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	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracelen Care Center	10948 S.E. Boise Portland, OR 97266

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41458 Based on observation, interview and record review it was determined the facility failed to ensure residents were treated with dignity related to dining needs for 1 of 2 sampled dining rooms reviewed for dining. This placed residents at risk for lack of a dignity. Findings include: The facility's 3/2022 Assistance with Meals Policy indicated residents would receive assistance with meals in a manner that met the individual needs of each resident. Residents unable to feed themselves would be fed with attention to safety, comfort and dignity including not standing over residents while assisting them with meals. On 4/2/24 between the hours of 11:55 AM and 12:30 PM, during the lunch meal in the East dining room, the following observations were made: -The East dining room consisted of four tables with two to three residents placed at each table, one resident placed at a bedside table and another resident sitting in a wheelchair. -Staff 8 (CNA) provided assisted with the lunch meal at a table with three males, standing over one resident as she provided eating assistance. While Staff 8 stood, she also assisted a second resident, alternating eating assistance between the two residents. -Staff 22 (RN) arrived at the table and assisted the third resident with eating assistance while standing over the resident. Both Staff 8 and Staff 22 stood while assisting the residents with their meals. On 4/2/24 at 12:30 PM Staff 8 stated CNAs were not supposed to stand over residents while assisting them at meals because it was not dignified. Staff 8 stated there were not enough stools for all of the CNAs so she had to stand. On 4/2/24 at 12:30 PM Staff 22 stated staff were not supposed to stand while assisting residents during meals. Staff 22 stated staff were to sit and be face-to-face with residents when assisting them. Staff 22 stated there were not enough stools to allow each staff to sit when assisting residents during meals. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/24 at 10:33 AM Staff 2 (DNS) stated staff were not supposed to stand while providing eating assistance to residents as this was considered a lack of dignity and she expected staff to sit when assisting residents with their meals.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 39632 Based on interview and record review it was determined the facility failed to ensure consent was obtained prior to administering psychotropic and antiviral medications to 2 of 5 sampled residents (#s 12 and 29) reviewed for medications. This placed residents at risk for being uninformed about their medications. Findings include: 1. Resident 29 was admitted to the facility in 12/2023 with diagnoses including Alzheimer's disease. Resident 29's Profile Information Sheet indicated the resident's spouse was the resident's responsible party. Resident 29's 12/2023, 1/2024, 2/2024, 3/2024 and 4/2024 Physician Orders included mirtazapine (antidepressant) and quetiapine (antipsychotic). Resident 29's 12/2023, 1/2024, 2/2024, 3/2024 and 4/2024 MARs revealed the resident received mirtazapine 15 mg daily and quetiapine 25 mg - 50 mg daily. Review of Resident 29's health record revealed no documentation to indicate the resident or her/his representative was informed of the risks, benefits and potential side effects of mirtazapine and quetiapine and no evidence the resident consented to receive the medications. On 4/5/24 at 1:00 PM Staff 12 (LPN Resident Care Manager) reviewed Resident 29's health record and was unable to locate evidence the resident or the resident's representative was informed of the risks, benefits and potential side effects of mirtazapine and quetiapine and was unable to provide documentation the resident's representative consented to the medications prior to administration. On 4/5/24 at 1:32 PM Staff 2 (DNS) was notified of the findings of this investigation and acknowledged the lack of evidence regarding medication information and consent. 43690 2. Resident 12 was admitted to the facility in 2024 with diagnoses including anxiety disorders and depression. a. Resident 12's 3/19/24 Physician Order indicated the resident was prescribed clonazepam (anti-seizure) for anxiety and restlessness. Resident 12's 3/2024 and 4/2024 MARs revealed the resident received clonazepam daily. Review of Resident 12's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of clonazepam. b. Resident 12's 3/29/24 Physician Order indicated the resident was prescribed Celexa (anti-depressant) for depression. