

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  03/10/2026
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>Based on interview and record review it was determined the facility failed to report an incident of suspected physical abuse in a timely manner for 2 of 4 sampled residents (#s 6 and 7) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 6 was admitted to the facility in 11/2024 with diagnoses including major depressive disorder. Resident 7 was admitted to the facility in 1/2026 with diagnoses including senile degeneration of the brain with anxiety and agitation. On 2/14/26 at 6:27 PM, a FRI was submitted which indicated on 2/14/26 at 10:00 AM, Resident 7 struck Resident 6 with her/his reader stick after Resident 6 wandered into Resident 7's room looking for her/his items. A Progress Note on 2/14/26 at 12:28 PM, indicated Staff 7 (Social Services Director) noticed Resident 7 received assistance with a bandage to her/his knee. When asked, Resident 7 stated she/he was hit by another resident after she/he entered Resident 7's room and approached her/him. On 3/10/26 at 12:26 PM, Staff 2 (DNS) stated she was aware of the incident of potential abuse between Resident 6 and Resident 7 and acknowledged allegations needed to be reported within 2 hours of the incident occurring. Staff 2 acknowledged the incident of potential abuse was not reported within the 2-hour time frame. On 3/10/26 at 2:40 PM, Staff 7 stated she wrote the incident report involving Resident 6 and Resident 7 and informed both Staff 1 (Facility Administrator) and Staff 2 of the incident on 2/14/26 after completing the incident report at approximately 12:00 PM.</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