STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385136	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glisan Post Acute	9750 NE Glisan Street Portland, OR 97220

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review it was determined the facility failed to ensure medications and biologicals were secured for 1 of 4 medication carts and 1 of 3 treatment carts reviewed for safe medication storage. This placed residents at risk for unauthorized access to medications. Findings include: The facility's undated Storage of Medication Policy indicated only licensed nurses, pharmacy staff and those lawfully authorized to administer medications (such as medication aides) are allowed access to the medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. 1. On 3/11/26 from 5:08 AM to 5:22 AM, an unlocked and unattended treatment cart was observed in the east hall across from the nurse's station. Two boxes of enoxaparin (an injectable anticoagulant [blood thinner]) for Resident 15 were observed on top of the cart. CNA staff were in the area, one resident was observed to self-propel in her/his wheelchair near the cart, and the contents of the cart were accessible. On 3/11/26 at 5:22 AM, Staff 37 (LPN) acknowledged the treatment cart was unlocked and unattended and confirmed the cart contained insulins. Staff 37 stated the cart should be locked at all times when unattended and medications should not be stored on top of the cart. On 3/12/26 from 3:33 PM to 3:37 PM, an unlocked and unattended medication cart was observed on the south side of the facility. CNA staff were in the area, and the contents of the cart were accessible. On 3/12/26 at 3:37 PM, Staff 16 (CMA) acknowledged the medication cart was unlocked and unattended and confirmed the cart contained all of the day and evening shift medications for the residents in Rooms 131 through 138. Staff 16 stated the cart should be locked at all times when unattended. 2. On 3/11/26 at 11:17 AM a treatment cart was observed to be unlocked and unattended in the Intermediate Care Facility (ICF) hallway near the nurse's station. On 3/11/26 at 11:21 AM Staff 9 (RN) returned to the treatment cart and stated he left the cart unlocked and unattended. The cart contained residents' insulin, creams and other treatment supplies. On 3/11/26 at 11:25 AM Staff 2 (DNS) stated it was her expectation for the treatment carts to be locked when unattended. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/26 at 12:40 PM, Staff 2 (DNS) stated she expected medications to be stored inside a locked medication cart when not in use and the medication and treatment carts to be locked and secured at all times when unattended.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to properly store food and failed to maintain sanitary conditions for 1 of 1 unit refrigerators and 1 of 1 unit freezers. This placed residents at risk for food borne illness and contaminated food. Findings include:The facility's 11/2022 Food Receiving and Storage Policy indicated:-All foods stored in the refrigerator or freezer are covered, labeled and dated; and;-Foods in the walk-ins are stored off the floor. On 3/9/26 at 9:03 AM, observation of the unit refrigerator and the unit freezer revealed the following items:-Two unlabeled, undated plastic bags of hot dogs;-One unlabeled, undated large container of sliced pepperonis;-One unlabeled, undated small container of lemon wedges;-One unlabeled, undated large container of shredded cheese;-One unlabeled plastic container of pulled pork;-One unlabeled medium container of corn dated 3/2;-One unlabeled medium container of chicken fried steak dated 2/17;-One unlabeled medium container of spaghetti sauce dated 12/3;-One box of opened ice cream bars stored on the floor of the freezer;-One box of opened bags of corn stored on the floor of the freezer;-Two unlabeled, undated plastic bags of premade egg patties stored on a shelf in the freezer. On 3/9/26 at 9:31 AM Staff 4 (Dietary Manager) acknowledged the unlabeled and undated food items and the food stored on the floor of the freezer and stated food items should be labeled, dated and stored off the floor.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 appropriate use and disposal of personal protective equipment in accordance with CDC guidelines and failed to ensure the separation of soiled and clean linens for 1 of 1 facility. These failures placed residents at risk for infections and cross contamination. Finding include: The CDC's 2/11/25 Eye Protection for Infection Control website, https://www.cdc.gov/niosh/ppe/eye-safety/infection-control.html, specified to remove eye protection, such as face shields, by only handling the parts that secure it to the head (like plastic temples, elastic bands, or ties) and to avoid touching the front of face shields, as those surfaces are most likely contaminated by sprays or droplets. Non-disposable eye protection should be placed in a designated container for cleaning and disinfection. The facility's Droplet/Contact Precautions sign dated 5/2020 included the following: - Wear eye protection (face shield or goggles).- Remove mask and eye cover from earpiece or ties to discard - do not grab from front of mask.The facility's Laundry and Linen Policy dated 1/2014 included the following:- Separate soiled and clean linen at all times.