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 12's 3/2024 and 4/2024 MARs revealed the resident received Celexa daily. Review of Resident 12's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of Celexa. c. Resident 12's 3/30/24 Physician Order indicated the resident was prescribed asenapine (antipsychotic) for psychotic symptoms. Resident 12's 3/2024 and 4/2024 MARs revealed the resident received asenapine daily. Review of Resident 12's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of asenapine. On 4/4/24 at 12:40 PM Staff 3 (LPN Resident Care Manager) reviewed Resident 12's health record, acknowledged there was no documentation to indicate the resident was informed of the risks and benefits of asenapine, clonazepam and Celexa. Staff 3 confirmed consent was not obtained from Resident 12 prior to the resident starting the medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43690 Based on observation, interview and record review it was determined the facility failed to provide reasonable accommodations for 1 of 1 sampled resident (#37) reviewed for wheelchair accommodations. This placed residents at risk for unmet needs. Findings include: Resident 37 admitted to the facility in 4/2021 with diagnoses including Parkinson's disease (a disorder affecting movements). Observation on 4/3/24 at 12:21 PM revealed Resident 37 was sitting in her/his wheelchair with her/his calves pressed against the back of exposed metal on her/his chair and the left arm rest pad was missing, leaving a metal bar exposed for her/his arm to rest on. On 4/5/24 at 10:08 AM Resident 37 stated the back of her/his legs hurt. On 4/5/24 at 10:34 AM Staff 10 (CNA) stated she reported the missing arm rest pad to maintenance a while ago. On 4/5/24 at 11:22 AM Staff 3 (LPN Resident Care Manager) stated she was not aware of Resident 37's missing arm rest pad or and that her/his legs were resting against exposed metal. Staff 3 observed the back of Resident 37's calves and stated there were bad indentations because of the exposed metal. Staff 3 stated Resident 37 needed a cushion or wedge to keep her/his legs from resting on the metal. On 4/5/24 at 1:01 PM Staff 7 (Maintenance Director) stated he was not aware of Resident 37's missing arm rest pad or the metal being exposed on the seat of the wheelchair.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43691 Based on observation, interview and record review it was determined the facility failed to obtain consent, assess, monitor and reevaluate for use of a restraint for 1 of 1 sampled resident (#5) reviewed for restraints. This placed residents at risk for inappropriate use of a restraint. Findings include: The facility's 4/2017 Use of Restraints Policy stated the following: -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. -Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. - Resident and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. Resident 5 was admitted to the facility in 8/2007 with diagnoses including schizophrenia and dementia with behavioral disturbances. A 7/12/23 Annual MDS reported Resident 5 had a severe cognitive impairment. On 4/3/24 at 9:27 AM Resident 5 was observed laying in bed with four bolster pillows (long tube-shaped pillows) at the left and right sides of the bed. Two pillows were placed on either side of Resident 5's upper body and two pillows were placed on either side of Resident 5's lower body. Review of Resident 5's records revealed consent was not obtained regarding the use of the bolster pillows. Assessment, monitoring and reevaluation of the continued use of the bolster pillows was not performed for the use of bolster pillows. On 4/8/24 at 9:19 AM Staff 3 (LPN Resident Care Manager) stated Resident 5 was able to move in bed and the bolster pillows were there to prevent her/him from falling out of bed. Staff 3 confirmed consent was not obtained from Resident 5's representative for the use of bolster pillows. Staff 3 confirmed no assessment, monitoring or reevaluation was performed for the use of bolster pillows for Resident 5.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41458 Based on observation, interview and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 1 of 2 sampled residents (#8) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: Resident 8 was admitted to the facility in 12/2023 with diagnoses including schizoaffective disorder (a mental health condition), bipolar disorder (a mental health condition) and stroke. Resident 8's current care plan indicated the following: -Resident 8 required extensive assistance of one person for toileting. -Resident 8 required extensive assistance of one person for dressing and personal hygiene. -Resident 8 required extensive assistance of one person for ambulation while using a front wheeled walker. -Resident 8 required extensive assistance of one person for bed mobility and transfers. Multiple observations from 4/2/24 through 4/8/24 between the hours of 8:00 AM and 3:30 PM revealed Resident 8 independently moved in her/his bed, transferred from the bed to standing and/or to her/his wheelchair without assistance, dressed herself/himself and ambulated independently around her/his room without an assistive