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	07/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to report an incident of potential abuse to the State Agency within the required timeframe for 1 of 1 sampled resident (#1) reviewed for abuse. This placed residents at risk for abuse. Findings include: The facility's 6/12/18 Abuse Prevention Policy and Procedure revealed it was the policy of the facility that all suspected or alleged cases of abuse shall be reported according to State and Federal regulations. On 7/21/25 at 6:55 PM Witness 3 (Family Member) stated Resident 1 moved rooms because her/his former roommate, Resident 8, shoved her/him into a wall. Witness 3 reported the physical altercations to facility staff immediately. On 7/25/25 at 10:18 AM Staff 21 (RN) stated she did not contact the State Agency to report the allegation of abuse. Staff 21 stated the incident occurred prior to the start of her shift at 6:00 PM and the information was reported to her during shift change. Staff 21 stated she called Staff 1 (Administrator) and Staff 2 (DNS) to report the allegation more than two hours after she was aware of the allegation. On 7/25/25 at 11:32 AM Staff 1 confirmed no report of an allegation of abuse was made to the State Agency which involved Resident 1 and Resident 8. Staff 1 expected all allegations of abuse to be reported to the State Agency within the required two-hour time frame.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to complete a thorough investigation of an allegation of abuse for 1 of 1 sampled resident (#1) reviewed for abuse. This placed residents at risk for abuse and inaccurate investigations. Findings include:The facility's 6/12/18 Abuse Prevention Policy and Procedure revealed all suspected or alleged cases of abuse shall be thoroughly and completely investigated. The procedure directed staff as soon as a report of alleged or suspected abuse was received, the investigation would begin and be completed within five days. Resident 1's 7/18/25 progress note revealed she/he had been moved to a new room following an altercation with her/his former roommate. On 7/21/25 at 6:55 PM Witness 3 (Family Member) stated Resident 1 moved rooms because her/his former roommate, Resident 8, shoved her/him into a wall. Witness 3 reported the altercation to staff immediately. On 7/25/25 at 10:18 AM Staff 21 (RN) stated staff told her of an incident which occurred prior to the start of her shift at 6:00 PM, between Resident 1 and Resident 8. Staff 21 spoke to Witness 3 who indicated Resident 8 shoved Resident 1 into a wall. On 7/25/25 at 11:32 AM Staff 1 (Administrator) confirmed a thorough investigation had not been completed for the 7/18/25 allegation of possible abuse between Resident 1 and Resident 8 timely. Staff 1 expected all allegations of abuse to be thoroughly investigated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to implement the care plan for 2 of 5 sampled residents (#s 3 and 59) reviewed for accidents. This placed residents at risk for avoidable injury. Findings include:1. Resident 59 was admitted to the facility in 10/2024 with diagnoses including stroke and anxiety. A Fall Risk assessment dated [DATE] determined Resident 59 was at high risk for falling. The 5/21/25 Care Plan identified Resident 59 a high fall risk for falls. Interventions included a fall mat to be placed at bedside when the resident was in bed. On 7/24/25 at 8:32 AM Resident 59 was observed asleep in bed without a fall mat in place. On 7/24/25 at 8:34 AM Staff 7 (CNA) stated Resident 59 was at risk for falls but did not have any fall interventions in place. On 7/24/25 at 8:59 AM Staff 3 (Resident Care Manager-LPN) stated Resident 59's Care Plan included having a fall mat in place when the resident was in bed. Staff 3 confirmed Resident 59's care plan were not being implemented, and all CNAs were expected to implement and follow the care plan. 2. Resident 3 was admitted to the facility in 7/2023 with diagnoses including dementia and stroke. Resident 3’s 7/2/25 care plan revealed she/he was a fall risk with interventions including placement of a fall mat when she/he was in bed. On 7/23/25 at 3:22 PM and 7/25/25 at 9:51 AM, Resident 3 was observed in bed sleeping with no fall mat on the floor. On 7/25/25 at 10:12 AM, Staff 11 (CNA) was not sure of the fall interventions for Resident 3. On 7/25/25 at 10:17 AM, Staff 13 (CNA) acknowledged Resident 3 was a fall risk but did not know about her/his fall interventions. On 7/25/25 at 10:38 AM, Staff 3 (Resident Care Manager-LPN) stated Resident 3 was a fall risk, had a history of falling, and expected CNA staff to place a fall mat by Resident 3’s bed when she/he was in bed. Staff 3 observed Resident 3 in bed and acknowledged the absence of a fall mat on the floor and was unable to locate a fall mat in Resident 3's room.