- Consider all soiled linen to be potentially infectious and handle with standard precautions.1. rooms [ROOM NUMBERS] were identified as Transmission Based Precautions (TBP) rooms where COVID-19 positive residents resided.On 3/9/26 at 11:45 AM, Staff 24 (CMA) stated before going inside of rooms [ROOM NUMBERS], everyone was required to don PPE (Personal Protective Equipment), including a face shield due to the two rooms being on TBP Droplet Precautions. On 3/9/26 at 12:20 PM, Staff 35 (CNA) was observed exiting room [ROOM NUMBER] after delivering a meal. She was observed using her ungloved hand to remove the face shield from the front to remove it from her head and placed it behind the hand rails of the wall near room [ROOM NUMBER]. At 12:29 PM, Staff 35 was observed donning PPE, retrieving the face shield from behind the hand rails of the wall, and donning the face shield before entering room [ROOM NUMBER]. At 12:31 PM, Staff 35 was observed exiting room [ROOM NUMBER], removed the face shield by using her ungloved hand on front of face shield, and placing it behind the hand rails of the wall near room [ROOM NUMBER].Observations on 3/10/26 at 8:36 AM, 3/10/26 at 1:31 PM and 3/11/26 at 5:24 AM revealed a face shield was tucked behind the hand rails of the wall near room [ROOM NUMBER].On 3/10/26 at 8:40 AM, Staff 29 (CNA) was observed donning PPE and entered room [ROOM NUMBER] without a face shield.On 3/10/26 at 8:45 AM, Staff 35 was observed entering room [ROOM NUMBER] without a face shield.On 3/10/26 at 1:59 PM, Staff 29 was observed entering room [ROOM NUMBER] without a face shield. At 2:02 PM, Staff 29 stated she knew some staff wore the face shield and others did not. Staff 29 stated she did not wear a face shield, because she used two masks and had her own personal eyeglasses on. On 3/10/26 at 2:21 PM, Staff 36 (CNA) came out of room [ROOM NUMBER] with an N95 and face shield on. She was observed removing her face shield and placing it inside of the PPE cart. Staff 36 was observed still wearing the N95, entering the soiled linen room, then entering nurse's station where she was observed doffing her N95. On 3/11/26 at 5:56 AM, Staff 37 (CNA) was observed entering room [ROOM NUMBER] without donning PPE to deliver a pitcher of water and came out. At 6:08 AM, Staff 37 was observed entering room [ROOM NUMBER] without donning PPE to deliver briefs and came out. On 3/12/26 at 10:51 AM, Staff 38 (LPN/Infection Preventionist) stated she expected staff to follow the signage for TBP Droplet Precautions, including donning PPE and a face shield before staff enter a room. She stated all PPE must be removed before exiting the room, but the face shield could be reused if it was cleaned and disinfected. She stated she expected staff to not handle the face shield by the front, as the front of the face shield could potentially be contaminated. On 3/13/26 at 1:22 PM, Staff 2 (DNS) stated if a resident room was identified on TBP for Droplet Precautions, staff were expected to don the required PPE before crossing through the doorway of the room. Staff 2 stated appropriate PPE included a gown, gloves, respirator and face shield which should be donned prior to entrance and doffed upon exit. Staff 2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated face shields could be reused if cleaned and disinfected, but not stored in or on PPE carts or behind hand rails of the wall. 2. Observations on 3/11/26 at 6:14 AM revealed Staff 43 (CNA) placing clean linens onto a shelf inside of the [NAME] hall shower room. Observed inside of the shower room were a covered barrel with trash, a covered barrel with soiled linens, and folded wash cloths and bath towels on top of a shower chair. Staff 43 stated when residents were ready to shower, staff took out the barrels for residents to shower. Staff 43 acknowledged a clean linen room was directly across from the shower room and stated she replenished clean linens in both rooms.Observations on 3/12/26 at 8:24 AM revealed folded towels on top of a shower chair, clean linens on a shelf above two barrels, and staff placing a bag into the soiled linen barrel located inside of the [NAME] hall shower room. On 3/12/26 at 10:17 AM, Staff 44 (CNA) stated the garbage barrel and soiled linen barrel were stored inside of the [NAME] hall's shower room due to inadequate space. Staff 44 stated clean linens were not supposed to be stored in the shower room, as there was a clean linen storage across from the shower room. She stated clean linens were placed in the shower room when a resident was ready to shower immediately.On 3/12/26 at 10:51 AM, Staff 38 (LPN/Infection Preventionist) stated clean linens and soiled linens were expected to be kept and stored separately due to the risk of cross contamination. Staff 38 acknowledged the [NAME] hall had a garbage barrel and a soiled linens barrel inside of the shower room, as well as a clean linen storage room directly across from the shower room. Staff 38 stated she expected for staff to store clean linens in the clean linen storage room and not in the shower room. On 3/13/26 at 1:22 PM, Staff 2 (DNS) stated she expected for clean linens to be stored separately from soiled linens to prevent cross contamination.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed to self-administer medications for 3 of 3 sampled residents (#s 10, 13 and 60) reviewed for self-administration. This placed residents at risk for unsafe medication administration. Findings include:The facility's Self Administration of Medication dated 8/2024 included the following:- No medications are stored at bedside nor self-administered until evaluation complete.- A physician order is obtained indicating the specific medications that resident is able to self-administer.- If the resident chooses to have the medications at the bedside, they are contained in a locked cupboard or drawer.