STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385133	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairlawn Health and Rehab of Cascadia	3457 NE Division Street Gresham, OR 97030

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to ensure food was labeled and stored in a manner to avoid spoilage in 2 of 2 kitchens and failed to properly follow dish sanitizing practices and sanitization of food preparation surfaces for 1 of 2 kitchens. This placed residents at risk for food-borne illnesses. Findings include:Review of the US FDA 2022 Food Code indicated the following:-Food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded.-Food must be labeled with a use-by-date if stored for at least 24 hours.-Food could be stored up to seven days.The facility's Food Safety and Storage policy, dated 11/28/2017, indicated the facility stored and handled all food, non-food items and food preparation supplies in a manner that ensured safety, sanitation and compliance with federal, state and local regulations. Practices followed the FDA Food Code (2022). 1. On 3/23/26 between the hours of 9:33 AM and 9:59 AM, a brief tour was completed of both facility kitchens, accompanied by Staff 3 (Dietary Manager) which revealed the following: Freezer in first kitchen: -three open cartons of ice cream were undated.-five popsicles were undated.-1/4 of an angel food cake in a plastic bag was undated. Walk-in refrigerator in second kitchen: -two pans of previously roasted potatoes, dated 3/17/26, were outdated. -one plastic container of broccoli-cheese soup, dated 3/17/26, was outdated. -one large bag of shredded lettuce was wilted. -two, five-pound bags of white cheese were undated. -three, five-pound bags of yellow cheese were undated. Standing refrigerator in second kitchen: -one opened jar of Cesar dressing was undated. -one pitcher of apple juice had a use-by-date of 3/14/26. -one pitcher of iced tea was undated. -one partial pitcher of orange juice was undated. -one opened 12-ounce container of horseradish was undated. Walk-in freezer in second kitchen: -two dozen unbaked biscuit squares in a plastic bag were undated. -one bag of curly fries was dated 12/2025. On 3/23/26 at 9:33 AM and 9:59 AM, Staff 3 confirmed the above items were either undated or expired. Staff 3 stated all items should be dated and any items out-of-date should have been discarded. 2. On 3/26/26 at 9:40 AM, a load of freshly washed and sanitized dishes and trays was observed in the dishwasher. Staff 5 (Dietary Aide) tested the sanitizer level by obtaining a test strip located on the wall and dipped the test strip in the residual water in the dishwasher. The test strip was removed and revealed a white color. Staff 5 then completed a second test which, again, revealed a white color. The white color indicated there were 10 or less parts per million of sanitizer which was less than the required minimum concentration of available sanitizer needed for properly sanitized dishware. Staff 5 then tested the red bucket containing sanitized water used to clean the steam table and food preparation counters. She dipped a test strip into the water which indicated 0 parts per million of sanitizer and stated the water did not meet the required sanitizing requirements. On 3/26/26 at 12:49 PM, Witness 1 (Vendor representative) stated the dishwasher's sanitizing dispenser was not functioning properly and he was unable to determine how long the sanitizing system had not been working. Staff 5 and Staff 6 (Prep Cook) stated they did not test the dishwasher sanitizer prior to washing dishes. Staff 3 stated the dishwasher sanitizing system should be tested prior to starting dishwashing and the sanitizer for the dishwasher and sanitizing buckets did not meet the required sanitizing levels. Staff 3 stated she retested the dishwasher's sanitizing system prior to Witness 1 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	arriving, and the sanitizer tested a white color which confirmed the system was not properly sanitizing dishes and dishware.On 3/27/26 at 10:00 AM, Staff 4 (Assistant Dietary Manager) verified the red bucket sanitization water should test at 200 to 400 parts per million of sanitizer and the dishwasher should test at 75 to 200 parts per million for effective sanitization.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 follow infection control precautions for 2 of 3 sampled hallways (north hall and west hall) reviewed for infection control. This placed the residents at risk of acquiring an infection. Findings include:According to the Center for Disease Control and Prevention (CDC) website https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html: -Use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission. -Use personal protective equipment (PPE) appropriately, including gloves and gowns. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. According to the Centers for Disease Control and Prevention (CDC)'s 6/2021 Consideration for Use of Enhanced Barrier Precautions (EBP) (protective measures taken by nursing home staff for residents with specific germs or medical devices) in Skilled Nursing Facilities (https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html) - EBP is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of multidrug-resistant pathogens. - EBP was recommended for residents with wounds or indwelling medical devices. a. On 3/23/26 at 10:20 AM and 3/24/26 at 12:29 PM, Staff 7 (RN) entered room [ROOM NUMBER], which was on Contact Precautions. Prior to entering the room, Staff 7 did not don PPE. A CDC Contact Precautions sign was prominently displayed on the outside wall, next to the room door with large black letters indicating: NO ENTRY WITHOUT PPE. The sign indicated staff and visitors were to put on a gown and gloves before room entry and discard the gown and gloves before exiting the room. On 3/23/26 at 10:20 AM and 3/24/26 at 12:29 AM, Staff 7 stated individuals were allowed to