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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>385251 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avamere Rehabilitation of Hillsboro |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>650 SE Oak Street<br>Hillsboro, OR 97123 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46054</p> <p>Based on interview and record review, it was determined the facility failed to implement care plan interventions to prevent a fall for 1 of 1 sampled resident (#3) reviewed for accidents. As a result, Resident 3 sustained a fracture of the right distal femur (the lower portion of the thigh bone). Findings include:</p> <p>Resident 3 was admitted to the facility in 2013, with diagnoses including fracture of the right hip joint and right femur.</p> <p>Resident 3's 7/26/24 Care Plan revealed Resident 3 was a high fall risk related to a prior fall with right hip injury. Resident 3 was identified as a 2-person transfer with a Hoyer lift (a mechanical device used to lift and transfer residents who have difficulty moving themselves).</p> <p>A facility reported incident dated 8/29/24 revealed Staff 21 (CNA) reported Resident 3 had a fall while being transferred from her/his wheelchair to bed. Staff 21 reported Resident 3 slid from the edge of the bed which resulted in her/him twisting their ankle and falling on their right knee. The report indicated Staff 21 confirmed Resident 3 was transferred by one staff member instead of two staff members which resulted in her/him falling from the bed to the floor and a result was sent to the hospital for evaluation.</p> <p>A 9/6/24 Hospital Summary noted Resident 3 sustained a right distal femur fracture as a result of the fall.</p> <p>On 5/14/25 at 11:56 AM, Staff 17 (CNA) confirmed staff received training as a result of the fall that occurred between Staff 21 and Resident 3. Staff 17 stated Staff 21 attempted to self-transfer Resident 3 without a Hoyer lift, which resulted in the resident's fall with fracture.</p> <p>On 5/14/25 at 12:15 PM, Staff 21 (CNA) could not be reached for interview.</p> <p>A review of the facility's Investigation Summary dated 8/29/24, revealed the facility determined an accident had occurred with Resident 3 as a result of Staff 21 not following the resident's transfer care plan which resulted in Resident 3 sustaining a right distal fracture.</p> <p>(continued on next page)</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 |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 5/15/25 at 1:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) verified the incident occurred on 8/29/24 between Resident 3 and Staff 21, which resulted in Resident 3 sustaining a fracture from the fall.</p> |