- Medications are indicated on the MAR as self-administered. - The resident is reevaluated for continued ability to self-administer their medications annually and with significant change in condition.1. Resident 60 was admitted to the facility 7/2025 with diagnosis of metabolic encephalopathy (a syndrome of global brain dysfunction caused by underlying systemic illnesses). The Quarterly MDS with an ARD of 12/7/25 revealed Resident 60 had a BIMS score of 13, which indicated the resident was cognitively intact.Observations on 3/9/26 at 10:52 AM, 3/10/26 at 7:19 AM, and 3/12/26 at 8:29 AM revealed Resident 60 had Calcium Magnesium, Benadryl (over-the-counter antihistamine), Calamine lotion (over-the-counter topical medication), multivitamins, and Cetirizine Hydrochloride (over-the-counter antihistamine) on her/his nightstand and bedside table. A review of Resident 60's clinical record revealed no self-administration assessment for Calcium Magnesium, Benadryl, Calamine lotion, multivitamins, and Cetirizine Hydrochloride.A review of Resident 60's Medication Administration Record for 3/2026 revealed no indication for medications to be self-administered.On 3/12/26 at 8:49 AM, Staff 29 (CNA) stated she was unaware of any residents being authorized to self-administer medications. She stated if she saw medications at a resident's bedside, she would inform a nurse.On 3/12/26 at 9:33 AM, Staff 11 (CNA) stated residents were not supposed to have medications at their bedside. She stated if she saw medications at a resident's bedside, she would tell a nurse.On 3/12/26 at 9:35 AM, Staff 24 (CMA) stated she ensured residents completely swallowed oral medications safely prior to exiting the room and any medications at the bedside would be reported to a nurse.On 3/12/26 at 9:41 AM, Staff 22 (LPN) stated he did not know of many residents who were authorized to have medications at the bedside. At 9:43 AM, Staff 22 stated Resident 60 was known to purchase her/his own medications from outside of the facility and bring them back to her/his room. At 9:45 AM, Staff 22 entered Resident 60's room and confirmed she/he had Calcium Magnesium, Benadryl, Calamine lotion, multivitamins, and Cetirizine Hydrochloride in her/his room.On 3/13/26 at 10:34 AM, Staff 23 (LPN Resident Care Manager) stated the process for residents to have medications at the bedside included having a self-administration assessment completed for residents. Staff 23 stated he expected for staff to inform management if they observed residents to have medications at the bedside. At 10:47 AM, Staff 23 entered Resident 60's room and confirmed she/he had Calcium Magnesium, Benadryl, Calamine lotion, multivitamins, and Cetirizine Hydrochloride in her/his room.On 3/13/26 at 1:22 PM, Staff 2 (DNS) stated she expected for staff to inform nurses if medications were observed to be in a resident's room. Staff 2 stated residents should not have medications, unless a self-administration assessment was on file.2. Resident 13 was admitted to the facility 5/2023 with diagnosis of calculus of kidney (solid mineral that forms in the kidneys). The Quarterly MDS with an ARD of 12/11/25 revealed Resident 13 had a BIMS score of 15, which indicated the resident was cognitively intact.Observations on 3/9/26 at 10:22AM, 3/11/26 at 11:23 AM and 3/12/26 at 9:49 AM revealed Resident 13's dresser had a bottle of Vitamin B12, a bottle of Caltrate bone vitamins (high-potency calcium and Vitamin D3) and a box of artificial tears. Resident 13's bedside table was also observed to have a bottle of phenol throat spray (over-the-counter antiseptic and anesthetic spray). A review of Resident 13's clinical record revealed she/he had a self-administration assessment from 10/11/24 for Vitamin B Complex. The clinical record revealed no self-administration assessment for the last 12 months for Vitamin B12, Caltrate (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bone vitamins, artificial tears, or phenol throat spray.A review of Resident 13's Medication Administration Record for 3/2026 revealed no indication for medications to be self-administered.On 3/9/26 at 10:22 AM, Resident 13 stated she/he thought it was okay to have the medications in her/his room and had been using the throat spray to relieve her/his throat.On 3/12/26 at 8:49 AM, Staff 29 (CNA) stated she was unaware of any residents being authorized to self-administer medications. She stated if she saw medications at a resident's bedside, she would inform a nurse.On 3/12/26 at 9:33 AM, Staff 11 (CNA) stated residents were not supposed to have medications at their bedside. She stated if she saw medications at a resident's bedside, she would tell a nurse.On 3/12/26 at 9:35 AM, Staff 24 (CMA) stated she ensured residents completely swallowed oral medications safely prior to exiting the room and any medications at the bedside would be reported to a nurse. On 3/12/26 at 9:41 AM, Staff 22 (LPN) stated he did not know of many residents who were authorized to have medications at the bedside. At 9:49 AM, Staff 22 entered Resident 13's room and confirmed she/he had a bottle of Vitamin B12, a bottle of Caltrate bone vitamins, a box of artificial tears and a bottle of phenol throat spray in her/his room. Staff 22 stated Resident 13 was not authorized to self-administer the medications.On 3/13/26 at 10:34 AM, Staff 23 (LPN Resident Care Manager) stated the process for residents to have medications at the bedside included having a self-administration assessment completed for residents. Staff 23 stated he expected for staff to inform management if they observed residents to have medications at the bedside. At 10:46 AM, Staff 23 entered Resident 13's room and confirmed there was a bottle of Vitamin B12, a bottle of Caltrate bone vitamins, a box of artificial tears and a bottle of phenol throat spray in her/his room. and confirmed she/he needed to have a self-administration assessment on file. On 3/13/26 at 1:22 PM, Staff 2 (DNS) stated she expected for staff to inform nurses if medications were observed to be in a resident's room. Staff 2 stated residents should not have medications, unless a self-administration assessment was on file and self-administration assessments should be reviewed at least once a year.3. Resident 10 was admitted to the facility 1/2026 with diagnosis of cellulitis of right lower limb. The Admissions MDS with an ARD of 1/18/26 revealed Resident 10 had a BIMS score of 15, which indicated the resident was cognitively intact. Observations on 3/9/26 at 11:10 AM and 3/13/26 at 10:48 AM revealed Resident 10 had a bottle of nasal saline solution on her/his bedside table.A review of Resident 10's clinical record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer nasal saline solution.On 3/9/26 at 11:10 AM, Resident 10 stated staff had given