

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Cedar Crossings		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005</p> <p>Based on interview and record review it was determined the facility failed to provide bed rails needed for bed mobility for 1 of 3 sampled resident (#11) reviewed for environment. This placed residents at risk of ADL decline. Findings include:</p> <p>Resident 11 admitted to the facility in 5/17/24, with diagnoses including chronic kidney disease with dialysis.</p> <p>The Admission MDS dated [DATE] revealed Resident 11 had a BIMS score of 15, which indicated the resident was cognitively intact and required moderate assist with bed mobility.</p> <p>A 6/28/24 public complaint indicated Resident 11 had requested bed rails to assist with bed mobility. Resident 11 had to use the headboard to reposition herself/himself in bed, and waited a couple of weeks to have bed rails placed on her/his bed.</p> <p>A 5/17/24 nursing admission note indicated the Resident 11 requested side rails (bed rails).</p> <p>A 5/29/24 Resident Grievance Form filed by Resident 11 revealed the resident wanted bed rails.</p> <p>On 10/1/24 at 12:44 PM, Staff 9 (LPN) stated he recalled Resident 11 requested bed rails for bed mobility at the time of admission. Staff 9 stated he completed an assessment for the bed rails and requested an order from the physician.</p> <p>On 10/1/24 at 2:22 PM, Staff 2 (DNS) stated a bed rail assessment was not completed for Resident 11. Staff 2 stated a physician order for the bed rail was started on 5/29/24.</p> <p>On 10/1/24 at 2:40 PM, Staff 1 (Administrator) stated it was her expectation that if a resident requested bed rails a bed rail assessment would be completed, and a physician order would be obtained in a timely manner. Staff 1 acknowledged Resident 11 requested bed rails at the time of admission and did not receive the bed rails until 5/29/24.</p>

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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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to permit a resident to return to the facility for 1 of 4 sampled residents (#9) reviewed for discharge. This placed residents at risk for being unhoused. Findings include:</p> <p>Resident 9 admitted to the facility in 12/2023, with diagnoses including absence of right foot, heart failure and cocaine abuse.</p> <p>The 12/27/23 Discharge Care Plan indicated Resident 9 was homeless, and stayed in her/his car or in motels.</p> <p>A 3/4/24 Progress Note indicated Resident 9 was out of the facility at her/his mother's house.</p> <p>A 3/5/24 Progress note indicated Resident 9 continued to be out of the facility. Staff left a voice message for a return call.</p> <p>A 3/9/24 Progress Note indicated Resident 9 returned to the facility at approximately 4:30 AM and was out of the facility since 3/3/24. Staff 8 (RN) informed Resident 9 she/he was discharged per facility policy however Resident 9 went to her/his previous room and went to bed. Staff 8 placed a call the the on-call manager.</p> <p>A 5/3/24 public complaint indicated upon Resident 9's return to the facility, she/he found her/his belongings locked up and was informed she/he was discharged as AMA (against medical advice). The complaint further alleged the resident was escorted out of the facility.</p> <p>On 9/27/24 at 12:15 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated per review of Resident 9's documentation, Resident 9 was discharged AMA when she/he did not return to the facility when expected. Staff 1 verified the facility did not permit Resident 9 to return to the facility after she/he was late arriving from her/his therapeutic leave.</p> <p>On 9/30/24 at 12:01 PM, Staff 3 (Previous Administrator) stated he was unable to recall the event.</p> <p>On 9/30/24 at 12:34 PM, Staff 8 (RN) stated she was unable to recall the event.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>34702</p> <p>Based on interview and record review it was determined the facility failed to ensure meals were provided for a discharge for 1 of 3 sampled residents (#5) reviewed for discharge. This placed residents at risk for unsafe discharge. Findings include:</p> <p>Resident 5 admitted to the facility in 12/2023, with diagnoses including hypertension. Resident 5 discharged from the facility on 1/11/24.</p> <p>The 1/10/24 Discharge Instructions indicated Resident 5 was to be discharged to another state on 1/11/24. There was no indication a meal was ordered or provided for the resident for the extended transport.</p> <p>On 1/23/24 Witness 5 indicated Resident 5 was discharged from the facility and was transported to a nursing facility in another state.</p> <p>The Progress notes revealed Resident 5 discharged from the facility on 1/11/24 at 10:15 AM and was expected to arrive at the new facility at 5:30 PM.</p> <p>On 10/3/24 at 10:14 AM, Staff 10 (CNA) stated she observed Resident 5 discharge on 1/11/24. Staff 10 stated the resident was sent out by medical transport and a meal was not provided for the transport.</p> <p>On 10/3/24 at 10:33 AM, Staff 1 (Administrator) acknowledged staff did not send a meal with Resident 5 for the extended transport to another state upon discharge.</p>