STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385251	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Hillsboro	650 SE Oak Street Hillsboro, OR 97123

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** 42222 Based on interview and record review it was determined the facility failed to evaluate elopement risks for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for unsafe elopement. Findings include: On 8/8/24, the Past Noncompliance was corrected when the facility implemented a plan of correction, which included: -An Elopement Risk Evaluation was completed for residents upon admission, quarterly and with a significant change of condition to determine risk factors for elopement; -Assigned Resident 1 a one-to-one aide until a memory care unit was located; -Provided in-service training to all nursing staff for elopement risk, elopement drills and proper notification for serious events; -Provided signature sheets verifying nursing staff had completed the training. Resident 1 admitted to the facility in 8/2022, with diagnoses including dementia. Resident 1's 5/30/24 Quarterly MDS revealed she/he had severe cognitive impairment and was rarely or never understood. On 7/26/24 the facility submitted a report to the State Survey Agency (SSA) which stated Resident 1 was reported missing on 7/26/24 at 11:07 AM. A facility and neighborhood search was initiated and Resident 1 was not located. She/he was located later in the afternoon at the nearby hospital's Emergency Department (ED) after she/he was found a few blocks away by a passerby. The resident fell and was transported as a [NAME] Doe to the ED. Resident 1 was diagnosed with a UTI, had no serious injuries from the fall and returned to the facility on [DATE]. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility initiated a risk management report on 7/26/24 which included a statement by Staff 15 (assigned CNA) which stated I was in the dining room assisting with feeding a resident and Resident 1 was still eating during the time trays were picked up about 10:40 AM. Staff 13 (CNA) was giving a shower (to another resident) and Staff 8 (CNA) was on break. I continued my rounds on the hall and Resident 1 was still in the dining room. I went to check on a call light and when I came back, the resident was not in the dining room. I asked Staff 8 and Staff 13 if they had seen her/him and they said she/he was in the dining room. I informed them she/he was not and began looking for her/him. I let the nurse know at this time. On 9/9/24 at 12:10 PM, Staff 8 revealed she had provided care for Resident 1 several times in the past year and said the resident had always loved to walk. She stated on 7/26/24, the resident had been observed in the dining room eating lunch before she/he eloped. She/he was observed sitting with the residents after meal trays were picked up. The dining room staff began to assist other residents to their rooms. Staff 8 assisted another resident to their room, returned to the dining room and was told Resident 1 could not be located. Staff 8 stated she observed Resident 1 standing by an exit door earlier in the day on 7/26/24, but she/he was easily re-directed and did not have a history of elopement. On 9/9/24 at 12:59 PM, Staff 13 (CNA) stated Resident 1 liked to walk laps around the facility and she would follow the resident if she was assigned to her/him. Staff 13 stated she previously observed Resident 1 try to push through the double doors in the back of the building and re-directed her/him. Staff 13 stated it was well known the resident would try to leave the building while walking and at times tried to walk without her/his walker. Staff 13 stated she was not working the day shift on 7/26/24 but worked the evening shift and was informed about the elopement. On 9/9/24 at 1:24 PM, Staff 14 (CNA) revealed Resident 1 liked to get up, go for walks, had attempted to walk out of the facility several times but was always stopped by staff. Staff 14 stated the resident tried to leave the facility because she/he wanted to go outside but did not wish to elope. She stated Resident 1 was very confused and probably just went for a stroll and forgot her/his way back. Staff 14 stated she was on lunch when the resident eloped and when she returned everyone was looking for the resident. Staff 14 stated Resident 1 was placed on one-to-one supervision after her/his return to the facility. On 9/9/24 at 2:19 PM, Staff 6 (RCM) stated Resident 1 did not actively exit seek on 7/26/24 but liked to walk around the building. She noted the resident usually stayed in the 200 hall (where the resident's room is located) but that week had expanded to walking in other parts of the building. Staff 6 stated the resident was easily re-directed and always came with staff if they requested she/he go to her/his room. Staff 6 confirmed the resident had eloped on 7/26/24 and was on one-to-one supervision until a memory care placement was found. On 9/10/24 at 10:20 AM, Staff 15 (CNA) stated on 7/26/24 she was assigned to Resident 1 and assisted the resident to the dining room for lunch. She left the dining room to check on a call light after 11:00 AM and when she returned saw Resident 1 was gone. She asked Staff 8 and Staff 13 if they saw the resident and they told her the resident was probably walking around. Staff 15 stated she looked throughout the whole building and did not locate the resident. She notified other CNA's and a facility wide search for the resident was started. Staff 15 recalled this was the first time she was assigned to Resident 1 and the resident had been on 15 minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Three observations of Resident 1 were made on 9/9/24 at 11:00 AM, 9/9/24 at 2:01 PM and 9/10/24 at 11:13 AM. She/he was observed with a one-to-one aide with her/him at all times. On 9/20/24 at 11:30 AM, Staff 1 (Administrator) and Staff 2 (DNS) were advised of the findings of the investigation and provided no additional information.