her/him the saline solution to use independently.On 3/12/26 at 8:49 AM, Staff 29 (CNA) stated she was unaware of any residents being authorized to self-administer medications. She stated if she saw medications at a resident's bedside, she would inform a nurse.On 3/12/26 at 9:33 AM, Staff 11 (CNA) stated residents were not supposed to have medications at their bedside. She stated if she saw medications at a resident's bedside, she would tell a nurse.On 3/12/26 at 9:35 AM, Staff 24 (CMA) stated she ensured residents completely swallowed oral medications safely prior to exiting the room and any medications at the bedside would be reported to a nurse. Staff 24 stated she thought it was okay for Resident 10 to have the saline nasal solution. On 3/12/26 at 9:41 AM, Staff 22 (LPN) stated he did not know of many residents who were authorized to have medications at the bedside. At 9:43 AM, Staff 22 entered Resident 10's room and confirmed the saline nasal spray was on Resident 10's bedside table. Staff 22 stated Resident 10 needed a self-administration assessment. On 3/13/26 at 10:34 AM, Staff 23 (LPN Resident Care Manager) stated the process for residents to have medications at the bedside included having a self-administration assessment completed for residents. Staff 23 stated he expected for staff to inform management if they observed residents to have medications at the bedside. At 10:48 AM, Staff 23 entered Resident 10's room and confirmed there was nasal saline solution on Resident 10's bedside and confirmed she/he needed to have a self-administration assessment on file. On 3/13/26 at 1:22 PM, Staff 2 (DNS) stated she expected staff to inform nurses if medications were observed to be in a resident's room. Staff 2 stated residents should not have medications, unless a self-administration assessment was on file.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review it was determined the facility failed to ensure a comfortable and homelike environment for 1 of 1 sampled resident (#1) reviewed for environment. This placed residents at risk for lack of a homelike environment and loss of sleep. Findings include:The facility's 2/2021 Homelike Environment Policy indicated the facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including comfortable sound levels. Resident 1 was readmitted to the facility in 3/2023 with diagnoses including insomnia. Resident 1's 2/5/26 Quarterly MDS revealed the resident was cognitively intact. On 3/10/26 at 9:50 AM, Resident 1 was observed in her/his room in bed. Resident 1 stated the backdoor, located just outside of her/his room, was broken and the alarm attached to the door would ring and ring and ring when the door was not shut properly. Resident 1 stated the sound of the alarm was constant, and at night, it prevented her/him from sleeping. Resident 1 stated the residents at the facility were expected to just have to deal with the constant sound of the alarm. The door to the resident's room was shut, and at 10:05 AM, the sound of the alarm was heard inside the resident's room.On 3/10/26 from 2:32 PM to 3:54 PM and from inside Resident 1's room with the door shut, the alarm to the backdoor was observed to loudly sound on five different occasions. On 3/11/26 from 5:21 AM to 5:26 AM, the alarm to the backdoor was observed to loudly sound. At 5:34 AM, Resident 1 stated the sound of the alarm was very intrusive and makes you nuts, and stated she/he had complained about the noise to everybody and anybody who would listen. At 5:47 AM, the alarm to the backdoor sounded again. On 3/11/26 at 5:59 AM, Staff 20 (CNA) stated residents were constantly going in-and-out of the backdoor, so the alarm sounded all of the time at night. Staff 20 stated the alarm sounded the loudest in Resident 1's room, and he would loose his mind if he were a resident and had a room by the backdoor because of the constant sound from the door alarm. On 3/11/26 at 6:08 AM, Staff 21 (CNA) stated Resident 1 complained she/he can't stand the noise from the backdoor's alarm.On 3/12/26 at 8:36 AM, Staff 11 (CNA) stated Resident 1 complained the noise from the backdoor's alarm was annoying. Staff 11 further stated the door alarm sounded at least ten times during her shift. On 3/12/26 at 9:12 AM, Staff 22 (LPN) stated Resident 1 slept during the day. At 9:16 AM, the alarm to the backdoor sounded and Staff 22 excused himself to turn it off. Upon his return, Staff 22 stated the noise from the alarm was bothersome to the residents, and it sounded at all times of the day, including during the middle of the night. On 3/12/2026 at 11:58 AM, Staff 1 (Administrator) stated she expected staff to notify her of complaints regarding sound levels at the facility so she could implement systems to address the complaints. Staff 1 further stated she was unaware of Resident 1's complaint about the noise from the backdoor alarm and did not consider the alarm sounding throughout the day and night to constitute a homelike environment.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, interview and record review it was determined the facility failed to complete comprehensive assessments in the areas of cognition and mood for 1 of 1 sampled resident (#62) reviewed for respiratory care. This placed residents at risk for inaccurate assessments and unassessed needs. Findings include:Resident 62 was admitted to the facility in 2/2026 with diagnoses including acquired absence of larynx (the surgical removal of the voice box [laryngectomy]) and encounter for attention to tracheostomy (a surgically created opening [stoma] in the front of the neck leading directly into the trachea [windpipe] to create a new airway for breathing). Resident 62's 2/26/26 admission MDS revealed the resident had no speech but was able to communicate to and understand others without difficulty. The MDS further revealed the Brief Interview for Mental Status (BIMS) and Resident Mood Interview (PHQ-2 to 9) were not completed as the resident was rarely/never understood. On 3/9/26 at 