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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385068 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/04/2026 |
| NAME OF PROVIDER OR SUPPLIER Village Health Care | | STREET ADDRESS, CITY, STATE, ZIP CODE 3955 SE 182nd Avenue Gresham, OR 97030 | |
| 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 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review it was determined the facility failed to implement proper safety protocols for bathing equipment, which contributed to a fall for 1 of 3 sampled resident (#1) reviewed for falls. This placed resident at risk for injury. Findings include: Resident 1 was admitted to the facility in 2/2025 with diagnoses including spinal stenosis (spinal canal narrowing resulting in pain, numbness, or weakness) and chronic kidney disease. A care plan dated 9/9/25 revealed Resident 1 required partial to moderate assistance with bathing and bathing transfer tasks. A Fall Without Fracture Incident Report dated 11/10/25 completed by Staff 4 (RN) stated Resident 1 received assistance from Staff 8 (NA Student) with transporting her/him back to her/his room in a rolling shower chair. When Staff 8 attempted to cross over the transition strip to Resident 1's room, the rolling shower chair got stuck in the transition strip on the floor of the door frame. Staff 8 attempted to lift the rolling shower chair from the backrest which resulted in the backrest becoming detached. The loss of the back support resulted in Resident 1 falling backwards onto the floor. Staff 4 assessed Resident 1 found no injury, assisted her/him to stand and then walked her/him to bed. On 2/3/26 at 1:11 PM Resident 1 stated she/he recalled falling out of the shower chair and stated she/he was afraid immediately after the incident. Resident 1 stated staff assessed her/him and assisted her/him back to bed after determining no injury had occurred. Resident 1 stated she/he did not experience a significant increase in pain after the fall. On 2/3/26 at 1:27 PM Staff 6 (Maintenance Director) demonstrated how the backrest became detached from the rolling shower chair used on 11/10/25. Staff 6 stated the backrest becoming detached was a design flaw, which he addressed after the incident on 11/10/25 by securing the pipes together with screws to prevent them from detaching easily. On 2/3/26 at 3:50 PM Staff 8 stated she assisted with Resident 1's shower on 11/10/25. Staff 8 stated she assisted Resident 1 to her/his room after the shower. When they arrived at the doorway, Resident 1 reported she/he was usually assisted in backwards to her/his room because of the transition strip. Staff 8 reported Resident 1's rolling shower chair became stuck in the transition strip. To dislodge the stuck wheel, Staff 8 pulled up on the backrest of the wheelchair which resulted in the backrest being removed and Resident 1 falling to the floor. Staff 8 stated Resident 1 experienced pain and cried after the incident but stated she/he did not experience increased pain after the fall. On 2/4/26 at 10:54 AM, Staff 7 (CNA) stated she was the shower aide on 11/10/25 and directed Staff 8 to assist Resident 1 back to his/her room. Staff 7 stated she did not witness the fall but reported Resident 1 mentioned a minimal increase in back pain after the fall and that there was no indication of injury after she/he was assessed. On 2/4/26 at 11:12 AM Staff 4 stated she assessed Resident 1 after the incident for injury. Resident 1 showed no signs of major injury and was able to stand and walk to her/his bed without any major injury. On 2/4/26 at 12:12 PM Staff 2 (DNS) confirmed Resident 1 experienced a fall due to incorrect and unsafe techniques used by Staff 8.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 385068 | Facility ID: 385068 If continuation sheet Page 1 of 1 |