STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385278	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Linn Care Center	2330 Debok Road West Linn, OR 97068

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. 34324 Based on interview and record review it was determined the facility failed to follow the resident's plan of care to prevent a fall for 1 of 1 sampled resident (#1) reviewed for falls. This placed residents at risk for falls with injury. Findings include: Resident 1 admitted to the facility in 2021 with diagnoses including dementia. The 8/16/23 revised Care Plan indicated Resident 1 was at risk for falls related to cognitive impairment and required assistance with mobility. Interventions included the use of a Hoyer (mechanical lift) for transfers. The Care Plan also indicated Resident 1 was resistant to care with interventions including to use a calm tone/approach and to not rush during care. A 9/28/23 facility fall investigation indicated Staff 5 (CNA) transferred Resident 1 using a Sara lift (sit to stand transfer device) when the resident's foot slipped and the resident lost her/his balance. The resident hit her/his mouth and sustained a cut on the lower lip with bruising. Resident 1 was care planned for a two-person transfer using a hoyer lift. Staff 5 did not follow the Care Plan and used a Sara lift instead of the Hoyer to transfer the resident. On 6/18/24 at 10:12 AM Staff 5 stated she was familiar with Resident 1. Staff 5 stated on the day of the incident, Resident 1 was to suppose to receive a shower. Staff 5 stated she was scared to use the Hoyer sling on Resident 1 due to her/his aggression when she/he was placed on the sling. Staff 5 further stated stated the facility was out of Hoyer slings at the time and instead of getting three or four staff to assist with transferring Resident 1, she decided to use the sit to stand to transfer the resident. Staff 5 stated Resident 1 did not fall but was guided to the floor. Staff 5 stated Staff 6 (LPN) was present during the entire incident. Staff 5 acknowledged Resident 1 was care planned for two-person assistance with a Hoyer for transfers. On 6/18/24 at 10:27 AM Staff 2 (RNCM) stated she was asked to look at Resident 1 after the fall. Staff 2 stated Resident 1 had a history of being resistant to care if she/he was not approached in a calm manner, and required a two person transfer. Staff 2 stated she asked Staff 5 if she used the sit to stand to transfer Resident 1 and Staff 5 indicated she did. Staff 2 stated she was informed by Staff 5 that Staff 5 transferred Resident 1 by herself. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385278	A. Building B. Wing	06/18/2024

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(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	On 6/18/24 at 10:50 AM Staff 3 (CMA) stated she was next door in the medication room when Staff 5 asked for assistance with Resident 1. Staff 3 stated she and Staff 6 went into the room, and Resident 1's feet were off the sit to stand with her/his face leaning on part of the device. Staff 3 stated Staff 3 was present in the room when Staff 5 was told she was not suppose to use the sit to stand to transfer Resident 1, and was not suppose to transfer the resident alone. On 6/18/24 at 11:22 AM Staff 6 stated she was not in the room during Resident 1's fall and did not enter the room until Staff 5 yelled for assistance. Staff 6 stated Staff 5 tried to tell staff she was in the room with her but she was not. Staff 6 stated when she entered the room with Staff 5, the resident's lip was resting against the bar of the sit to stand. Staff 6 further stated Staff 5 was aware she was not supposed to use the sit to stand to transfer Resident 1. On 6/18/24 at 9:30 AM and 12:05 PM Staff 1 (Administrator) stated Staff 5 was terminated as a result of the incident on 9/28/23. Staff 1 acknowledged Staff 5 did not follow the care plan, resulting in Resident 1's fall.