11:51 AM, Resident 62 was observed in her/his room. The resident was nonverbal but able to appropriately communicate with the state surveyor through written communication. On 3/11/26 at 11:54 AM, Staff 19 (Social Services Director) stated she was responsible for completing the BIMS and PHQ-2 to 9 interviews. Staff 19 stated she did not attempt a BIMS interview with Resident 62 because the resident was unable to verbally communicate. Staff 19 stated she entered the resident's room on one occasion to attempt the mood interview but was unable to start the interview as the resident was busy with nursing staff. Staff 19 stated she did not reattempt to complete the mood interview with the resident. On 3/11/26 at 1:12 PM, Staff 2 (DNS) stated she expected the BIMS and PHQ-2 to 9 interviews to be attempted with all residents using the residents' preferred method of communication. Staff 2 further stated she expected the staff to reapproach and reattempt the interviews if initially refused.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review it was determined the facility failed to provide the necessary care and assistance to maintain good grooming and hygiene for 2 of 2 sampled residents (#s 3 and 72) reviewed for ADLs. This placed residents at risk for poor grooming and loss of dignity. Findings include:1 Resident 3 was admitted to the facility in 9/2025 with diagnoses including quadriplegia and Type 2 diabetes. On 3/9/26 at 11:10 AM Resident 3 was observed in her/his room. Resident 3's fingernails were long and contained a thick, skin-colored debris beneath the nails. The ADL Function CAA dated 8/14/25 indicated Resident 3 required maximum assistance with all ADLs. A Physician Order dated 9/10/25 directed a licensed nurse to check Resident 3's fingernails and toenails weekly on bath days and trim as needed. A review of the 2/2026 and 3/2026 TAR indicated a licensed nurse was to check Resident 3's fingernails and toenails weekly on bath days and trim as needed. On 3/10/26 at 2:22 PM Staff 10 (CNA) stated a licensed nurse would have to trim Resident 3's fingernails due to Resident 3 being diabetic. Staff 10 observed Resident 3's nails and stated they were long and needed to be trimmed. On 3/10/26 at 2:30 PM Staff 11 (CNA) stated she would cut or trim residents' nails if they were not diabetic. Staff 11 observed Resident 3's nails and stated the fingernails were long. During this observation, Resident 3 stated her/his fingernails needed to be cut and they hurt from being so long. On 3/10/26 at 3:18 PM Staff 8 (LPN) stated Resident 3 had previously told her she/he bit her/his fingernails, so she did not need to trim them. On 3/10/26 at 3:30 PM Staff 7 (LPN Resident Care Manager) stated Resident 3 was care planned to have her/his nails trimmed by a licensed nurse. Staff 7 further stated the resident had requested to have her/his nails cut and the resident had been treated for a fungal infection on the fingernails and toenails. Staff 7 observed Resident 3's fingernails and stated they were long and needed to be filed. Staff 7 asked Resident 3 when the last time staff had soaked her/his nails and the resident replied it had been a long time ago. On 3/10/26 at 4:30 PM and on 3/12/26 at 3:47 PM Staff 2 (DNS) stated she was aware Resident 3's fingernails were long and the resident was scheduled for weekly nail care by a licensed nurse. Staff 2 acknowledged Resident 3's fingernails had not been trimmed since admission to the facility and stated it had not been reported to her the resident had experienced pain related to the length of her/his fingernails. 2. Resident 72 was admitted to the facility in 12/2024 with diagnoses including schizophrenia (mental disorder) (men. Resident 72's 12/11/25 Annual MDS revealed the resident was able to make herself/himself understood and understand others without difficulty, required substantial-to-maximal assistance from (continued on next page)

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	385136	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glisan Post Acute	9750 NE Glisan Street Portland, OR 97220

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff with personal hygiene tasks and she/he did not reject care. Resident 72's 12/24/25 ADL and Behavior Care Plans revealed the following:-The resident preferred to bathe on Wednesday and Sunday evenings and required assistance from one person. -The resident required set-up assistance and encouragement as needed with hygiene. -The resident's behaviors included talking to herself/himself, hallucinations and delusions. A review of Resident 72's Personal Hygiene Task Log from 2/12/26 to 3/12/26 revealed the resident refused personal hygiene care on 2/18/26 and 2/27/26 but was otherwise cooperative. On 3/10/26 at 2:03 PM, Resident 72 was observed in her/his room in bed. [NAME] hair that curled at the end of some of the strands, approximately one inch in length, was observed on both sides of her/his chin. Resident 72 stated she/he did not have the opportunity to look in the mirror much, so she/he was not always aware if she/he had any facial hair. Resident 72 felt the hair on her/his chin, bothered her/him and wanted the facial hair removed. Resident 72 stated staff did not offer to trim her/his facial hair, but if they had, she/he would accept the offer. On 3/13/26 at 8:22 AM, Resident 72 was observed in her/his wheelchair in the dining room. Long white facial hair was observed on either side of the resident's chin. Resident 72 stated she/he wanted her/his chin hair removed but staff had not offered. On 3/13/26 at 8:54 AM, Staff 30 (CNA) stated residents were offered facial hair grooming when they received a shower. Staff 30 stated she did not work on Resident 72's scheduled shower days, so she had never offered to assist the resident to shave her/his facial hair, but the resident did not refuse care. On 3/13/26 at 9:01 AM, Staff 31 (CNA) stated residents were offered facial hair grooming when they received a shower, and she provided facial