STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385284	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crossings	6003 SE 136th Avenue Portland, OR 97236

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42222 Based on interview and record review it was determined the facility failed to re-evaluate elopement risks and modify care plan interventions after ongoing elopement attempts and exit seeking behaviors for a resident with cognitive impairment and inability to effectively communicate her/his needs due to aphasia and CVA. This failure, determined to be an immediate jeopardy situation, resulted in Resident 1's elopement from the facility on 6/12/24 and placed residents at risk for an unsafe elopement. Findings include: The facility's 3/2019 Wandering and Elopement policy indicated the facility would identify residents at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The resident's care plan was to include strategies and interventions to maintain the resident's safety. Resident 1 admitted to the facility in 4/2024, with diagnoses including stroke, dysphagia (difficulty swallowing) and aphasia (a language disorder which causes difficulty speaking). Resident 1's 4/2024 Admission MDS: Section C - Cognitive Patterns and Section E - Behavior, revealed a BIMS score of 0, indicating severe cognitive impairment and she/he exhibited wandering behaviors one to three days during the resident's look back period of seven days. Resident 1's Cognition CAA revealed she/he was unable to participate in the BIMS interview, experienced confusion and disorientation and the resident's care plan would address her/his cognitive deficits with the goal of preventing decline. Resident 1's Progress Notes from 4/17/24 to 4/20/24 and on 4/24/24 revealed she/he exhibited exit seeking behaviors. Resident 1's Provider Notes from 4/16/24 through 6/12/24 revealed the resident spoke gibberish, was unable to remember her/his name and was an elopement risk due to her/his severe confusion, ability to independently ambulate, and exit seeking tendency. Resident 1's care plan dated 4/22/24 revealed she/he had elopement and wandering behaviors. Interventions included: to anticipate her/his needs and wants, attempt to determine a routine while the resident was up and attempt to determine effective communication strategies. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 1's SLP Therapy Note dated 6/6/24 revealed she/he had a lack of word comprehension, sentence comprehension, word finding, grammatical construction and reading levels were measured as severe due to her/his cognitive impairment. On 6/12/24 at 10:45 AM, the facility submitted a FRI which revealed Resident 1 was last seen in the facility on 6/12/24 at 6:30 AM. At 7:45 AM, Resident 1 was not in her/his room and a search of the building and surrounding area was initiated. At 8:10 AM, the facility contacted law enforcement and reported the resident missing. On 6/14/24 at 10:08 AM, Staff 1 (Administrator) stated the resident had not returned to the facility. Staff 1 stated as part of the investigation he had learned Resident 1 packed her/his belongings the night before, was watching the exits and was overheard by staff to state I'm leaving. Staff 1 stated it was difficult to ascertain her/his cognitive level because the resident could not communicate and was primarily Spanish speaking. Staff 1 stated Resident 1 was care planned for elopement. Staff 1 stated he had observed Resident 1 in the parking lot on two previous occasions unsupervised and had gone outside to bring her/him back into the facility. Staff 1 stated previous elopement attempts and exit seeking behaviors by Resident 1 were not always charted by staff, which was a problem he was working on. On 6/14/24 at 10:35 AM and 3:07 PM, Staff 3 (RCM) stated Resident 1 was exit seeking when she/he first admitted to the facility and was placed on alert charting at the time. She stated the resident was not on alert status when she/he eloped from the facility. Staff 3 stated she was only aware of one time the resident previously tried to leave the building and the resident was stopped at the front door by Staff 2 (DNS). Staff 3 stated she was not aware Resident 1 was actively exit seeking, stated the CNA's had not informed her of this and did not think the resident would try to elope. Staff 3 stated after the elopement on 6/12/24 she learned from staff Resident 1 had packed her/his bags and belongings and indicated she/he was leaving. Staff 3 acknowledged Resident 1 was not placed on alert charting. On 6/14/24 at 11:47 AM, Staff 7 (CNA) stated she worked on Resident 1's unit on 6/12/24 but was not assigned to the resident that day. Staff 7 confirmed she had provided care for Resident 1 previously, did not know the resident was considered an elopement risk and did not recall any staff providing her information related to the resident's exit seeking behaviors. On 6/14/24 at 12:17 PM, Staff 6 (CNA) stated on 6/12/24 she was Resident 1's CNA for day shift. Staff 6 stated she was aware the resident was an elopement risk and the resident was constantly by the front door, side doors, trying to put the codes in (referring to the security doors) and was always pacing up and down the halls. Staff 6 stated she was not made aware by any night shift staff the resident had packed her/his bags and did not receive report when she started her shift at 6:00 AM because she could not locate the night shift CNA. Staff 6 stated she initially wasn't concerned about Resident 1's absence because the resident frequently went into a different unit to watch TV. Staff 6 stated she completed vital checks, and after about an hour went back to check on Resident 1 and was unable to locate her/him. She then checked all areas where the resident could have been, realized the resident was missing and notified another CNA and the charge nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/14/24 at 1:20 PM, Staff 9 (SLP) stated Resident 1 did not have the ability to let others know her/his wants and needs. She stated Resident 1 was only able to say a couple of perseveratory phrases but was unable to communicate any other way. Staff 9 stated Resident 1 spoke word salad most of the time and only could point at things such as the clock when she would check in with her/him about upcoming therapy appointments. Staff 9 stated the resident struggled with a communication board and was not able to communicate with words and spoke a combination of English and Spanish, but the communications usually did not make sense. Staff 9 stated she considered Resident 1 as cognitively impaired. On 6/14/24 at 3:26 PM, Staff 8 (CNA) stated he was Resident 1's assigned CNA on 6/12/24 night shift. Staff 8 stated he recalled the resident went to bed around 2:00 AM and did not see the resident again until around 6:15 AM. Staff 8 stated he had not observed Resident 1 packing her/his bags the evening before the resident eloped and had not observed exit seeking behaviors. Staff 8 stated he had not given Staff 6 report when she arrived for her shift as he was providing care to another resident. Staff 8 acknowledged the resident had made statements of wanting to leave the facility when she/he first admitted . On 6/14/24 at 3:49 PM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to re-evaluate elopement risk and modify care plan interventions after repeated exit seeking behaviors and elopement attempts to prevent an elopement which resulted in Resident 1's continued missing status. On 6/14/24 at 5:45 PM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions: -All current residents with cognitive impairment will have an elopement risk assessment completed on 6/14/24; -Residents with an identified elopement risk will have care plans reviewed for effective interventions and updated as needed; -Behavior monitors will be created and/or updated to reflect identified elopement risks and interventions; -Weekly audits to be conducted of elopement risks for care plan, interventions and behavior monitor 4 times and twice a month; -Audits will be brought to QAPI for review; -Nursing staff were to update themselves regarding wandering protocol at the start of every shift; -Residents with known elopement/wandering risks observed to be exit seeking would be monitored by staff, who were not to leave the resident and tell other staff to alert the charge nurse; -Nurses were to chart any type of exit seeking behaviors; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At the beginning of each shift, all care staff will do walking rounds and all residents must have visual checks completed by staff; -Elopement risk assessments will be completed on admission, quarterly and with any behavioral changes. The Plan of Correction would be completed by 5:00 PM on 6/17/24. The IJ was removed on 6/17/24 at 12:00 PM, as confirmed by onsite verification by the survey team.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46054 Based on interview and record review, it was determined the facility failed to develop and present a QAPI plan to the State Survey Agency (SSA) and failed to present documentation and evidence of an ongoing QAPI Program. This placed residents at risk of not receiving the care and services for optimal resident outcomes. Findings include: A review of facility QAPI records presented by Staff 1 (Administrator) showed no evidence the facility had developed a QAPI plan. Staff 1 also acknowledged there was no ongoing QAPI program. On 6/17/24 at 11:39 AM, Staff 1 (Administrator) acknowledged the facility had not developed a QAPI Plan.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46054 Based on interview and record review it was determined the facility failed to have a quarterly QAA (Quality Assessment and Assurance) committee meeting and failed to include the Medical Director reviewed for quality assurance. This placed residents at risk of not receiving the care and services for optimal resident outcomes. Findings include: A review of facility records presented by Staff 1 (Administrator) showed no evidence nor documentation the facility conducted quarterly QAA meetings and with no Medical Director involvement. On 6/17/24 at 11:39 AM Staff 1 (Administrator) acknowledged the facility QAA committee had not met quarterly and the facility's Medical Director had no involvement.