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	05/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to accurately document an elopement assessment for 1 of 1 sampled resident (#1) reviewed for elopement. This placed residents at risk for inaccurate medical records. Findings include:Resident 1 admitted to the facility on [DATE] with diagnosis including monoplegia of upper limb following nontraumatic intracerebral hemorrhage (stroke) affecting left dominant side.On 5/13/26 at 12:16 PM, Resident 1 was observed to ambulate independently without an assistive device.Resident 1's care plan initiated on 4/30/26 documented Resident 1:-Had an alteration in neurological status related to monoplegia of the upper limb following a nontraumatic intracranial hemorrhage affecting left dominant side;-Was independent for ambulation and transfers and did not use an assistive device; and-Was alert and oriented times three. Resident 1's 4/29/26 hospital Occupational Therapy Note indicated with independent activities of daily living tasks in unfamiliar/novel environments, [Resident 1] struggles much more. For example, during a basic tea-making task, [Resident 1] needed mod-max direct verbal cues for safety, sequencing and decision-making.Resident 1's 4/30/26 Elopement Assessment completed by Staff 6 (RN) documented Resident 1: -Was not cognitively impaired with poor decision-making skills;-Did not ambulate independently with or without the use of assistive device; and-Did not have a diagnosis of dementia, cognitive impairment or a diagnosis impacting gait and mobility.Resident 1's 5/7/26 admission MDS documented Resident 1 was independent for mobility without an assistive device.The facility's elopement assessment incorrectly documented Resident 1 as non-ambulatory, no deficits in gait, mobility or decision-making, which was inconsistent with Resident 1's care plan, Occupation Therapy Notes and comprehensive MDS assessment.On 5/13/26 at 12:38 PM, Staff 6 stated she inaccurately documented Resident 1's 4/30/26 elopement assessment.On 5/13/26 at 2:18 PM, Staff 2 (DNS) stated Resident 1's 4/30/26 elopement assessment was inaccurate.

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