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 12/19/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41453 Based on observation, interview, and record review it was determined the facility failed to protect a resident's right to be free from mental abuse by staff for 1 of 5 sampled residents (#8) reviewed for abuse. This placed residents at risk for further mental abuse. Findings include: On 9/5/24 the State Survey Agency received a public complaint which alleged Resident 8 was spoken to rudely and threatened by a CNA. Resident 8 was admitted to the facility in 9/2024, with diagnoses including vascular dementia and a hip fracture. Resident 8's 9/9/24 Admission MDS indicated she/he was cognitively intact. On 12/17/24 at 9:00 AM, Staff 5 (CNA) stated Staff 3 (CNA) stated to her and Staff 4 (CNA) tell Resident 8 that you will put them in a room by herself/himself with the door closed and no call light if Resident 8 was on the call light too much. Staff 5 stated Staff 3 informed them she knew Resident 8 from the hospital and saying those things worked there. Staff 5 stated they immediately reported to management. On 12/19/24 @ 8:03 AM, Staff 4 (CNA) stated Staff 3 (CNA) stated to her and staff 5 (CNA) tell Resident 8 that you will put them in a room by herself/himself with the door closed and no call light if Resident 8 was on the call light too much. Staff 4 stated Staff 3 informed them she knew Resident 8 from the hospital and saying those things worked there. Staff 4 stated her, and Staff 5 reported the incident immediately to management. On 12/19/24 at 9:51 AM, this surveyor attempted to reach Staff 3 via phone. Staff 3 refused to speak to this surveyor. On 12/19/24 at 10:40 AM, Resident 8 stated she/he recalled being threatened by a staff member for using the call light too much. Resident 8 stated they told me if I used the call light too much I would have been put in a room by myself and would not receive any help no matter how much I called. Resident 8 stated Staff 3 (CNA) did also turn off the lights one time. Resident 8 screamed and Staff 3 turned the lights back on. Resident 8 stated it was a terrifying few moments. On 12/13/24 at 2:49 PM, Staff 1 (DNS) and Staff 2 (Administrator) confirmed the incident occurred.

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

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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 12/19/2024
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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 41453 Based on interview and record review it was determined the facility failed to document the basis for transfer and failed to include code and health status to the receiving provider for 1 of 3 sampled residents (#7) reviewed for hospitalization . This placed residents at risk for inaccurate health care. Findings include: Resident 7 was admitted to the facility in 8/2024, with diagnoses including traumatic brain injury and delirium. Resident 7's 10/3/24 Discharge MDS indicated the resident was discharged to an acute care hospital. Review of Resident 7's medical record revealed no documentation to indicate the basis for the transfer and if appropriate information was communicated to the receiving hospital. There was no information demonstrating why the facility could not meet the resident's needs and whether the discharge was initiated by the resident or the facility. On 12/19/24 at 10:40 AM, Staff 1 (DNS) was informed of the findings of this investigation and acknowledged the discharge information was not documented in Resident 7's medical record.