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	08/25/2022

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on interview and record review it was determined the facility failed to ensure Staff 11 (CNA) followed professional standards of practice regarding the dietary needs for 1 of 3 sampled residents (#500) reviewed for accidents. This resulted in Resident 500 eating solid food and she/he choked, which resulted in her/his death in the facility. The facility identified the noncompliance and immediately initiated a plan of correction which resulted in disciplinary action and additional care plan training with instructions to follow the resident's care plan for all staff who provided care. This incident was identified as meeting the criteria for past noncompliance. Findings include: Oregon Board of Nursing Rule [DATE] Authorized Duties and Standards for Certified Nursing Assistant 1 (6) Standards of Care for Certified Nursing Assistants. In the process of client care the CNA shall consistently: (d) Follow the care plan as directed by the licensed nurse Oregon Board of Nursing Rule [DATE] Conduct Unbecoming a Nursing Assistant A CNA, regardless of job location, responsibilities, or use of the title CNA, whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to: 2) Conduct related to achieving and maintaining clinical competency: (a) Failing to conform to the essential standards of acceptable and prevailing nursing assistant performance of duties. Actual injury need not be established. Resident 500 was admitted to the facility on [DATE] with diagnoses including Dysphagia (difficult to swallow) and dementia. (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 0658 Level of Harm - Actual harm Residents Affected - Few	Resident 500's MDS Quarterly dated [DATE] revealed a BIMS score of 3, indicating severe cognitive impairment. The dietary assessment dated [DATE] revealed Resident 500 was prescribed a mechanically altered diet which consisted of pureed foods and thickened liquids. She/he was edentulous (no teeth) and was dependent on staff for eating and supervision. A document titled Gracelen Terrace CNA/NA Standards of Care detailed expectations for resident care and safety, including to follow resident care plans. The document was signed by Staff 11 on [DATE]. An [DATE] at 9:45 AM progress note by Staff 5 (RN) revealed on [DATE] around 8:55 PM she overheard other staff say call the nurse, stood up and observed Resident 500 in her/his wheelchair choking. Staff 5 was informed the resident choked on a regular textured sandwich given to her/him by Staff 11. Staff 5 immediately began abdominal thrusts and instructed staff to call 911. 911 was called on [DATE] at 8:57 PM. A CNA assisted Staff 5 with back blows to Resident 500 and continued with abdominal thrusts. Resident 500 was unresponsive, placed on the floor and her/his airway was cleared. CPR was initiated and food particles came out of the resident's mouth. Emergency personnel on the phone continued to give instructions and CPR was continued until EMTs (Emergency Medical Technicians) arrived at 9:08 PM but Resident 500 did not regain a pulse. EMT's called the resident's time of death at 9:11 PM. The facility's [DATE] investigation summary and revealed the root cause of Resident 500's death was the care plan was not followed by Staff 11. Staff 11 made sandwiches for several residents and did not review food textures for Resident 500 or other residents prior to handing out the sandwiches. Resident 500 was given a sandwich by Staff 11, who left the resident unsupervised. Staff 11 was immediately counseled and placed on administrative leave following the incident. A statement written and signed by Staff 6 (Staffing Coordinator) on [DATE] revealed on Monday, [DATE] she met with Staff 11 at the facility to do orientation which included a review of CNA/NA standards of care, Kardex (plan of care), the one page care plan location and the master copy of the diet textures location. On [DATE] at 12:22 PM Staff 6 stated she was responsible for hiring and scheduling CNAs. Newly hired and agency staff were given orientation by Staff 6. Staff 6 revealed Staff 11 was agency staff from another state (Texas) and reported to the facility on [DATE]. He filled out paperwork, was given access to the electronic medical record, given CNA standards of care, shown how to access the Kardex and other basic information. Staff 6 revealed Staff 11 read and signed the standards of care form. On [DATE] at 10:42 AM Staff 11 stated he met with Staff 6 on [DATE]. He revealed Staff 6 gave him the paperwork with CNA duties, asked him if he knew how to access Kardex and the electronic medical records which he confirmed he knew. Staff 11 confirmed he made sandwiches on [DATE] and gave a sandwich to Resident 500. He went to another hall and upon return observed Resident 500 on the floor and observed staff performing CPR on Resident 500. Staff 11 confirmed he did not check anyone's care plan that night for diet textures, including Resident 500. On [DATE] at 1:15 PM, Staff 1 (Administrator) confirmed it was an expectation that facility staff reviewed resident care plans. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	The situation met the criteria for past noncompliance as follows: 1. The incident indicated noncompliance for F689. 2. The noncompliance occurred after the exit date of the last standard recertification survey [DATE] and before the date of this survey [DATE]. 3. There was sufficient evidence the facility corrected the noncompliance and was in substantial compliance with F689 as evidenced by: - No deficient practice was found at F689 with additional sampled residents. - Evidence the deficient practice was identified by the facility; the facility took immediate action to immediately suspend, counsel the staff responsible, trained all staff for care plan implementation and diet texture. The Diet Textures training material was signed by 38 staff and indicated the training was completed by [DATE]. - Staff 1 confirmed Staff 11 will never be allowed to work in the facility and had not worked in facility since immediately following the [DATE] incident. Refer to F689