device. The resident was also observed walking down the east hallway with her/his walker without staff assistance. On 4/4/24 at 10:16 AM Staff 36 (CNA) reported Resident 8 completed most of her/his ADL care on her/his own and she checked on her/him occasionally to see if the resident needed any help. Staff 36 reported Resident 8 used a urinal and CNA staff emptied it for her/him. Staff 36 stated Resident 8 toileted, transferred and fed herself/himself without assistance. On 4/5/24 at 10:24 Staff 19 (CNA) stated Resident 8 did everything on her/his own. Staff 19 stated the resident changed her/his own brief independently and ambulated with a walker outside frequently to feed the squirrels. On 4/5/24 at 1:01 PM Staff 3 (LPN Resident Care Manager) reported she spoke to CNAs and reviewed Resident 8's care task logs and confirmed Resident 8's care plan did not accurately reflect her/his level of ADL care needs. On 4/8/24 at 10:33 AM Staff 2 (DNS) stated she expected Resident 8's care plan to accurately reflect her/his current level of ADL functioning.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 43690 Based on interview and record review it was determined the facility failed to complete a discharge summary for 1 of 1 sampled resident (#53) reviewed for discharge. This placed residents at risk for unmet discharge needs. Findings include: Resident 53 was admitted to the facility in 10/2023 with diagnoses including normal pressure hydrocephalus (abnormal buildup of fluid in the brain). The resident was discharged from the facility on 1/14/24 as a resident initiated discharge. A review of Resident 53's health record indicated there was no discharge summary documentation. On 4/8/24 at 10:55 AM Staff 2 (DNS) was not able to provide documentation of a discharge summary for Resident 53.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632 Based on observation, interview and record review it was determined the facility failed to follow physician orders for 2 of 3 sampled residents (#s 8 and 19) reviewed for edema and hospice services. This placed residents at risk for unmet care needs. Findings include: 1. The undated Hospice and Nursing Facility Services Agreement specified the facility shall provide in a timely manner, those drugs related to the management of the terminal illness. Resident 19 was admitted to the facility in 4/2018 with diagnoses including Huntington's disease (a degenerative disease which affects movement and cognitive functions). Resident 19's 2/8/24 Significant Change MDS indicated the resident received Hospice services. On 4/2/24 at 10:58 AM Witness 1 (Hospice RN) stated an order for glycopyrrolate 1 mg, prescribed to control Resident 19's oral secretions, was faxed to the facility on [DATE]. Review of Resident 19's health record revealed the glycopyrrolate was not implemented and administered to Resident 19 until 4/3/24, five days after the medication was prescribed. On 4/4/24 at 4:14 PM Staff 3 (LPN Resident Care Manager) reviewed Resident 19's health record and acknowledged the glycopyrrolate was ordered on 3/29/24 and was not implemented and administered to Resident 19 until 4/3/24. Staff 3 explained Hospice provided medication orders by fax and she expected staff to implement the medication orders upon receipt. On 4/8/24 at 10:17 AM Staff 1 (Administrator) and Staff 2 (DNS) were notified of the findings of this investigation and acknowledged the medication was not implemented as ordered. 41458 2. Resident 8 was admitted to the facility in 12/2023 with diagnoses including schizoaffective disorder (a mental health condition), bipolar disorder (a mental health condition) and stroke. A 1/18/24 Physician Order instructed nursing staff to monitor Resident 8's bilateral, lower leg edema (swelling caused by too much fluid trapped in tissues) every 12 hours. There was no evidence in Resident 8's health record to indicate nursing staff monitored Resident 8's bilateral, lower leg edema. On 4/2/24 at 1:21 PM, both of Resident 8's lower legs and ankles were observed to be swollen. On 4/5/24 at 1:35 PM Staff 34 (LPN) stated she was unaware Resident 8 had edema in her/his lower legs and she had not been monitoring the resident's edema until a new order popped up today. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 1:42 PM and 2:24 PM Staff 3 (LPN Resident Care Manager) reported she expected nursing staff to monitor Resident 8's bilateral, lower leg edema. Staff 3 confirmed there was no evidence in Resident 8's health record to indicate the resident's bilateral, lower leg edema was monitored by nursing staff. On 4/8/24 at 10:33 AM Staff 2 (DNS) stated she expected nursing staff to follow physician orders for monitoring Resident 8's lower leg edema.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39632 Based on interview and record review it was determined the facility failed to ensure nursing staff competencies for 5 of 5 sampled staff (#s 14, 22, 23, 24 and 25) reviewed for competencies. This placed residents at risk for poor quality of care. Findings include: On 4/4/24 at 3:08 PM and 4/5/24 at 8:40 AM Staff 2 (DNS) and Staff 27 (Staffing Coordinator) were asked to provide evidence of staff competencies for Staff 14 (RN), Staff 22 (LPN), Staff 23 (LPN), Staff 24 (RN) and Staff 25 (RN). On 4/4/24 at 4:40 PM and 4/5/24 at 2:38 PM Staff 2 provided an incomplete competency review for Staff 14. Staff 1 (Administrator) and Staff 27 stated they did not have the requested competencies for Staff 22, Staff 23, Staff 24 and Staff 25. Refer to F880

