STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E188	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracelen Care Center	10948 S.E. Boise Portland, OR 97266

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure equipment was properly secure to prevent falls for 1 of 1 sampled resident (#1) reviewed for accidents. This failure resulted in Resident 1 experiencing an avoidable fall, resulting with a fractured hip which required surgery. The facility identified the failed practice; an avoidable accident related to improper use of a shower gurney (a specialized piece of equipment designed to bathe individuals who are unable to sit upright during a shower). The facility removed the device from use until staff were trained, and competency was demonstrated. Corrective actions were completed on 1/17/25. This failed practice was identified as past noncompliance. Findings include:Resident 1 admitted to the facility in 2023 with diagnosis including movement disorder and chronic incomplete quadriparesis (form of paralysis affecting all four limbs with some motor function and sensation preserved). Resident 1's 8/23/24 Annual MDS revealed the resident was cognitively intact and was dependent on staff for bathing. A FRI was submitted to the State Agency on 11/11/25 at 9:43 AM to report Resident 1 experienced a fall in the shower at 7:50 AM. A 1/11/25 at 10:09 AM Progress Note by Staff 2 (LPN) revealed Resident 1 fell in the shower, 911 was called and the resident was sent to the hospital. At 5:38 PM the hospital called the facility and Resident 1 was admitted to the hospital with a left hip fracture. A care plan dated 1/11/25 indicated Resident 1 was dependent on one staff member for assistance during showers. A 1/17/25 facility investigation revealed on 1/11/25 Staff 3 (CNA) provided Resident 1 with a routine shower in the facility's shower room. The investigation determined the staff failed to ensure the shower gurney was properly locked for safety which caused Resident 1‘s head to lower and fall to the floor. Resident 1 re-admitted to the facility on [DATE] with a diagnosis including a post-surgical repair of the left hip.On 8/28/25 at 9:35 AM Resident 1 recalled her/his 1/11/25 fall in the shower in detail and believed the fall was a freak accident. Resident 1 stated Staff 3 followed her/his care plan and tried to make her/his head more comfortable when the shower gurney head went down. Resident 1 stated she/he did not experience pain at the time of the incident. On 8/28/25 at 10:34 AM Staff 3 stated she provided Resident 1 a shower on 1/11/25 which resulted in a fall. Staff 3 recalled she tried to put a towel under Resident 1's head, the head of the shower gurney (a specialized piece of medical equipment designed to bathe individuals who are unable to stand or sit upright during a shower) fell backwards and the resident fell to the floor. Staff 3 reported the shower gurney was a new piece of equipment and believed it appeared and felt safe when she transported Resident 1 to the shower room. After the fall Staff 3 stated she learned the gurney had a safety clip that should have been in secured however, she was not trained on how to use the equipment prior to its use. On 8/28/25 at 11:00 AM Staff 2 stated she was called to the shower room after Resident 1 had fallen to the floor. She recalled when she arrived at the shower room, the head and lower part of the leg section of the shower gurney had fallen down and Resident 1 was on the floor. Staff 2 called 911, the resident was sent to the hospital and had surgery for a hip fracture. On 8/28/25 at 11:09 AM Staff 4 (Maintenance Director) stated the shower gurney used in Resident 1's 1/11/25 fall was a new piece of equipment and was different from the other shower chairs used in the facility. He stated he inspected the shower gurney after the incident and observed the medal pin was not locked in the pin bar which was necessary for safety. Staff 4 immediately removed the shower gurney from the facility, education was provided, and he was unaware of any other falls from equipment in disrepair or misused. Observations were made of the facility's shower chairs and gurneys on 8/28/25 at 11:14 AM with Staff 4. Staff 4 demonstrated the shower equipment movements and how to place them in locked position. No shower equipment was found in disrepair. On 8/28/25 at 11:40 AM Staff 2 (DNS) confirmed Resident 1's 1/11/25 fall in the shower resulted in hospitalization and hip surgery. Staff 2 confirmed she completed the 1/17/25 investigation which concluded the fall was due to staff not properly securing the shower gurney. She expected all staff to use the shower equipment properly and all parts should be locked while providing a shower. On 1/17/25, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined staff was not trained for the proper use of the new shower gurney. The Plan of Correction included: 1. Staff educated on shower equipment use. 2. The new shower gurney was removed from the facility until staff were trained and competency was demonstrated. 3. The Maintenance Director inspected all the shower equipment to ensure safety. 4. If new shower equipment was purchased, which was different than current shower equipment used, the Maintenance Director would conduct training prior to the use of the new equipment. 5. The Maintenance