizophrenia. Investigation initiated and employee statements were taken. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation did not include who completed the investigation, when the investigation was initiated and completed, and if the Administrator or DNS reviewed the investigation. The Root Cause Analysis did not address the facility's security failure which resulted in the resident eloping or how the resident left the building undetected. No CNA staff who searched for and found Resident 1, nor any CNA staff working the evening shift on 11/23/24 was interviewed as part of the investigation. On 12/5/24 at 9:33 AM, Staff 14 (CNA) stated she was Resident 1's assigned CNA for the evening shift on 11/23/24. She returned from her break at approximately 6:30 PM and went to Resident 1's room to check on her/him. Staff 14 stated she was unable to locate the resident and notified the charge nurse. Staff 14 stated she and two other CNAs searched the neighborhood for the resident, who was found by Staff 16 (CNA) a short time later. Staff 14 stated no management came to the facility after the elopement and she was not interviewed by anyone. On 12/5/24 at 9:40 AM, Staff 15 (CNA) stated she was not assigned to Resident 1's hall on 11/23/24, but heard about Resident 1's elopement and decided to search for her/him, along with Staff 14 and Staff 16. Staff 15 stated she observed Resident 1 headed west on a busy street and the resident had walked a long way and was waiting for the bus. Staff 15 stated no management came to the facility after the elopement and she was not interviewed by anyone. On 12/5/24 at 2:15 PM, Staff 16 stated he was working on the other hall and was informed by the charge nurse Resident 1 was missing. Staff 16 stated he walked into a couple of businesses and did not find the resident. He continued to walk west and saw Resident 1 standing at a bus stop. He stated he ran across the street to stop Resident 1 from boarding the bus and if it would have been two minutes later, [the resident] would have been gone. Staff 16 stated he walked with Resident 1 back to the facility. Staff 16 stated no management came to the facility after the elopement and he was not interviewed by anyone. On 12/5/24 at 3:15 PM, Staff 1 (Administrator) reviewed the Investigation and Conclusion Report with this surveyor and confirmed no staff was identified by name, there was no dates or times of interviews, and no CNA staff who participated in Resident 1's search or worked at the time of Resident 1's elopement was interviewed.