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	10/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure a resident's change of condition was assessed in a timely manner for 1 of 1 sampled resident (#7) reviewed for accidents. This placed residents at risk for a delay of care and unmet treatment needs. Findngs include:Resident 7 was admitted to the facility in 11/2024 with diagnoses including end stage kidney disease and diabetes.Provider Notes dated 11/15/24 and 11/29/24 indicated Resident 7 was alert but tired on exam. Resident 7 was able to answer questions appropriately. Resident 7's 11/29/24 admission MDS indicated the resident had moderate cognitive impairment.A CMA Medication Administration Note dated 12/8/24 at 8:42 AM Staff 26 (CMA) indicated the following:-Resident 7 was unable to stay awake long enough to drink fluids despite cueing and redirection.-Staff 43 (RN) completed an assessment and directed Staff 26 to wait 20 minutes before reattempting medication administration.-Upon the second attempt, Resident 7 continued to fall asleep. -Medications could not be administered, and Staff 43 was notified for reassessment. Review of Resident 7's medical record on 12/8/24 between 8:42 AM and 1:51 PM revealed no documentation Staff 43 performed a reassessment, checked blood sugars, or contacted the on-call provider. A blood pressure reading was recorded at 1:51 PM and no other vital signs were recorded.In a 12/8/24 at 2:27 PM Nursing Note the charge nurse documented Resident 7 was sent out to the hospital at 2:20 PM per the family's request.A 1/4/25 Hospitalist Progress Note, revealed Resident 7 had been admitted to the hospital on [DATE] with sepsis (a body's extreme reaction to infection) due to a urinary tract infection.On 10/14/25 at 9:14 AM Witness 3 (Family Member) stated they visited Resident 7 on 12/8/24, were alarmed by the resident's appearance and requested the resident be sent to the hospital. On 10/16/25 at 10:02 AM Staff 26 stated they observed Resident 7 to be lethargic and difficult to rouse on 12/8/24 at approximately 8:00 AM. Staff 26 reported their concerns to Staff 43 because Resident 7 was not at baseline for mental alertness, and they requested a reassessment after the resident was unable to take her/his medications. Staff 26 stated Staff 43 only looked at the resident but did not perform a physical assessment, speak to the resident, take vital signs, a blood sugar check, or contact the on-call provider. Staff 26 stated Resident 7's changed mental status persisted through the morning and despite their multiple reports of concern, Staff 43 did not take further action.On 10/17/25 at 10:39 AM Staff 24 (CNA) stated they were assigned to Resident 7 during the day shift on 12/8/24. Staff 24 stated the resident was usually pretty alert, but throughout the day she/he was difficult to rouse and minimally responsive. Staff 24 stated they expressed their concerns to Staff 43 several times throughout the morning. Staff 43 was unavailable for interview.On 10/17/25 at 1:05 PM Staff 7 (LPN) stated if staff reported signs of altered mental status, such as inability to stay awake or follow direction, the resident should be assessed right away as it may indicate a change of condition. Staff 7 stated they would perform a head-to-toe assessment, take a full set of vital signs and check blood sugar levels if the resident was diabetic. Staff 7 stated depending on the findings they would contact the on-call provider for further direction. On 10/17/25 at 1:20 PM Staff 41 (NP) stated they rounded on Resident 7, who was normally alert, and they would expect an immediate call if there were a change in the resident's mentation such as not able to be aroused or the inability to follow direction and take medications. Staff 41 stated they expected an assessment by the licensed nurse and blood sugar levels checked.On 10/20/25 at 9:27 AM Staff 42 (NP) stated they were on-call on 12/8/24 and did not receive a notification of Resident 7's change of change in mental status.On 10/20/25 Staff 4 (LPN Resident Care Manager) stated they expected the nurse to assess the resident, obtain a set of vital signs, and based on findings contact the on-call provider when a change of condition was reported to them. Staff 4 reviewed Resident 7's medical record and acknowledged there was no documentation by Staff 43 of an assessment, vital signs, blood sugar checks or communication with the on-call provider on 12/8/24. On 10/20/25 Staff 2 (DNS) stated if staff expressed concerns to the charge nurse about a resident's change of condition, such as signs of altered mental status, they expected the nurse to perform a full assessment, take vital signs, if appropriate check blood sugar levels, and contact the on-call provider. Staff 2 acknowledged there was no documentation to indicate an assessment was performed, vital signs taken, blood sugar levels were checked, or the on-call provider was notified for Resident 7 on 12/8/24 by Staff 43 after they were notified of the resident's change of condition.