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 41458 Based on interview and record review it was determined the facility failed to ensure CNAs received annual performance reviews for 4 of 5 randomly selected CNA staff (#s 8, 17, 18 and 19) reviewed for staffing. This placed residents at risk for lack of care by competent staff. Findings include: A review of personnel records on 4/5/24 with Staff 27 (Staffing Coordinator) indicated the following employees had not received their annual performance evaluations: -Staff 8 (CNA), adjusted seniority date 10/4/08: no annual performance review was completed. -Staff 17 (CNA), adjusted seniority date 11/22/22: no annual performance review was completed. -Staff 18 (CNA), adjusted seniority date 1/21/20: no annual performance review was completed. -Staff 19 (CNA), adjusted seniority date 10/9/21; no annual performance review was completed. On 4/5/24 at 11:52 AM Staff 27 confirmed annual performance reviews for Staff 8, Staff 17, Staff 18 and Staff 19 were not completed. On 4/8/24 at 10:33 AM Staff 2 (DNS) reported she was aware many CNA staff did not have their annual performance reviews completed including Staff 8, Staff 17, Staff 18 and Staff 19.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 39632 Based on interview and record review it was determined the facility failed to ensure residents were not prescribed unnecessary medications for 1 of 5 sampled residents (#29) reviewed for medications. This placed residents at risk for experiencing adverse medication effects. Findings include: Resident 29 was admitted to the facility in 12/2023 with diagnoses including Alzheimer's disease. A 1/11/24 Physician Order included acyclovir (anitviral medication used to treat herpes simplex viral infections), 800 mg, take one half tablet twice a day for prophylaxis (action taken to prevent disease). The order did not specify which disease the medication was prophylactically prescribed and no further information or rationale for the medication was included in the order. Resident 29's 1/2024, 2/2024, 3/2024 and 4/2024 MARs revealed the resident received acyclovir daily beginning 1/12/24. On 4/5/24 at 1:00 PM Staff 12 (LPN Resident Care Manager) was asked about the indication for use of acyclovir. Staff 12 stated today she asked Staff 35 (Physician) for clarification regarding the use of acyclovir and Staff 35 ordered the medication to be discontinued and to watch for flares. When asked to define what the flares would be in relation to, Staff 12 stated she did not know. Staff 12 stated she reviewed Resident 29's records and was not able to determine an appropriate diagnosis or rationale for the use of daily acyclovir. Staff 12 stated she expected an antiviral medication order to include a proper indication for use and a stop date. On 4/8/24 at 10:38 AM Staff 2 (DNS) and Staff 12 were notified of the findings of this investigation. Staff 12 provided documentation which indicated the acyclovir medication was ordered to be given in addition to chemotherapy which ended in 8/2023. Staff 2 and Staff 12 acknowledged the acyclovir should not have been ordered in 1/2024 or administered beyond 8/2023 and Resident 29 received the acyclovir unnecessarily.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43691 Based on observation and interview it was determined the Dietary Manager failed to obtain the required certification to provide dietary management services for 1 of 1 facility reviewed for qualified dietary staff. This placed residents at risk for unmet dietary needs. Findings include: From 4/2/24 through 4/8/24 between the hours of 8:00 AM and 5:00 PM, Staff 33 (Dietary Manager) was observed providing Dietary Manager services in the facility kitchen. On 4/5/24 at 11:31 AM Staff 33 stated he had been the Dietary Manager since 4/2022 and had not completed the required certification required for his position as Dietary Manager. On 4/8/24 at 11:04 AM Staff 1 (Administrator) confirmed she was aware Staff 33 had not obtained the required certification.