

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Gracelen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43690</p> <p>Based on observation and interview it was determined the facility failed to maintain a homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for living in an unkempt environment. Findings include:</p> <p>Observations of the facility's general environment and residents' rooms from 4/2/24 through 4/8/24 identified the following issues:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] had a section of missing cove base behind the door, scrapes of missing paint along the wall under the window, gouges of missing wood on the window sill and the bedside table base was covered with paint chips. -Floor mats in multiple resident rooms were torn and tattered. -West hall sitting area across from the DNS office had an approximate 12 inch piece of wall covering peeling from underneath the window sill, a long crack in the wall with missing paint above the hand hygiene dispenser, and four large screws sticking out of the wall below the flag quilt. -The west dining room had an area on the north wall with missing paint and brackets were sticking out. <p>On 4/8/24 at 11:31 AM Staff 7 (Maintenance Director) acknowledged these issues created an unkempt environment.</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.

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: 38E188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Gracelen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43690</p> <p>Based on observation, interview and record review it was determined the facility failed to protect the residents' rights to be free from physical abuse by Residents (#s 3, 18, 26 and 46) for 4 of 4 sampled residents (#s 3, 4, 18, and 46) reviewed for physical abuse. This placed residents at risk for physical abuse. Findings include:</p> <p>1. Resident 26 was admitted to the facility in 11/2022 with diagnoses including dementia and behavioral disturbance.</p> <p>Resident 26's 3/8/24 Quarterly MDS indicated a BIMS score of 6 (severe cognitive impairment) and no behaviors.</p> <p>Resident 4 was admitted to the facility in 2/2024 with diagnoses including dementia.</p> <p>Resident 4's 2/8/24 5 Day MDS indicated a BIMS score of 15 (cognitively intact) and no behaviors.</p> <p>On 3/14/24 the facility submitted a FRI which indicated Resident 26 punched Resident 4 on the right shoulder once and twice to the right side of the face.</p> <p>On 4/4/24 at 5:15 PM Staff 13 (LPN) stated he witnessed Resident 26 hit Resident 4 pretty hard on the right shoulder and the right side of her/his face twice.</p> <p>On 4/8/24 at 10:35 PM Staff 1 (Administrator) confirmed the 3/14/24 incident between Resident 26 and Resident 4 occurred.</p> <p>43691</p> <p>2. Resident 3 was admitted to the facility in 12/2020 with diagnoses including dementia with agitation.</p> <p>Resident 3's 11/9/23 MDS indicated a BIMS of 1 which indicated severe cognitive impairment.</p> <p>Resident 18 was admitted to the facility in 12/2020 with diagnoses including dementia with behavior disturbance and delusional disorder.</p> <p>Resident 18's 10/2/23 Aggression/Violence Risk Assessment indicated a moderate risk for aggressive/violent behavior.</p> <p>On 7/25/22 the facility submitted a FRI which indicated Resident 18 and Resident 3 were overheard yelling at each other. When Staff 32 (CNA) went to check on the residents, they were observed hitting each other and staff intervened to separate Resident 18 and Resident 3.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Gracelen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/2/24 to 4/8/24 from 8:00 AM through 5:00 PM Resident 3 was observed walking throughout the facility without supervision and Resident 18 was observed sitting in her/his wheelchair around other residents during dining and activities.</p> <p>On 4/2/24 interviews were attempted with Resident 3 and Resident 18. Both residents were determined to be not interviewable.</p> <p>On 4/4/24 at 9:20 AM Staff 32 recalled the incident and stated she had to rush in to intervene when Resident 3 and Resident 18 were hitting each other.</p> <p>On 4/5/24 at 1:36 PM Staff 1 (Administrator) confirmed the incident of abuse between Resident 3 and Resident 18 occurred.</p> <p>3. Resident 3 was admitted to the facility in 12/2020 with diagnoses including dementia with agitation.</p> <p>Resident 3's 11/9/23 MDS indicated a BIMS of 1 which indicated severe cognitive impairment.</p> <p>Resident 46 was admitted to the facility in 12/2023 with diagnoses including alcohol dependence with alcohol-induced persisting dementia.</p> <p>Resident 46's 1/3/24 MDS indicated a BIMS of 3 which indicated severe cognitive impairment.</p> <p>A 3/10/24 FRI indicated Resident 3 punched Resident 46 on his back after Resident 46 sat on Resident 3's bed. In response, Resident 46 punched Resident 3 in the stomach. Staff intervened to separate the residents.</p> <p>On 4/2/24 to 4/8/24 from 8:00 AM through 5:00 PM Resident 3 was observed walking throughout the facility without supervision and Resident 46 was observed sitting in her/his room with the door open across the hall from Resident 3's room.</p> <p>On 4/2/24 interviews were attempted with Resident 3 and Resident 18. Both residents were determined to be not interviewable.</p> <p>On 4/5/24 at 9:27 AM Staff 31 (Housekeeping) stated she witnessed the incident. Staff 31 stated she saw Resident 46 walk with a cup and attempted to set the cup down on Resident 3's bed. Resident 3 observed this, got upset and started hitting Resident 46. Resident 46 immediately responded by hitting Resident 3. Staff 31 stated she had to get assistance from another staff member to intervene with the incident.</p> <p>On 4/5/24 at 1:36 PM Staff 1 (Administrator) confirmed the incident of abuse between Resident 3 and Resident 46 occurred.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38E188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Gracelen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43691</p> <p>Based on interview and record review it was determined the facility failed to report an incident of suspected abuse in a timely manner for 2 of 4 sampled residents (#s 3 and 18) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 3 was admitted to the facility in 12/2020 with diagnoses including dementia with agitation.</p> <p>Resident 18 was admitted to the facility in 12/2020 with diagnoses including dementia with behavior disturbance and delusional disorder.</p> <p>On 7/25/22 at 11:53 AM a FRI was submitted which indicated on 7/22/22 at 6:17 PM Resident 18 and Resident 3 were overheard yelling at each other and then observed hitting each other.</p> <p>On 4/5/24 at 1:36 PM Staff 1 (Administrator) confirmed the incident of abuse between Resident 3 and Resident 18 occurred and there was a delay in reporting the incident within the required two hour reporting timeframe.</p>