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide care planned interventions to prevent falls for 1 of 4 sampled residents (#48) reviewed for falls. This placed residents at risk for injury from falls. Findings include:Resident 48 admitted on 1/2025 with diagnoses including fibromyalgia (health condition which causes pain and tenderness throughout the body).The Quarterly MDS dated [DATE] indicated Resident 48 was cognitively impaired and she/he had a history of falls.The Quarterly MDS dated [DATE] indicated Resident 48 used a FWW (front wheel walker) and wheelchair to assist with ambulation.A review of Resident 48's medical record revealed the resident fell on 1/27/25, 5/11/25, 5/20/25 and 6/4/25.The 5/19/25 care plan indicated Resident 48 was to have a call don't fall sign within eyesight of the resident and was to have a FWW.On 7/21/25 at 9:55 AM and 1:03 PM, Resident 48 was observed leaning behind her/his wheelchair and used it to ambulate to the restroom. Resident 48 stated she/he was not offered a FWW to use. Random observations of Resident 48's room from 7/21/25 through 7/24/25 revealed no visual sign in her/his room and no FWW.On 7/24/25 at 1:59 PM, Staff 17 (CNA) stated there used to be a sign in Resident 48's room, but it was not currently posted. The sign was to remind Resident 48 to use her/his call light before getting out of bed. Staff 17 stated Resident 48 pushed her/his wheelchair and used it to ambulate. Staff 17 stated she/he was not given a FWW. On 7/25/25 at 10:14 AM, Staff 18 (CNA) stated there was no sign in Resident 48's room to remind the resident to utilize her/his call light prior to getting out of bed.On 7/25/25 at 10:38 AM, Staff 5 (LPN) stated Resident 48 walked behind the wheelchair to ambulate. Staff 5 stated she/he was not offered a FWW.On 7/25/25 at 10:44 AM, Staff 3 (Resident Care Manager- LPN) acknowledged the care plan indicated there was supposed to be a sign to remind Resident 48 to utilize the call light prior to getting out of bed. Staff 3 stated Resident 48 used a FWW to ambulate and was unaware Resident 48 used her/his wheelchair to ambulate.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to ensure RN coverage for 8 consecutive hours 7 days per week for 8 of 62 days reviewed for staffing. This placed residents at risk for lack of care. Findings include: A review of the Direct Care Staff Daily Reports for 7/1/24 through 7/31/24 and 6/19/25 through 7/24/25 revealed there were eight days without eight consecutive hours of registered nurse coverage on any shift in a 24 hour period:-7/7/24-7/13/24-7/14/24-7/21/24-7/22/24-7/28/24-7/29/24-7/13/25On 7/25/25 at 9:12 AM Staff 16 (Staffing Coordinator) acknowledged the facility did not have adequate RN coverage on the above dates and understood the need to staff the facility with an RN in order to provide residents with care and assessments they needed. On 7/25/25 9:44 AM Staff 1 (Administrator) stated she expected the facility to be staffed appropriately with RN coverage to ensure residents received appropriate care and services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review it was determined the facility failed to ensure a medication administration error rate of less than 5%. There were three errors in 25 opportunities resulting in a 12% error rate. This placed residents at risk for reduced medication efficacy and adverse medication side effects. Findings include: The 2019 Insulin Lispro Solostar Pen Manufacturer Instructions for Use and the 2022 How to Use Lantus Pen Manufacturer Instructions specified the following:- to inject your dose, clean site with an alcohol swab, keep the pen straight, insert the needle into your skin, use the thumb to press the injection button all the way down. When the number in the dose window returns to zero as you inject, slowly count to 10 before removing (counting to 10 will makes sure residents received the full insulin dose), release the button and remove the needle from your skin.The facility's 3/2025 Insulin Administration Policy specified the following:-Depress the plunger and remove the needle after approximately five seconds.The 2024 What Happens If I Take CREON Without Food Manufacturer Instructions specified the following:-Creon needs to be taken with every meal and snack to work as expected. The digestive enzymes in CREON need to mix with food and enter the stomach and the small intestine at the same time.The facility's 4/2019 Administering Medications Policy specified the following:- Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).1.Resident 3 was admitted to the facility in 2/2024 with diagnoses including type 2 diabetes mellitus (impaired insulin production).Resident 3's 7/2025 MAR included the following:- Insulin lispro injection solution, inject five units subcutaneously with meals.- Insulin glargine solution pen-injector, inject 46 units subcutaneously in the morning.On 7/23/25 at 7:36 AM, Staff 8 (LPN) was observed during Resident 3 and 52's medication administration. Staff 8 prepared five units of lispro insulin and injected Resident 3's arm and immediately removed the needle from the skin. Staff 8 did not perform the safety steps as indicated in the manufacturer's instructions.On 7/25/25 at 11:25 AM, Staff 2 (DNS) was informed about Resident 3 insulin administration and the improper use of the insulin pens, which were not held for 10 seconds before needle removal from the resident's skin, and the safety steps were not followed prior to administration. Staff 2 stated she expected staff to follow the safety steps for administering insulin. 2. Resident 52 was admitted to the facility in 12/2022 with diagnoses including type 2 diabetes mellitus (impaired insulin production).Resident 52's 7/2025 MAR included the following:- Insulin glargine solution pen-injector, inject 19 units subcutaneously two times a day.On 7/23/25 at 7:36 AM, Staff 8 (LPN) was observed during Resident 52's medication administration. Staff 8 prepared 19 units of glargine insulin and injected Resident 52's arm and immediately removed the needle from the skin. Staff 8 did not perform the safety steps as indicated in the manufacturer's instructions.On 7/25/25 at 11:25 AM, Staff 2 (DNS) was informed about Resident 52's insulin administration and the improper use of the insulin pens, which were not held for 10 seconds before needle removal from the resident's skin, and the safety steps were not followed prior to administration. Staff 2 stated she expected staff to follow the safety steps for administering insulin. 