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39632 Based on observation, interview and record review it was determined the facility failed to ensure appropriate infection control practices for 3 of 11 sampled staff (#s 8, 14 and 15) observed during medication administration and dining. This placed residents at risk for the spread of infection. Findings include: 1. The CDC website, section titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration specified there was an increased risk for exposure to bloodborne viruses through contaminated equipment, such as glucometers (a device used to measure blood sugar levels) when shared. Using a glucometer for more than one person without cleaning and disinfecting it in between uses contributed to transmission of HBV (Hepatitis B virus). Glucometers should be cleaned and disinfected after every use. The facility's 7/2023 Glucometer Disinfection Policy & Procedure specified glucometers were disinfected after each use with an EPA-registered disinfectant that was effective against viruses. The disinfecting procedure directed staff to wash hands before and after the procedure and to remove and discard gloves and perform hand hygiene prior to exiting the resident room. The facility's 8/2015 Handwashing/Hand Hygiene Policy & Procedure specified hand hygiene was the primary means to prevent the spread of infections. Staff should perform hand hygiene before and after direct contact with residents, before and after handling medications, after contact with objects in the immediate vicinity of residents and after removing gloves. a. Resident 36 was admitted to the facility in 4/2022 with diagnoses including stroke. Resident 41 was admitted to the facility in 3/2022 with diagnoses including type 2 diabetes. (continued on next page)

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	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracelen Care Center	10948 S.E. Boise Portland, OR 97266

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 from 11:55 AM to 12:26 PM Staff 14 (RN) was observed for capillary blood glucose monitoring and insulin administration for Resident 36 and Resident 41. Staff 14 stood at the treatment cart, did not perform hand hygiene, donned gloves, unlocked and opened the cart drawers, obtained Resident 41's insulin pen and obtained blood glucose monitoring supplies including a glucometer. Staff 14 entered Resident 41's room, placed the glucometer on the resident's walker seat and placed the insulin and other supplies directly on the resident's bedside table. Staff 14 used a lancet (a sharp device used to prick the finger to obtain blood) to prick the resident's finger, put a sample of blood on the test strip, plugged the test strip into the glucometer and placed the glucometer onto the resident's bedside table. Staff 14 then lifted Resident 41's shirt and administered the resident's insulin into her/his stomach. Staff 14 gathered all of the used supplies into her right gloved hand and escorted the resident to the dining room. Staff 14 returned to the treatment cart, discarded the used lancet and test strip and placed the used glucometer on the surface of the cart. Staff 14 used her gloved hands to retrieve keys from her shirt pocket, unlocked the cart, typed on the keyboard, opened the cart drawer and placed the glucometer into the cart drawer. Staff 14 did not disinfect the glucometer before or after use. Without changing her gloves or performing hand hygiene, Staff 14 then obtained Resident 36's insulin from the cart and drew up five units of insulin from the resident's insulin vial. At 12:17 PM Staff 14 entered Resident 36's room, picked up the resident's personal glucometer from the resident's table, scanned the resident's implanted glucose monitoring device, replaced the glucometer on the table, lifted the resident's shirt sleeve and administered the five units of insulin into the resident's arm. Staff 14 gathered all of the used supplies into her right gloved hand, returned to the cart, doffed her gloves, did not perform hand hygiene and entered the dining room where she stated she was needed to assist residents. On 4/4/24 at 12:31 PM and 1:33 PM Staff 14 was asked about the frequency of hand hygiene and stated she usually washed her hands after contact with a resident if she was not wearing gloves. Staff 14 stated if she wore gloves then she washed her hands after removing the gloves. Staff 14 was asked about her understanding related to glove use and stated if she got something on the gloves, then she put on a new pair. Staff 14 stated the same gloves should not be worn for other residents. When asked about her understanding related to glucometer use and disinfection, Staff 14 stated she was supposed to wipe it down with alcohol between residents and stated I have not done that at all today. On 4/4/24 at 1:49 PM review of Resident 36's, Resident 41's, and all other diabetic residents' health records revealed no diagnoses including viral bloodborne pathogens. On 4/4/24 at 3:08 PM Staff 2 (DNS) was informed about Staff 14's lack of appropriate infection control practices during insulin administration and blood glucose monitoring. Staff 2 stated she expected staff to disinfect the glucometer between each use with an appropriate virucidal (destroys viruses) disinfecting wipe and to wait for the the adequate amount of time for the product to work. Staff 2 stated she expected staff to follow basic infection control practices, perform hand hygiene between resident contact, before and after glove use, and to change gloves if they were soiled and between residents. b. Resident 6 was admitted to the facility in 4/2017 with diagnoses including vascular disease. Resident 20 was admitted to the facility in 4/2022 with diagnoses including heart failure. (continued on next page)