hair grooming outside of a scheduled shower only if the resident requested it. Staff 31 stated Resident 72 was really cooperative with care. Staff 31 further stated she had never offered to assist the resident with facial hair grooming, and she was unaware of the resident's facial hair preference. On 3/13/26 at 9:12 AM, Staff 32 (CNA) stated Resident 72 never refused care, but she/he did require some cueing and encouragement to get out of bed. Staff 32 stated she had not offered facial hair grooming assistance to Resident 72. On 3/13/26 at 9:57 AM, Staff 28 (RN) stated facial hair grooming was offered by CNAs to residents during their scheduled showers and as needed. Staff 28 stated Resident 72 was cooperative with care, and she had not received any reports of the resident refusing care, including facial hair grooming. On 3/13/26 at 10:02 AM, Staff 33 (LPN) stated she was unsure of Resident 72's preferences for facial hair but stated this information was found in the resident's Kardex (a quick reference that provides an overview of patient care plans). On 3/13/26 at 10:17 AM, Staff 34 (CNA) stated Resident 72 was cooperative with care, including with trimming her/his facial hair. Staff 34 stated she assisted the resident with a shower on 3/11/26 and she did not offer to assist the resident to trim her/his facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/26 at 12:27 PM, Staff 7 (LPN Resident Care Manager) stated facial hair grooming was a sensitive subject for some residents, so it was provided per resident request. Staff 7 stated she had not considered residents with a limited access to a mirror or residents who were unable to request the assistance may still be interested in receiving assistance with facial hair grooming. Staff 7 further stated facial hair grooming should be completed according to resident preference, and she was unaware of Resident 72's preference for facial hair.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activities program for 1 of 2 sampled residents (s 3) reviewed for activities. This placed residents at risk for a decline in psychosocial well-being and diminished quality of life. Findings include: An undated Facility Activity Programs Policy Statement indicated:-Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident.-The activities program is provided to support the well-being of residents and to encourage both independence and community interaction.-Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.-The activities program is ongoing and includes facility organized group activities, independent individual activities and assisted individual activities.-Activities are scheduled 7 (seven) days a week.-Our activity programs consist of individual, small group and large group activities designed to meet the needs and interests of each resident.-All activities are documented in the resident's medical record.1 Resident 3 was admitted to the facility in 9/2025 with diagnoses including quadriplegia and Type 2 diabetes.Resident 3's 8/8/25 Activity Care Plan revealed the following:-The resident enjoyed Bible study, cell phone, music, one on one visits, individual activities versus group activities, television and friends and family visits.-In room activities were to be offered, which included an activity calendar, music, books, newspapers and magazines.Resident 3's 8/14/25 admission MDS indicated the resident was cognitively intact.A review of Resident 3's Activity Task Records for the 30-day period from 2/9/26 through 3/9/26 revealed no documented in-room activities, no documented one-to-one activity visits, and no documented participation in any facility activity programming.On 3/9/26 at 11:10 AM Resident 3 was observed in her/his room in bed. The resident required total assistance due to quadriplegia and was unable to independently engage in activities without staff assistance. No books, magazines or newspapers were visible in the resident's room. Resident 3 stated she/he enjoyed watching television, Bible study, seeing pets and visiting with family over the phone. Resident 3 stated she/he preferred to stay in her/his room and not participate in group activities.Observations of Resident 3 conducted on 3/9/26 through 3/13/26 during various times of the day revealed the resident remained in bed in her/his room with the television on. The resident was not observed participating in any activities, being offered in-room activity materials, or receiving one-to-one visits from activity staff. The resident's room did not contain activity materials such as books, magazines, newspapers, puzzles, music devices or other items identified in the resident's care plan.On 3/10/26 at 2:22 PM, Staff 10 (CNA) stated Resident 3 spent her/his time in her/his room in bed watching television. Staff 10 stated the resident required staff assistance to use the phone and primarily spoke with family when staff helped dial the number. Staff 10 stated she/he had not observed activity staff offer the resident in-room activities or visit the resident for one-to-one engagement.On 3/10/26 at 2:39 PM, Staff 11 (CNA) stated Resident 3 spent most of the day in bed watching television or movies. Staff 11 stated she/he had not observed Resident 3 participate in group activities or receive one-to-one visits from activity staff. Staff 11 stated she/he had not observed the resident being offered music, reading materials, or other in-room activity options.On 3/10/26 at 3:18 PM, Staff 8 (LPN) stated she was unsure what type of activities the resident preferred other than watching television or movies. Staff 8 stated the activity department was responsible for assessing resident interests and providing appropriate individualized activities.On 3/10/26 at 3:30 PM, Staff 7 (LPN Resident Care Manager) stated she was unable to show documentation to support Resident 3's activity engagement other than the care plan noting the resident preferred to remain in her/his room. Staff 7 confirmed she could not locate documentation showing