STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385270	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanley Post Acute	12045 SE Stanley Avenue Milwaukie, OR 97222

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 - 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 interview and record review it was determined the facility failed to implement care plan interventions to prevent a fall for 1 of 3 sampled residents (#2) reviewed for falls. As a result, Resident 2 suffered bilateral femur fractures. Findings include:Resident 2 admitted to the facility in 2015 with diagnoses of diabetes and urinary incontinence.Resident 2's 1/9/26 MDS assessment indicated Resident 2 was dependent on staff for ADLs including bed mobility and toileting.Resident 2's Care Plan documented Resident 2 required two-person assistance and was dependent on staff for ADLs including toileting and bed mobility. Resident 2's Progress Notes documented:-At 7:40 PM on 2/7/26, Staff 3 (LPN) charted Resident was transferred to the hospital after a witnessed fall at 4:40 PM.-At 10:30 AM on 2/8/26, Staff 7 (RN) charted that a hospital social worker called to report Resident 2 required surgery on her/his legs.A 2/7/26 Fall Report initiated by Staff 3 on 2/7/26 at 6:50 PM documented:-Staff 5 (CNA) left the resident's room to request barrier cream from Staff 3, leaving Staff 4 (CNA) with Resident 2.-Resident 2 was left on her/his side.-While outside Resident 2's room, Staff 5 heard Staff 4 yell, Help! Help!-Staff 5 and Staff 3 found Resident 2 on the floor.-Staff 4 stated she had gotten a washcloth from Resident 2's drawer and wet it in the sink. Resident 2 suddenly yelled that she/he was rolling.-Staff 4 yelled for help and Staff 5 and Staff 3 came into the room.-On 2/9/26, the fall report was updated to reflect Resident 2 sustained bilateral femur fractures.In a written statement signed on 2/7/26, Staff 4 stated she was the only person in the room when Resident 2 fell.On 2/18/26 at 11:51 AM, Staff 3 stated Resident 2 required assistance of two staff for all ADL care including bed mobility and incontinence care for the duration of cares. She stated that on 2/7/26 around 6:30 PM, Staff 4 and Staff 5 were assisting Resident 2 with incontinence care. Staff 5 exited the room to request barrier cream from Staff 3, leaving Staff 4 alone with Resident 2. Staff 3 stated another CNA notified her of the fall. Staff 3 stated Resident 2 looked injured and she called 911. She stated Resident 2 sustained femur fractures as a result of the fall.On 2/19/26 at 2:22 PM, Staff 5 stated Resident 2 was unable to perform any bed mobility for her/himself. Staff stated Resident 2 was on her/his side when Staff 4 left the room to get barrier cream. Staff 5 stated she was ringing out a washcloth while Resident 2 remained on her/his side when she heard the resident say, Oh, I'm falling.On 2/19/26 at 2:38 PM, Staff 4 stated she and Staff 5 were in the middle of changing Resident 2's brief and Resident 2 was on her/his side when Staff 4 left the room to get barrier cream. Staff explained Resident 2 required assistance of two people for bed mobility and incontinence care and that Resident 2 was dependent and unable to roll her/himself in bed independently. Staff 4 stated Resident 2 should have been rolled onto her/his back before she left the room. On 2/20/26 at 7:37 AM, Staff 8 (CNA) stated Resident 2 required assistance from two staff for bed mobility including rolling and for incontinence care. Staff 8 stated two staff were required to remain with Resident 2 for the duration of care or the resident should be rolled onto her/his back before staff left the room.On 2/20/26 at 7:42 AM, Staff 7 (RN) stated two-person dependent meant two (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 - Actual harm Residents Affected - Few	staff must assist at all times during bed mobility and when changing Resident 2's brief.On 2/20/26 at 7:49 AM, Staff 18 (CNA) stated two-person dependent required two staff to assist Resident 2 for the duration of incontinence care and bed mobility, with one staff supporting Resident 2 on her/his side while the second staff completed care.On 2/20/26 at 9:01 AM, Staff 21 (LPN/Care Manager) stated Resident 2 was fully dependent on staff for all cares and required two-person assistance for bed mobility and toileting. She stated if a care plan documented two-person dependent, then two staff must remain with the resident throughout the care and should not leave the resident on her/his side unattended to prevent falling. On 2/20/26 at 9:13 AM, Staff 2 (DNS) stated for a two-person dependent resident, both staff must remain through the care and reposition the resident onto her/his back before leaving.