

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Rivercrest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 148 Hood Street Oregon City, OR 97045	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to provide supervision to prevent elopement for 1 of 3 sampled residents (#6) reviewed for accidents. This placed residents at risk for elopement. Findings include: Resident 6 admitted to the facility on [DATE] with diagnoses including post motor vehicle accident, stimulant abuse with intoxication and aphasia (a disorder that affects how you communicate).A 6/19/26 facility Elopement Risk Evaluation completed at the time of admission revealed Resident 6 was risk to wander. The evaluation revealed the resident wandered in the past month and tried to leave the facility alone without signing out. A 6/22/26 care plan indicated Resident 6 was an elopement risk; staff were to allow wandering in safe areas within the facility, attempt to refocus when exhibiting behaviors, and educate on use of the facility check in/check out log. The 6/24/26 admission MDS revealed Resident 6 had a BIMS score of 8 (moderate cognitive impairment).A 7/20/26 Elopement Investigation indicated Resident 6 eloped from the facility on 7/20/26. The resident was missing for approximately 10 minutes and was found on a main street near the facility. Prior to the elopement Resident 6 was agitated and pacing back and forth, and made statements of wanting to leave the facility. It was determined Resident 6 exited the facility through an improperly latching magnetic door at the perimeter of the facility.Observations made from 7/28/26 to 7/30/26 revealed Resident 6 with one-on-one supervision with her/him at all times. No other residents were observed making any attempts to elope from the facility. On 7/28/26 at 12:11 PM Staff 3 (Restorative Aide) stated Resident 6 was agitated all morning on 7/20/26, stating she/he wanted to leave the facility. Staff 3 stated she tried to redirect Resident 6 with snacks or with calling her/his family but the resident refused. Staff 3 stated she saw Resident 6 standing at the nurses station, looking very agitated, and then she saw the resident walk toward her/his room. Staff 3 stated she went to the resident's room but did not see the resident. She walked out to the smoking area in the enclosed courtyard, which required a door code, and did not see Resident 6. Staff 3 stated she noticed a side fence gate slightly open and went out to look for Resident 6 but did not see her/him, so she notified the nursing staff.On 7/29/26 at 2:11 PM Staff 6 (LPN) stated Resident 6 was antsy and tried to go outside on 7/20/26. Staff 6 stated Resident 6 was redirected to the outdoor fenced in area. Resident 6 told staff she/he wanted to run away and did not enjoy being at the facility. Staff 6 stated she did not know how Resident 6 got outside of the fenced area. Staff 6 stated she and Staff 2 (DNS) drove around for 10 minutes and found Resident 6 about one block away from the facility at a bus stop on the main road with a bag of her/his belongings.On 7/30/26 at 8:45 AM a staff member was observed to go through the back fence gate without inputting a code.On 7/30/26 at 8:55 AM a staff member was observed to go through the back fence gate without inputting a code. On 7/30/26 at 11:40 AM Staff 18 (Maintenance Director) stated on 7/20/26 the landscapers were working and might (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 385245 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have forgotten to close the gate. Staff 18 stated he was in the process of installing stronger magnets on the gate. Staff 18 stated he was working on the locks and gate all week while waiting for the supplies to arrive and acknowledged there were some times when the gate was not locked. On 7/30/26 at 12:42 PM Staff 2 acknowledged Resident 6 eloped the facility. Staff 2 stated Resident 6 was placed on one on one supervision after the incident and the facility was in the process of educating staff and securing the fence.		