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to assess, monitor, and treat pressure ulcers for 1 of 1 sampled resident (#7) reviewed for wound care. This placed residents at risk for unassessed wounds, unmet treatment needs and worsening pressure ulcers. Findings include:The 2019 National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries Quick Reference Guide indicated the following recommendations regarding pressure ulcer assessment:- Assess the pressure ulcer initially and re-assess it at least weekly to monitor progress towards healing;- Document the results of all wound assessments;- Assess and document physical characteristics including: location, category/stage, size, tissue type(s), color, peri-wound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor; - Select a uniform, consistent method for measuring wound length, width, depth or wound area to facilitate meaningful comparisons of wound measurements across time; - Ensure pressure ulcers are correctly differentiated from other skin injuries, particularly incontinence associated dermatitis or skin tears.Resident 7 was admitted to the facility in 11/2024 with diagnoses including end stage kidney disease and diabetes.Resident 7's 11/13/24 Nursing admission Database completed by Staff 23 (LPN) indicated the resident had an unstageable sacral (a bone at the base of the spine) wound; no further description, measurements or staging of the wound was provided.Resident 7's 11/29/24 admission MDS indicated the resident had moderate cognitive impairment and was at risk for pressure injury development related to decreased mobility, end stage kidney disease, incontinence and diabetes.Review of Resident 7's medical record revealed there was no comprehensive assessment conducted of the resident's wound to capture characteristics such as location, stage, measurements, tissue type(s), color, wound edges, undermining or tunneling, draining or odor, or documentation of notification to the facility provider the resident had a sacral wound. No evidence was found that wound care or treatment was provided to the resident between 11/13/24 through 11/19/24 (six days).Resident 7 was hospitalized [DATE] through 11/23/24 with hypoglycemia (low blood sugar). Resident 7's 11/23/24 Hospital After Visit Summary directed the resident to receive the following daily wound care orders:1. Sacrum:-Cleanse the sacrum with normal saline;-Apply Venelex ointment (a medicated treatment for wounds) over the entire wound bed;-Cover with a sacral foam dressing;-Change daily. 2. Left and right heels:-Paint with betadine swab (a medicated applicator) daily for antimicrobial (to reduce germs) and to keep dry.Review of Resident 7's 11/2024 TAR revealed Resident 7 did not receive sacral wound care treatment from 11/23/24 through 11/27/24 (five days) and did not receive left heel wound care from 11/23/24 through 12/5/24 (13 days). There was no evidence found that treatment for the right heel wound was ever initiated. On 10/14/25 at 9:14 AM Witness 3 (Family Member) stated Resident 7 admitted to the facility with a sacral wound, which worsened during her/his stay. On 10/15/25 at 1:12 PM Staff 41 (Former NP) stated facility staff were expected to notify them of all wounds so treatment orders could be initiated as soon as possible. Witness 41 did not recall being notified of Resident 7's sacral wound.On 10/16/25 at 2:46 PM Staff 23 (LPN) stated they completed Resident 7's initial skin assessment upon admission which noted a sacral wound. Staff 23 stated they were responsible for entering wound care orders into the resident's record, and they believed Staff 4 then took photos and a wound care provider was to round on the resident. Staff 23 stated resident's wound did not improve while at the facility. On 10/20/25 at 9:39 AM Staff 29 (LPN) stated when a resident was admitted to the facility with wounds but without treatment orders, they would promptly notify the Resident Care Manager, who was responsible for assessment and the initiation of care. Staff 29 stated when a resident was admitted with wound treatment orders the admitting nurse and their counterpart were responsible for verifying and entering the orders into the resident's record. On 10/20/25 at 10:30 AM Staff 4 (LPN Resident Care Manager) stated they expected the admitting nurse to thoroughly assess and photograph all wounds within the first eight hours of admission and make a referral to the wound clinic. Staff 4 stated they expected wound care orders to be implemented the same day as receipt. Staff 4 acknowledged no assessment of Resident 7's wound was performed upon admission on [DATE] and there was no documentation in the TAR or progress notes of wound care treatment provided between 11/13/24 and 11/19/24. Staff 4 acknowledged Resident 7 was readmitted to the facility on [DATE] with treatment orders for wounds to the sacrum and both heels. Staff 4 acknowledged treatment for the sacral wound was not initiated until 11/28/24, treatment for the left heel was not initiated until 12/6/24 and there was no record of treatment provided for the right heel