STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385268	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Care and Retirement	39 NE 102nd Avenue Portland, OR 97220

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** 46053 Based on observation, interview and record review it was determined the facility failed to ensure safety interventions were in place to prevent elopement for 1 of 1 sampled resident (#1) reviewed for elopement. This put residents at risk for potentially avoidable accidents. Findings include: The facility's undated Wandering and Elopements Policy indicates: If a resident is missing, initiate the elopement/missing resident emergency procedure: -Determine if the resident is out on an authorized leave or pass; -If the resident was not authorized to leave, initiate a search of the building(s) and premises; and -If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. , emergency management, rescue squads, etc.). Resident 1 was admitted to the facility in 11/2023 with diagnoses including peripheral vascular disease (a circulatory condition charactarized by reduced blood flow to the limbs) and cellulitis (a bacterial skin infection). A review of Resident 1's 11/28/23 care plan revealed she/he used a four-wheeled walker for ambulation. A review of Resident 1's 3/4/24 Elopement Risk Evaluation revealed she/he was cognitively impaired with poor decision-making skills and she/he ambulated independently. A 3/24/24 nursing progress note at 5:59 PM by Staff 9 (LPN) indicated Resident 1 was out of the facility. On 4/1/24 at 12:19 PM Staff 3 (CNA) stated Resident 1 left the faciity on [DATE]. She added,[She/ He didn't tell anybody [she/he] was leaving. [She/he] stayed out for two days, went to the hospital, and then readmitted here. (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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(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	No documentation was found in Resident 1's electronic health record or in the facility's Resident Sign Out Log to indicate she/he left the faciity on [DATE]. On 4/1/24 at 12:42 PM Staff 6 (RN) stated she provided wound care to resident 1 on 3/24/24 at about 1:00 PM and then gave a report to Staff 9, the oncoming nurse at shift change. Staff 6 stated residents who are alert and oriented are allowed to leave the facility if they sign out and provide staff information about where they are going and when they will be back. She added Resident 1 previously left the facility and was gone all night. Staff 6 stated she called the police when this happened but she did not recall the date. On 4/2/24 at 1:39 PM Staff 9 stated she did not know when Resident 1 left on 3/24/24 but called Staff 2 (DNS) to tell her Resident 1 was out of the facility. On 4/2/24 at 1:45 PM Staff 2 stated she told the night shift nurse to hold off on calling the police because this was a recent change in behavior for Resident 1. On 4/2/24 at 1:57 PM Staff 10 (Assistant Administrator) stated Resident 1 left the faciity on the afternoon of 3/24/24 and was out of the facility all day on 3/25/24. She stated she expected the care plan to reflect a resident's behavior of leaving the facility without telling staff or signing out. No evidence was found in Resident 1's Care Plan to indicate staff developed interventions related to Resident 1's behavior of leaving the facility without informing staff. On 4/2/24 at 2:05 PM Staff 1 (Administrator) acknowledged the facility staff did not know where Resident 1 was from 3/24/24 to 3/26/24 and stated, We should have called the police, updated [Resident 1's] Care Plan with the behavior of [her/him] leaving the facility and documented that we were educating him. She also stated, We have some gaps in the documentation that we need to address as a system.