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	04/03/2026

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 - 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. Based on observation, interview, and record review it was determined the facility failed to ensure staff were aware of residents who were an elopement risk and aware of elopement care plan interventions for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for elopement. Findings include:Resident 1 admitted to the facility in 1/2025 with diagnoses including dementia with anxiety, bilateral hearing loss and cataracts.Resident 1's 5/21/25 Care Plan indicated Resident 1 was at risk for elopement due to her/his poor cognition. Interventions included frequent monitoring and visual checks by staff and to ensure staff were aware of the resident's wander risk. Resident 1 was also care planned for bilateral hearing loss, visual impairment and frequent falls. Resident 1's 6/17/25 Progress Notes indicated the following:-At 1:51 PM, Resident 1 displayed exit seeking behavior and was to be closely monitored.-At 2:20 PM, CMA was instructed to administer an anxiety pill to Resident 1 for anxiety and exit seeking.-At 11:41 PM, Resident 1 eloped from facility; last seen approximately 6:30 PM. Found by bystander in the community at 9:21 PM. Resident returned to the facility at 11:30 PM. Resident 1 indicated she/he walked out the front door with her/his belongings. Resident 1 stated she/he was not able to get a cab so started walking back to her/his house and stated she/he walked approximately seven miles. Resident 1's 6/18/25 BIMS (cognitive assessment) score was 10 out of 15, which indicated moderate cognitive impairment.A 11/5/25 Progress note indicated Resident 1 had increased agitation and was exit seeking. Resident 1's 12/3/25 Elopement Assessment indicated Resident 1 was a high risk for elopement.Resident 1's 1/29/26 Annual MDS revealed a BIMs score of 6 out of 15 which indicated severe cognitive impairment .Resident 1's 2/12/26 ADL CAA indicated Resident 1 demonstrated functional limitations in ADLs, impacted her/his ability to independently complete routine self-care tasks and contributed to reduced safety awareness, slowed task initiation, impaired sequencing, and decreased endurance.Review of the facility's Elopement Book contained information about residents who were a high elopement risk and included Resident 1.Resident 1's 3/11/26 Progress Note indicated Resident 1 continued to be exit seeking. On 4/2/26 at 12:17 PM, Staff 4 (SSD Assistant) was unaware Resident 1 eloped from the facility. On 4/2/26 at 12:25 PM, Resident 1 was observed to be fully dressed and sitting on the side of the bed. Resident 1 stated she/he does not remember walking out of the building. Resident 1 stated she/he wanted to go home. On 4/2/26 at 12:27 PM, Staff 33 (CMA) stated she was unaware Resident 1 was an elopement risk and had elopement risk interventions in place. On 4/2/26 at 12:33 PM, Staff 36 (CNA) did not identify Resident 1 as an elopement risk and was unaware of any elopement risk interventions were in place. On 4/2/26 at 6:22 PM, Staff 17 (CNA) stated he did not know which residents were an elopement risk and was unaware Resident 1 had elopement risk interventions.On 4/2/26 at 6:22 PM, Resident 1 was observed to be fully dressed sitting on the side of the bed. On 4/2/26 at 6:30 PM, Staff 7 (RN) stated there were no residents in her section who were an elopement risk. On 4/2/26 at 6:35 PM, Staff 9 (LPN) stated Resident 1 was an exit seeker. Resident 1 dressed nicely and sat by the door to the outside. Staff 9 stated she could see how visitors could mistake Resident 1 for another visitor. On 4/2/26 at 8:25 PM, Staff 14 (CNA) stated Resident 1 made the bed, cleaned the room and stated I am going home. On 4/3/26 at 11:18 AM, (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	Resident 1 was observed ambulating in the hall and stated she/he wanted to go home.On 4/3/26 at 3:45 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged staff did not follow Resident 1's care plan and staff were not aware of Resident 1's elopement risk.