3. Resident 60 admitted to the facility in 11/2024 with diagnoses including type 2 diabetes mellitus (impaired insulin production).Resident 60's 7/2025 Physician Orders included the following:- Creon delayed release capsule, give one capsule by mouth with meals for digestion.On 7/24/25 at 11:48 AM, Staff 19 (CMA) was observed during Resident 60's medication administration. Staff 19 administered the scheduled medication without offering a snack or meal, and no food was observed in the resident's room. Staff 19 stated it was difficult to coordinate scheduled medications with meals or when meal trays arrived. She mentioned having one hour before and after the scheduled medication times to administer medications.On 7/25/25 at 11:25 AM, Staff 2 (DNS) was informed about Resident 60's Creon not administered with a snack or meal. Staff 2 stated she expected staff to implement and follow physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure medication storage was free from expired biologicals for 1 of 1 medication rooms and treatment carts were locked and secured appropriately for 2 of 2 treatment carts observed (West Hall and East Hall) during random observations for medication and treatment cart storage and medication rooms. This placed residents at risk for unsafe access to stored medications and diminished treatment efficacy. Findings include:The facility's 11/2020 Storage of Medications Policy specified the following: - Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 1.On [DATE] at 11:15 AM, one open, vial of tuberculin (used for the testing in the diagnosis of Tuberculosis) dated [DATE] was observed inside the refrigerator located in the medication storage room. On [DATE] at 11:35 PM, Staff 2 (DNS) acknowledged the vial of tuberculin was expired and expected staff to discard tuberculin vial within 30 days of opening. 2. On [DATE] at 8:19 AM, the East Hall treatment cart was unlocked. Staff and residents were observed to be walking by the treatment cart. On [DATE] at 8:32 AM, Staff 4 (LPN) acknowledged the unlocked treatment cart. The contents inside of the cart included insulin, insulin pens, needles, and resident prescribed oral medications. Staff 4 stated he was supposed to lock the treatment cart before walking away from the treatment cart.3. On [DATE] at 8:30 AM, the [NAME] Hall treatment cart was unlocked. The treatment cart contained insulin supplies, dressings, creams, and resident tube feeding medications. On [DATE] at 8:38 AM, Staff 6 (RN) stated the [NAME] Hall treatment cart was supposed to locked when unattended. On [DATE] at 10:15 AM, Staff 2 (DNS) stated she expected medication and treatment carts to be locked when staff were not in view of them.4. On [DATE] at 12:27 PM, the East Hall treatment cart was unlocked. The contents in the cart included insulin, insulin pens, needles, lubricants, and resident prescribed oral medications. Residents and staff were observed walking past the unlocked treatment cart. On [DATE] at 12:43 PM, Staff 5 (LPN) and Staff 2 (DNS) acknowledged the East Hall treatment cart was unlocked. Both stated treatment carts should not be unlocked when left unattended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to perform hand hygiene for 1 of 1 sampled resident (#11) reviewed for wound care. This placed residents at an increased risk of infected wounds. Findings include:Resident 11 was admitted to the facility in 2025 with diagnoses including quadriplegia (partial or complete paralysis of all four limbs).The 2024 CDC Clinical Safety: Hand Hygiene for Health care workers specified the following:-Clean your hands immediately after glove removal to prevent the spread of germs and potential infections.A review of Resident 11's Quarterly MDS dated [DATE] indicated the resident was admitted with four pressure ulcers.A review of Resident 11's Annual MDS dated [DATE] indicated the resident acquired an in-facility pressure ulcer.A review of Resident 11's 7/2025 MAR indicated daily wound care to the sacrum (a bone at the base of the spine) and the right ischium (a bone forming the lower and back part of the hip bone) pressure ulcers.On 7/23/25 at 11:01 AM, During wound care to the ischium wound, Staff 8 (LPN) was observed to perform peri-care, removed gloves and donned new gloves. Staff 8 proceeded to cleanse wound, removed gloves and donned new gloves. Staff 8 proceeded to apply dressing, removed gloves and donned new gloves. No hand hygiene was observed in between donning and doffing of gloves.On 7/23/25 at 11:10 AM, During wound care to the sacral wound, Staff 8 was observed to cleanse wound, removed gloves and donned new gloves. No hand hygiene was observed in between donning and doffing of gloves.On 7/23/25 at 11:15 AM, Staff 8 stated he performed hand hygiene before and after care the wound care treatments. He acknowledged the lack of hand hygiene after removing gloves during wound care. On 7/25/25 at 11:25 AM, Staff 2 (DNS) stated she expected staff to perform hand hygiene after removal of gloves when performing wound care.