the resident had been offered individualized or one-to-one activities.On 3/10/26 at 4:02 PM, Staff 6 (Activity Director) stated she had spoken with Resident 3 informally but acknowledged she did not document these interactions. Staff 6 stated she had not provided in-room activity materials and had not offered individualized (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities such as music, reading materials, or other engagement options to the resident. Staff 6 stated although a volunteer provided Bible study on Saturdays, she had not offered the volunteer to visit Resident 3 individually.On 3/10/26 at 4:30 PM, Staff 2 (DNS) stated residents who are unable or unwilling to attend group activities should receive individualized, one-to-one activity engagement based on their interests and care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined the facility failed to ensure residents were comprehensively assessed to independently perform tracheostomy care and a person-centered care plan was developed for respiratory care for 1 of 1 sampled resident (#62) reviewed for respiratory care. This placed residents at risk for respiratory distress and unmet needs. Findings include:The facility's 8/2024 Respiratory Treatment Policy and Procedure indicated residents received respiratory treatments and monitoring according to their physician orders, standards of practice and care plan. Resident 62 was admitted to the facility in 2/2026 with diagnoses including acquired absence of larynx (the surgical removal of the voice box [laryngectomy]) and encounter for attention to tracheostomy (a surgically created opening [stoma] in the front of the neck leading directly into the trachea [windpipe] to create a new airway for breathing). Resident 62's 2/20/26 Nursing admission Assessment indicated the resident was cognitively intact, nonverbal and communicated her/his needs in writing. Resident 62's 2/20/26 Respiratory Care Plan indicated the following:-Provide respiratory treatments as ordered. -Tracheostomy care each shift and as needed. A 2/20/26 Progress Note written by Staff 12 (RN) revealed Resident 62 had a tracheostomy that was intact, and she/he was competent with self-directed suctioning with help with trach set ups. Resident 62's 2/24/26 Physician Orders directed the following:-The resident's laryngectomy tube insertion site was to be cleaned with soap and water or normal saline every day shift and as needed using a clean technique (a set of infection control practices that involve meticulous handwashing, maintaining a clean workspace and using clean, non-sterile gloves). -The resident's stoma was to be cleaned with a saline soaked cotton swab every day and as needed. -The resident's tracheostomy ties (a securement device used to hold a tracheostomy tube securely in place, preventing accidental dislodgement or movement) were to be changed on Mondays, Thursdays and as needed. -The resident's laryngectomy tube (a short, soft, flexible silicone tube inserted into the stoma after a total laryngectomy) could be removed and cleaned with normal saline every two hours as needed but should otherwise stay in place. Resident 62's 2/25/26 Self-Administration of Medication Observation Evaluation revealed the resident was determined to be appropriate to complete oral and laryngectomy tube suctioning (procedures used to remove mucus and secretions from the airway through a stoma) independently. A review of Resident 62's 3/2026 TAR revealed laryngectomy site care was completed and the resident's stoma was cleaned with a saline soaked cotton swab every day outside of 3/2/26 when the resident refused and on 3/4/26 when the resident was hospitalized . The TAR also revealed the resident's tracheostomy ties were changed on 3/2/26, 3/5/26 and 3/9/26, and the resident's laryngectomy tube was not removed and cleaned.No evidence was found in Resident 62's clinical record to indicate the type or size of the resident's laryngectomy tube. On 3/10/26 at 2:12 PM, Resident 62 was observed in her/his room in bed. Resident 62 used a pen and paper to communicate with the state surveyor. Resident 62 stated she/he completed all of her/his tracheostomy care independently. On 3/11/26 at 6:32 AM, Resident 62 stated in writing she/he was going to perform her/his tracheostomy care and offered for the state surveyor to observe. Without washing or sanitizing her/his hands or donning a pair of gloves, Resident 62 retrieved a partially opened package containing a laryngectomy tube and a wipe from an overbed table positioned on the left side of her/his bed and placed it on her/his stained sheets. A book was observed on top of a pink-stained wash cloth on an overbed table to the right of the resident's bed. The resident placed a free-standing mirror on top of the book and removed her/his tracheostomy tie and the laryngectomy tube. The resident placed the blood-tinged tube on the right side of the overbed table on top of the stained washcloth. The resident used the wipe located inside of the partially opened package that also contained a new laryngectomy tube and quickly wiped her/his stoma. Without performing any hand hygiene, the resident removed the new laryngectomy tube from the partially opened package, inserted it into her/his stoma, and attempted to secure the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy tie. From 6:39 AM to 6:51 AM, the resident attempted but was unable to re-thread her/his tracheostomy ties, and during this time period, placed the new laryngectomy tube both on her/his lap and on the stained washcloth. At 6:52 AM, the resident motioned for the state surveyor to assist her/him to thread the left side of the tracheostomy collar. The state surveyor indicated she was unable to assist with this process, and the resident declined the state surveyor's offer to obtain staff assistance. At 6:55 AM, the resident was able to secure the tracheostomy ties and placed gauze underneath the collar on either side of her/his stoma. On 3/11/26 at 10:36 