| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385237 | A. Building<br>B. Wing | 06/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fernhill Rehabilitation and Care | 5737 NE 37th Avenue<br>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 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>Based on interview and record review it was determined the facility failed to ensure a resident did not elope for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for injury. Findings include:<br><br>Resident 1 admitted to the facility in 5/2024 with a mental health diagnosis.<br><br>A 5/13/24 hospital Discharge Summary revealed Resident 1 experienced houselessness for more than 40 years and was diagnosed with a mental health condition several decades earlier. Resident 1's mental health was stable until she/he refused to take all medications. Resident 1's cognition was not able to be assessed due to her/his polite refusal to answer most questions.<br><br>Resident 1's Care Plan revised on 4/23/25 revealed she/he was at risk for elopement. Interventions included staff were to monitor the resident regularly, staff were to redirect, offer foods and fluids, and provide activities during Resident 1's episodes of wandering or exit seeking. Staff were also to provide 1:1 supervision until the exiting behavior resolved.<br><br>Resident 1's 5/20/25 Elopement Risk Evaluation revealed she/he was cognitively impaired with poor decision-making skills, was able to walk independently without an assistive device, and her/his wandering placed her/him at risk of being in an unsafe location. The assessment indicated Resident 1's former lifestyle affected her/his current behavior and placed the resident at risk for elopement.<br><br>Resident 1's 5/24/25 Annual MDS revealed she/he was independent with all ADLs, had a mental health diagnosis, refused to take medication, resulting in visual and auditory hallucinations, and the inability to ask for assistance.<br><br>Resident 1's 6/9/25 Progress Notes revealed the following:<br><br>- At approximately 4:20 AM a CNA called out to Staff 5 (RN) and reported Resident 1 left the facility. Staff looked for Resident 1 in the facility neighborhood, did not locate the resident, and police were notified.<br><br>-At 10:45 PM police located Resident 1 seven blocks from the facility on a private residence's porch. Staff 2 (DNS) went to Resident 1's location and as soon as Resident 1 saw Staff 2, she/he stated go away, and when Staff 2 tried to encourage her/him to return to the facility, she/he stated no, I don't want to go back. Staff 2 requested Staff 3 (RNCM) to assist with the situation.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -At 11:30 PM Staff 3 arrived at Resident 1's location and provided food and fluids. Resident 1 accepted the food but was resistive to any conversation related to returning to the facility. Staff 3 explained to Resident 1, if she/he did not return to the facility, she/he would be leaving against medical advice. Resident 1 voiced understanding and continued to state she/he did not want to return to the facility.<br><br>On 6/11/25 at 1:41 PM Staff 7 (CNA) stated on the night shift Resident 1 usually stayed in her/his room but at times would come out for food or to use the bathroom, and did not usually go to the front door. Staff 7 stated on 6/9/25 at approximately 4:11 AM she saw Resident 1 by the front door and her/his assigned CNA (Staff 6) was in a chair monitoring her/him. Staff 7 stated Staff 6 was not too close to Resident 1 because she/he did not like staff to be in her/his bubble. Staff 7 stated she was not sure how long Resident 1 was by the front door. Staff 7 indicated at approximately 4:20 AM she heard another resident call out and reported Resident 1 left the facility. Staff 7 stated when she/he arrived to the front door Resident 1 was no longer present. Staff 7 looked in Resident 1's bedroom, hall bathroom, and did not find Resident 1. Staff then searched the outside of the facility for Resident 1 but did not locate her/him.<br><br>On 6/12/25 at 4:02 PM Staff 5 stated, on the night shift, Resident 1 usually kept her/his door shut and stayed in her/his room. On 6/9/25 Staff 5 was at the nurses station and he heard a CNA call for assistance. When he arrived at the front door he was notified Resident 1 exited the facility. Staff looked for Resident 1 inside and around the facility neighborhood, but was not able to locate her/him. Staff 5 stated he notified the police. Staff 5 stated he was told Staff 6 monitored Resident 1 while she/he was at the front door, but left for a brief moment, to inform him Resident 1 was attempting to leave the facility. Staff 5 stated Staff 6 intended to write a note to place on the front door, to alert the incoming staff who might enter the front door, because Resident 1 might attempt to leave the facility.<br><br>On 6/11/25 at 11:59 AM and 6/12/25 at 4:16 PM a telephone call was placed to Staff 6. A return call was not received.<br><br>On 6/17/25 at 11:07 AM Staff 3 stated Resident 1 kept to herself/himself and did not frequently engage in exit-seeking behavior from the facility. Staff 3 stated Resident 1 had a mental health diagnosis and consistently refused medications which could have been beneficial. Resident 1 did not have a medical power of attorney and family declined to assume guardianship. Staff 3 stated the facility doors were locked with a posted code. Resident 1 was assessed to be at risk for elopement and staff were instructed to offer food and fluids and redirect her/him away from the door if an exit attempt was observed. Staff were to provide 1:1 supervision if Resident 1 was trying to leave the facility.<br><br>On 6/17/25 at 11:38 AM, Staff 2 acknowledged she was aware of Resident 1's elopement on 6/9/25. Staff 2 stated Resident 1 was at the front door on 6/9/25 and Staff 6 had been providing supervision, but left for a short timeframe in which Resident 1 was able to exit the facility. Staff 2 stated she expect 1:1 supervision whenever Resident 1 exhibited ex-seeking behavior. Staff 2 stated Staff 6 should not have left Resident 1 unattended by the doors without supervision.<br><br>The deficient practice was identified as Past Noncompliance based on the following:<br><br>On 6/9/25 the deficient practice was identified by the facility and determined there was a lack of supervision for a resident at risk for elopement. The Plan of Correction included:<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 | -All staff reviewed the Wandering and Elopement policy.<br><br>-Walkies (communication devices) were to be worn at all times by nursing staff on all shifts.<br><br>-When a resident exhibited exit seeking behaviors staff needed to remain with the resident at all times.<br><br>-Staff were to notify the DNS and the on-call nurse manager when a resident exhibited exit seeking behaviors.<br><br>-Staff were reeducated to ensure residents' Kardex were reviewed for elopement interventions.<br><br>-An elopement drill was performed on 6/9/25 at 11:45 PM. |