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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 0689 Level of Harm - 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** 38140 Based on interview and record review it was determined the facility failed to ensure physician orders and care planned interventions were followed for 1 of 3 sampled residents (#500) reviewed for dietary services. As a result of facility staff not following the care planned interventions related to diet textures, Resident 500 choked which resulted in her/his death. The facility identified the noncompliance and immediately initiated a plan of correction which resulted in disciplinary action and additional care plan training with instructions to follow the resident's care plan for all staff who provided care. This incident was identified as meeting the criteria for past noncompliance. Findings include: Resident 500 admitted to the facility in 2013 with diagnoses including dementia and dysphasia (difficult speech). A [DATE] physician order directed Resident 500 to be given a regular diet, pureed texture with liquid consistency at mildly thick nectar. The [DATE] Dietary Assessment by Staff 13 (RD) indicated Resident 500 needed a puree diet texture. Resident 500 did not have any reports she/he choked, pocketed food (held in mouth) or any reported swallowing difficulty. The [DATE] Quarterly MDS identified Resident 500 BIMS score of 3 (severe cognitive impairment), required a mechanically altered diet and was totally dependent for eating with one person assistance. Resident 500's [DATE] care plan identified her/him as an aspiration risk (food or liquid may enter airway) and directed staff to provide pureed texture for food. An [DATE] at 9:45 AM progress note by Staff 5 (RN) revealed on [DATE] around 8:55 PM she overheard people in the hall say call the nurse call the nurse. She immediately stood up and saw Resident 500 in the hall in her/his wheelchair choking. Staff 5 was informed the resident choked on a regular textured sandwich given to her/him by Staff 11 (CNA). Staff 5 immediately began abdominal thrusts and yelled to call 911. 911 was called on [DATE] at 8:57 PM. A CNA assisted her, and five back blows were given and abdominal thrusts continued. Resident 500 was unresponsive and was placed on the floor, the airway was cleared, CPR was initiated, food particles came out of the resident's mouth, emergency personnel on the phone gave instructions and CPR continued. No pulse was able to be attained on Resident 500, the crash cart was brought by a LPN with the connected defibrillator (provides electric thrust to restart the heart), instructions were given from the defibrillator to continue CPR shock to be given at that time. Staff 5 continued CPR, then Staff 7 (CNA) took over and continued CPR until EMS (Emergency Medical Services) arrived at 9:08 PM. EMS stopped the CPR for Resident 500. Resident 500 had no heart rate and the time of death was called on [DATE] at 9:11 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An [DATE] Incident Review/Summary progress note by Staff 3 (RNCM) summarized her investigation for the root cause of Resident 500's death was the care plan was not followed and Resident 500 was given a regular textured meat sandwich when she/he was to only have pureed texture. Resident 500 choked on the sandwich and was unable to cough, speak or call out for help due to the sandwich texture which prevented air to pass in the throat. Staff tried to intervene but were unable to dislodge the food. Staff 3, MD (Doctor of Medicine), and ARNP (Advanced Registered Nurse Practitioner) discussed Resident 500's comorbidities on [DATE] and [DATE]. The MD and ARNP agreed Resident 500's death would be documented as Accidental. On [DATE] at 12:22 PM Staff 6 (Staffing Coordinator) stated she was responsible for hiring and scheduling CNAs. New hires or agency staff were given orientation to the facility by Staff 6. Staff 6 revealed Staff 11 was an agency staff and started work at the facility on [DATE]. He completed paperwork, was given access to the electronic medical record, given CNA standards of care, shown how to access the Kardex (care plan) and other basic information. Staff 6 revealed Staff 11 read and signed the standards of care form and was given a tour of the facility. On [DATE] at 1:00 PM Staff 5 confirmed the accuracy of her progress note written on [DATE]. On [DATE] at 3:27 PM Staff 7 (CNA) stated he was working the evening of [DATE]. He was outside a resident's room and heard another staff say his name loudly, observed Resident 500 in her/his wheelchair and a staff member giving her/him the Heimlich Maneuver (abdominal thrusts). Staff 7 picked Resident 500 up and began the Heimlich