AM, Staff 13 (RN) stated Resident 62 completed her/his tracheostomy care independently since her/his admission to the facility. Staff 13 stated he informed the resident how to perform tracheostomy care, but he had never observed the resident to complete the care. Staff 13 stated his documentation on the TAR for the resident's tracheostomy care indicated the resident had completed the task. Staff 13 stated he did not know the size or type of the resident's laryngectomy tube. Staff 13 further stated this information should be in the resident's physician orders and confirmed it was not. On 3/11/26 at 11:23 AM, Staff 14 (Respiratory Therapist) stated she verbally went over the procedure for tracheostomy care with Resident 62, including changing out the laryngectomy tube, but she had never observed the resident to do a return demonstration of the procedure. Staff 14 stated the resident seemed pretty capable and knew enough of herself/himself, I felt like he would be okay. Staff 14 stated she usually obtained the type and size of a resident's laryngectomy tube at admission and thought Resident 62's laryngectomy tube was a size ten. On 3/11/26 at 11:35 AM, Staff 15 (RN) stated Resident 62 completed all of her/his tracheostomy care independently, and her documentation in the resident's TAR indicated she confirmed with the resident she/he had completed the care. Staff 15 stated she provided the resident with education about hand hygiene during tracheostomy care but had not provided education on how to clean her/his laryngectomy tube nor had she observed the resident to clean the used tube. Staff 15 further stated she thought the resident's laryngectomy tube was a size eight but she needed to check the resident's physician orders to confirm the size. On 3/11/26 at 12:45 PM, Staff 9 (RN) stated Resident 62 completed tracheostomy care independently. Staff 9 stated he provided education to the resident about wearing gloves during tracheostomy care but the resident used her/his bare hands. Staff 9 further stated he did not know the size or type of laryngectomy tube the resident utilized but thought he could find this information in the resident's physician orders. On 3/11/26 at 1:01 PM, Staff 17 (LPN Resident Care Manager) stated licensed nurses were expected to observe tracheostomy care for a resident, even if the resident preferred to complete the care independently, unless a Self-Administration of Medication Observation Evaluation was completed. Staff 17 also stated information on the size and type of laryngectomy tubes should be in a resident's physician orders and care plan. Staff 17 stated Resident 62 had not been assessed to complete tracheostomy care independently and no information on the size and type of her/his laryngectomy tube was in either her/his physician orders or care plan. On 3/11/26 at 3:24 PM, Staff 12 stated Resident 62 informed him that she/he was able to perform all care related to her/his tracheostomy independently. Staff 12 stated he observed the resident to change out the gauze under her/his tracheostomy tie on 2/20/26, and the resident did not wear gloves or perform hand hygiene prior to completing this care task. Staff 12 stated he had never observed the resident to remove or insert the laryngectomy tube, clean the laryngectomy tube insertion site with soap and water or normal saline or use a cotton swab to clean her/his stoma. On 3/11/26 at 1:12 PM and 3:30 PM, Staff 2 (DNS) stated laryngectomy type and size information should be included in a resident's care plan and confirmed this information was not in Resident 62's care plan. Staff 2 stated a resident who wanted to complete tracheostomy care independently was required to complete a return demonstration of the care tasks to a licensed nurse prior to doing so independently. Staff 2 confirmed Resident 62 had not been comprehensive assessed to perform tracheostomy care independently and should have been.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review it was determined the facility failed to obtain dental services for 1 of 2 sampled residents (#16) reviewed for dental. This placed residents at risk for difficulty with eating. Findings include:Resident 16 was admitted to the facility in 10/2020 with diagnoses including malnutrition.A 12/8/25 Quarterly MDS indicated Resident 16 had a BIMS score of 15 which indicated Resident 16 was cognitively intact. A 10/27/20 Care Plan indicated staff coordinated and made arrangements for dental care services and indicated Resident 16 had her/his own teeth. A 7/22/25 Dental Treatment Summary indicated Resident 16 had all her/his teeth extracted. On 3/9/26 at 2:38 PM, Resident 16 stated she/he had all her/his teeth extracted eight months earlier, had repeatedly asked staff about getting dentures without receiving a response, and was having trouble chewing and eating.On 3/12/26 at 11:35 AM, Staff 42 (CNA) stated Resident 16 had her/his own teeth and did not require assistance to complete dental hygiene. On 3/12/26 at 12:21 PM and 1:26 PM, Staff 19 (Social Services Director) stated Resident 16's mouth was swollen after her/his teeth were extracted and she had not scheduled an appointment to begin the denture process. Staff 19 stated the in-house dentist also had not scheduled an appointment, noted the denture process typically began eight weeks after extractions, and acknowledged Resident 16 had not started the process. On 3/12/26 at 12:38 PM, Staff 43 (Social Services Assistant) stated during a care conference Resident 16 mentioned she/he wanted dentures. On 3/12/26 at 2:38 PM, Staff 28 (RN) stated she was unsure Resident 16 had dentures. On 3/13/26 at 11:35 AM, Staff 17 (LPN Resident Care Manager) stated she expected staff initiate the process to receive dentures within eight weeks after the resident had their teeth extraction. On 3/13/26 at 12:04 PM, Staff 2 (DNS) stated dental services were not provided timely for Resident 16. Staff 2 stated she expected staff to ensure appropriate dental services were provided.