enter room [ROOM NUMBER] without PPE as long as no care was being provided to the residents. Staff 7 stated no resident in room [ROOM NUMBER] was on contact precautions and he was unsure why a contact precautions sign was posted. On 3/24/26 at 12:31 PM, Staff 10 (CNA) stated lots of people were confused regarding the PPE requirements for room [ROOM NUMBER]. On 3/25/26 at 9:54 AM, Staff 9 (Infection Preventionist) confirmed staff and visitors entering room [ROOM NUMBER] were required to wear PPE because a resident in the room was diagnosed with MRSA (a bacterium responsible for severe infections and resistant to many antibiotics) thus contact precautions were required. Staff 9 stated PPE was required upon entering room [ROOM NUMBER] for any reason. b. On 3/23/26 at 9:59 AM room [ROOM NUMBER] was observed to have a CDC EBP sign attached to the wall outside of the room listing glove and gown use were required with high contact cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/23/26 at 9:59 AM, 3/24/26 at 8:53 AM, 3/24/26 at 12:24 PM, 3/24/25 at 12:35 PM, and 3/24/25 at 1:43 PM facility staff were observed to have provided high contact care to the residents in room [ROOM NUMBER]. On 3/24/26 at 1:30 PM Staff 11 (CNA) confirmed she had not worn a gown because she did not know she was supposed to wear one. Staff 11 confirmed there was a sign posted outside of the room but had not noticed it. On 3/24/26 at 1:46 PM Staff 12 (Restorative Aide) confirmed she had not worn a gown because she did not believe the resident was on EBP. On 3/24/26 at 3:37 PM Staff 13 (LPN Care Manager) stated PPE would only be needed if the staff was working directly with the gastrostomy tube or wound but after reviewing the CCD EBP sign, she confirmed PPE would be required when providing all high contact care, not just when providing care with the indwelling medical device or wound. On 3/25/26 at 3:42 PM Staff 9 (Infection Preventionist/LPN) confirmed staff were required to wear PPE as outlined on the signage posted outside of the room when providing high contract cares since the residents in this room had an indwelling medical device and wounds. c. On 3/26/26 at 10:05 AM Staff 15 (CNA) was observed in room [ROOM NUMBER] assisting a resident with compression stocking and sock donning for both lower extremities while wearing only gloves. A sign directly outside room [ROOM NUMBER] indicated enhanced barrier precautions (EBP) were to be followed when direct contact care was provided including dressing. On 3/26/26 at 10:09 AM Staff 15 stated she provided lower body dressing care for the resident in room [ROOM NUMBER] without a gown. Staff 15 stated she was instructed to wear a gown only when she cleaned and touched an area near a wound or opening for a resident on EBP. Staff 15 stated gloves were all that were required when other direct contact care was provided. On 3/26/26 at 10:22 AM Staff 9 (Infection Preventionist/LPN) confirmed EBP were to be followed when any direct contact care was provided to the resident in room [ROOM NUMBER], including socks and compression stockings donning.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure the resident meals were served at an appetizing temperature in hallways for 1 of 1 facility reviewed for food. This placed residents at risk for inadequate nutritional intake. Findings include:Review of the 12/2025, 1/2026 and 2/2026 Resident Council meeting notes revealed the Resident Council expressed food concerns including hot food served cold.Resident 36 was admitted to the facility in 2/2026 with a diagnoses including sepsis (body's extreme response to an infection damaging tissue and organs) and nutritional deficiency.A 2/12/26 admission MDS assessed Resident 36 as cognitively intact. Resident 69 was admitted to the facility in 3/2026 with a diagnoses including occlusion and stenosis of the left posterior cerebral artery (condition where the main vessel supplies blood to the brain).A 3/9/25 admission MDS assessed Resident 69 as cognitively intact.Resident 90 was admitted to the facility 3/2026 with a diagnoses including a fractured tibia (shinbone).A 3/18/26 admission MDS assessed Resident 90 as cognitively intact.On 3/23/26 at 11:17 AM Resident 36 expressed concerns that her/his food was always served cold.On 3/23/26 at 11:52 AM Resident 69 stated her/his food was delivered cold. On 3/25/26 at 12:54 PM Staff 16 (CNA) stated the resident plates were often served without plate warmers and she usually needed to re-heat the meals for residents.On 3/26/26 at 8:32 AM Resident 90's tray was observed to be delivered to her/his room with no plate warmer.On 3/26/26 at 8:34 AM observation of Resident 36's food was delivered to her/his room with no plate warmer. Resident 36 stated her/his food was cold. Resident 36 was observed to request a CNA to re-heat the food.On 3/26/26 at 8:50 AM Resident 90 stated the meal plate was delivered without a plate warmer and the food was often served cold.On 3/25/26 at 12:54 PM Staff 16 (CNA) stated the residents' food was often cold, plates were often served without plate warmers and she usually needed to re-heat the meals for residents.On 3/26/26 at 10:02 AM Staff 6 (Prep Cook) stated the facility used the plate warmers to ensure residents were served meals at appetizing temperatures in the hallways. Staff 6 confirmed the kitchen did not have enough plate warmers to serve all the residents in the hallways.On 3/26/26 at 10:07 AM Staff 3 (Dietary Manager) acknowledged the kitchen used plate warmers to keep the residents' meals at an appetizing temperature when served in the hallways. Staff 3 stated she was unaware the kitchen did not have enough plate warmers to serve all the residents in the hallways. On 3/26/26 at 3:51 PM Staff 1 (Administrator) acknowledged she expected the residents to be served meals at an appetizing temperature and she was unaware the facility did not have enough to provide each resident with plate warmers at meals.