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	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/24 from 9:09 AM to 9:37 AM Staff 15 (CMA) was observed for medication administration. Staff 15 dispensed Resident 20's medications, entered the resident's room, repositioned the resident by using the bed control, handled items in the resident's immediate environment and then administered the medications. Staff 15 returned to the medication cart, did not perform hand hygiene, and began to dispense Resident 6's medications which included opening a medication capsule with her bare hands. Staff 15 approached Resident 6, obtained the resident's blood pressure and then administered Resident 6's medications. On 4/8/24 at 9:38 AM Staff 15 was asked about the frequency of hand hygiene and stated she should wash her hands after touching a resident or their items and upon entrance and exit of resident rooms. On 4/8/24 at 10:18 AM Staff 2 (DNS) was notified regarding Staff 15's lack of appropriate hand hygiene during medication administration. Staff 2 acknowledged the lack of appropriate infection control practices. 41458 2. On 4/2/24 between the hours of 11:55 AM and 12:30 PM, during the lunch meal in the East dining room, the following observations were made: -12:02 PM an unidentified CNA put on clean gloves and then removed them, positioned a resident upright for eating and placed a bedside table in front of the resident. The staff member then removed a clean pair of gloves from a box of gloves and put them on without completing hand hygiene. Staff 8 (CNA) also removed a pair of clean gloves from a box of gloves and put them on to pass a tray and set-up the resident to eat. Staff 8 removed her gloves, discarded the gloves and then immediately removed another pair of clean gloves from the box of gloves. Both staff put clean gloves on without completing hand hygiene. -12:11 PM Staff 8 repositioned a resident's leg onto leg rests then removed a clean pair of gloves from a box of gloves and put them on without completing hand hygiene. -12:14 PM Staff 8 wore the same pair of gloves while providing eating assistance to two residents at the same time. Staff 8 alternated between one resident and then the other without changing her gloves or completing hand hygiene between residents. -12:18 PM Staff 8 removed her gloves then obtained a clean pair of gloves from a box. Staff 8 put the clean gloves on, retrieved a stool and sat down to assist a resident with eating. Staff 8 did not complete hand hygiene. -12:30 PM Staff 8 assisted two residents with eating, alternating between the two residents while using the same pair of gloves. Resident 8 touched each resident to adjust clothing or sooth the residents. Staff 8 did not change her gloves or complete hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/24 at 12: 30 PM Staff 8 stated she was supposed to put on gloves, pass a tray, set-up the resident, remove the gloves, complete hand hygiene and put on a new pair of gloves. Staff 8 reported staff were not supposed to use the same gloves between residents. Staff 8 reported she did not consistently change her gloves between residents and did not complete hand hygiene after removing her gloves. She stated, I sometimes get with the motion and just go. On 4/8/24 at 10:33 AM Staff 2 (DNS) stated it was not ok for staff to wear the same gloves between residents and it was her expectation staff complete hand hygiene after removing dirty gloves and prior to putting on clean gloves.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41458 Based on interview and record review it was determined the facility failed to ensure CNA staff received 12 hours of in-service training annually for 4 of 5 randomly selected staff members (#s 16, 17, 18, and 19) reviewed for evidence of in-service training. This placed residents at risk for lack of quality care. Findings include: On 4/5/24 at 1:00 PM Staff 2 (DNS) provided a list of training hours for the sampled staff and confirmed the following: -Staff 16 (CNA): 8.6 annual training hours; -Staff 17 (CNA): 0 annual training hours; -Staff 18 (CNA): 9.10 annual training hours and -Staff 19 (CNA): 4 annual training hours. On 4/5/24 at 1:00 PM and 4/8/24 at 10:33 AM Staff 2 confirmed Staff 16, Staff 17, Staff 18 and Staff 19 did not complete the required 12 hours of annual in-service trainings. Staff 2 stated she was aware CNA trainings were not being completed.