Maneuver. Staff 7 said to get the nurse and Staff 5 came over, told the staff to lie Resident 500 on the floor and started CPR. Staff 7 and Staff 5 rolled the resident over and swept out her/his mouth and observed pieces of the sandwich in her/his mouth. Staff 7 revealed the CPR was stopped when paramedics arrived and the time of death was called by EMTs. Staff 7 recalled Staff 11 gave out sandwiches to residents earlier in the night. Staff 7 observed a paper plate with a sandwich with bites missing from the sandwich located next to Resident 500. Staff 7 revealed resident care plans were kept at the nurse's station and on the tablets located in resident hallways. On [DATE] at 5:17 PM Staff 10 (Housekeeping) stated he was working in the hall where Resident 500 was seated in her/his wheelchair. The first time Resident 500 was observed, she/he did not have a sandwich. When Staff 10 returned a few minutes later, he observed Resident 500 to eat the regular textured sandwich with a couple of bites taken out of it. Staff 10 gave the resident a napkin, turned around and a couple of seconds later heard Resident 500 cough. Another housekeeping staff said the resident might be choking and Staff 10 revealed Resident 500 looked as if she/he were trying to spit the food out. One of the agency CNAs said to get the nurse, and Staff 10 stated he did at that time. Staff 10 revealed he was unaware of Resident 500's dietary needs as he worked in housekeeping. On [DATE] at 10:42 AM Staff 11 stated he worked the evening shift on [DATE]. Staff 11 revealed a resident wanted a sandwich and he made sandwiches for everyone. Staff 11 confirmed he gave a regular textured sandwich to Resident 500. He went to another hall and upon return he observed Resident 500 on the floor and staff performing CPR. He ran down the hall and asked what was going on. Another staff said someone gave her/him a sandwich and Staff 11 told them he gave Resident 500 the sandwich. Staff 11 revealed he saw Resident 500 with a sandwich before at least twice and other staff said they also saw the resident with sandwiches before [DATE]. Staff 11 revealed he was assigned the room where the resident resided but did not have Resident 500 on his roster. Staff 11 confirmed he did not check anyone's care plan that night, including Resident 500's. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:32 PM Staff 12 (CNA) stated she worked the evening shift on [DATE]. She revealed after she saw Resident 500 on the floor, she asked Staff 11 what happened and he told her he gave Resident 500 a sandwich. Staff 12 asked Staff 11 why he gave a sandwich to Resident 500 because she/he was on a pureed diet. Staff 11 told her he didn't know that and nobody told him. Staff 12 revealed she never observed Resident 500 to eat sandwiches prior to [DATE] and nobody else who was present during the incident told her they observed Resident 500 eat regular textured sandwiches prior to [DATE]. On [DATE] at 1:15 PM Staff 3 (RNCM) stated Resident 500 required extensive assist with dressing, transfers and needed supervision to eat to ensure Resident 500 would eat. She confirmed Resident 500 had been requiring eating assistance for several years. Staff 3 revealed she did not heard from staff Resident 500 was given solid food prior to [DATE]. On [DATE] at 1:15 PM Staff 2 (DNS) stated new or agency CNAs were always given orientation to meet resident needs. She confirmed Staff 11 was given orientation when he started working at the facility, and it was an expectation staff would review and follow the resident care plans. On [DATE] at 1:15 PM Staff 1 (Administrator) confirmed it was an expectation facility staff reviewed and followed the resident care plans. On [DATE] at 1:15 PM Staff 3 confirmed Staff 11 did not follow Resident 500's care plan on [DATE]. Staff 3 revealed the facility immediately took steps to counsel and suspend Staff 11. In addition, all staff attended a training on care plans and diet texture, which was completed on [DATE]. On [DATE] and [DATE] Staff 3, Staff 4 (RNCM), Staff 5, Staff 7, Staff 8, Staff 9, and Staff 12 were interviewed and all expressed the standard of care was to review the care plan before they provided care, which included diet textures, for the residents. The situation met the criteria for past noncompliance as follows: 1. The incident indicated noncompliance for F689. 2. The noncompliance occurred after the exit date of the last standard recertification survey [DATE] and before the date of this survey [DATE]. 3. There was sufficient evidence the facility corrected the noncompliance and was in substantial compliance with F689 as evidenced by: - No deficient practice was found at F689 with additional sampled residents. - Evidence the deficient practice was identified by the facility; the facility took immediate action to immediately suspend, counsel the staff responsible, trained all staff for care plan implementation and diet texture. The Diet Textures training material was signed by 38 staff and indicated the training was completed by [DATE]. - New forms were developed and/or revised for communication of diet textures, new signage was posted for resident diets and a training at the CNA meeting for diet textures and instruction to follow the care plan was completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- DNS, RNCM, and CNA interviews indicated knowledge and awareness of diet textures and expectations to follow residents care plans.